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Ministry of Health & Family Welfare, Government of India
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Factors Influencing The Performance Of Targeted Interventions Among

DIAGNOSTIC STUDY

Project Hifazat: Strengthen the Capacity, Reach and Quality of IDU Harm Reduction Serives

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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 Program.

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Preface

In India, Targeted Intervention (TI), under the National AIDS Control Program (NACP) framework, is one of the core strategies for HIV prevention amongst Injecting Drug Users (IDUs). Apart from providing primary health services that include health education, abscess management, treatment referrals, etc., the TIs are also designated centres for providing harm reduction services such as Needle Syringe Exchange Program (NSEP) and Opioid Substitution Therapy (OST). The services under the TIs are executed through peer-based outreach, as well as, a static premise-based approach, that is, through Drop-In Centres (DIC) which in turn serves as the nodal hub for all the above activities to be executed.

To further strengthen these established mechanisms under the NACP and to further expand the reach to vulnerable IDUs, 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 (also called Project HIFAZAT), amongst others. In doing so, UNODC supports NACO through technical assistance for undertaking the following:

1) Conduct Operational Research
2) Develop Quality assurance SOPs
3) Develop Capacity Building / Training materials
4) Training of Master Trainers

It is in this context that a diagnostic study on the factors influencing the performance of IDU TIs in India has been conducted. The study aims to examine the gaps in the performance of IDU TIs in terms of service provision, outreach, access to DIC services, referrals and linkages and other performance-related issues, and ascertain the reasons for the gaps in performance.

This study therefore, has been conducted with a vision to serve as an invaluable tool for improving the performance of the IDU TI's in India to enable them to deliver quality services. 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 towards articulating and consolidating the study.

Acknowledgement

The UN office on Drugs and Crime, Regional Office for South Asia (UNODC ROSA), in partnership with national government counterparts from the drugs and HIV sectors and leading non-governmental organisations (NGOs) 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), which aims to strengthen the capacities, reach and quality of harm reduction among IDUs in India. It also involves providing support for scaling up of services for IDUs through the National AIDS Control Program.

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 towards the development of this document. Acknowledgements are also due to the NGOs implementing IDU TIs, STRCs, TSUs, SACS and NERO who participated in the study.

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

Contents

Abbreviations

AIIMS	All India Institute of Medical Sciences
ANM	Auxiliary Nurse Midwife
BCC	Behaviour Change Communication
CBNA	Capacity Building Needs Assessment
DDAP	Drug De Addiction Program
DIC	Drop-In Centre
DOTS	Daily Observed Treatment Strategy
EHA	Emmanuel Hospital Association
Hep C	Hepatitis C
HIV	Human Immunodeficiency Virus
HRG	High Risk Groups
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug User
IDUs	Injecting Drug Users
M&E	Monitoring and Evaluation
MARP	Most at-risk Population
MOH&FW	Ministry of Health and Family Welfare
MSJE	Ministry of Social Justice and Empowerment
NACO	National AIDS Control Organisation
NACP	National AIDS Control Program
NDDTC	National Drug Dependence Treatment Centre
NDPS Act	Narcotic Drugs and Psychotropic Substances Act
NGO	Non- Governmental Organisation
NSEP	Needle Syringe Exchange Program
OI	Opportunistic Infection
ORW	Outreach worker
OST	Opioid Substitution Therapy
PE	Peer Educator
PEP	Post Exposure Prophylaxis
PM	Project Manager
PMU	Project Management Unit
PO	Project Officer
RRTC	Regional Resource and Training Centre
RTTC	Regional Technical Training Centre
SACS	State AIDS Control Societies
SHGs	Self-Help Groups
STI	Sexually Transmitted Infections
STRC	State Training and Resource Centre
TB	Tuberculosis
TI	Targeted Intervention
TOT	Training of Trainers
TSU	Technical Support Unit
UNODC	United Nations Office on Drugs and Crime

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Executive Summary

Background

Injecting Drug Users (IDUs) are an important group vulnerable to acquiring and transmitting the HIV infection. While the National AIDS Control Organisation (NACO) has responded to HIV among IDUs by establishing and continually scaling up the TIs, there are issues related to the performance of IDU TIs which remain unexplored as yet. There is a need to explore various factors which influence their performance. To address this need, UNODC ROSA commissioned this study to explore factors influencing the performance of IDU TIs (also known as the 'diagnostic' study).

Methodology

This study was conducted with the objectives of:

1) Evaluating the factors associated with performance levels of IDU TIs

2) Providing recommendations for improving their performance

To achieve these objectives a combination of secondary data review and primary data collection was employed in the study. The collection of primary data involved an email survey, as well as, field visits to collect data from a variety of respondents - SACS, STRCs, TSUs, RRTCs and most importantly the IDU TIs. Once the collection was over, the data was triangulated and analysed using largely qualitative data analysis techniques. The findings were used for formulating the conclusion and recommendations.

Findings

Responses were obtained from 17 SACS, 19 TSUs, 15 STRCs, 7 RRTCs and 64 IDU TIs spread throughout the country resulting in response rates ranging from 63% to 100%.

Implementing IDU TIs: Problems and their Solutions

In each of the 20 problem areas explored, SACS officials, TSUs and TIs themselves could identify certain factors which influence the performance and also offered some important suggestions and solutions. Many of these problems and solutions were common across different entities surveyed. Frequent turn-over of staff was identified as the result of inadequate salaries. Existing procedures for staff recruitment at TIs were seen as inefficient, making it difficult to recruit and retain appropriate staff. Finding a suitable place to run a DIC is difficult in many states, owing to inadequate budgets and the stigma in the community on drug use issues. Frequent interruption in the supply of needles / syringes and condoms were reported by TIs but not by SACS. Limited capacities of staff were found to be linked to problems with line-listing and planning and conducting outreach. Waste disposal management is problematic in many areas, to address this, TSUs were reportedly assisting the TIs. Existing documentation and reporting formats were seen as too many and too complex for the staff (particularly the PEs) to understand. Absence of any specific guidelines and module or appropriate staff was seen as an impediment for the TIs in reaching out to female partners/spouses of IDUs. Female IDUs and adolescents were too small in number for the program implementers to start thinking about them. Logistic factors (such as distance and problems in commuting) and attitude of other service providers were found to affect referral, linkages and networking. Formation of Self-help Groups (SHGs) remained a non-starter in almost all states. On advocacy issues, the TIs expect government entities (like SACS) to take on a more proactive role.

Both SACS, as well as, TIs appear to appreciate the technical support and mentoring provided by the TSUs. Certain specific tasks were identified, where the POs from the TSUs provide support and training in field, in addition to the classroom training provided by the STRCs.

On the role of STRCs and on the issues related to capacity building, many responses were forthcoming. In general, STRCs have been training the TI staff as per the recommended formats of NACO. However, the TIs perceived the need for more regular trainings, delivered through innovative methods (participatory methods/ local languages) and which include exposure visits as well.

Overall, various suggestions to improve the performance of the IDU TI program, were obtained, which have been summarised below:

Table 1 Suggestions to improve the performance of IDU TI program

1) A Review and Revision of the Budgets
i. To incorporate better salaries for the staff and incentives for the PEs ii. More funds for NSEP / waste management and other TI activities
2) Additional Services in the TIs
i. Detoxification (camp / referral to the centres) ii. Nutrition support iii. Vocational rehabilitation support iv. OST
3) Linkages and Alliances
i. Formal linkages with other welfare schemes like Adhaar, Antodya, BPL and Shelter home. ii. Better linkages with medical and technical colleges iii. A more proactive role by the government to ensure that other sectors (hospitals, police, referral agencies) cooperate with the IDU TIs

4) Improvement in Program Management
i. Less documentation and reporting load ii. Timely release of funds iii. Staff number and type to commensurate with the workload
5) Capacity building
i. Training of staff at all levels ii. Improving the capacities of support structures (SACS / TSU) iii. Exposure visits to other TIs to facilitate cross learning

Conclusion and Recommendations

Crucial factors influencing the performance of IDU TIs (and recommendations to improve the same):

As per the findings of the study, these can be grouped in factors related to the following:

- *Staff: Recruitment, Retention and Capacity Building*
- *Enabling Environment in the Community*
- *Resources and Inputs to the TIs*

Table 2 Recommendations to Improve the Performance

Factor Related to Performance	Recommendations to Improve the Performance
Staff: Recruitment, retention and capacity building	1. Revise the budgets to optimise the salary structure of staff at all levels. 2. Revisit and simplify the staff recruitment procedures at NGO TIs. A more proactive role and support by the SACS is required for recruitment. 3. Review and strengthen the existing capacity building mechanisms. In addition to STRCs, other institutional support for capacity building must be explored. Similarly, the pool of resource persons and resource materials must be expanded. Newer and innovative training techniques must be employed.
Enabling environment in the community	1. Enhancing the capacity of TI staff in conducting advocacy with various stakeholders is important. A more proactive role on the part of SACS has been suggested as a part of advocacy. 2. TIs must be supported in their efforts to improve the access of IDUs to other referral and linkage services. The network of such referral services must be strengthened. Orientation programs aimed at creating IDU friendly services are required. 3. In order to make the service provision as comprehensive as possible, the element of drug treatment must be highlighted in the program. This can be accomplished through strengthening the linkages at the central level with MSJE and the Drug De-Addiction Program (DDAP) of Ministry of Health and Family Welfare (MOH&FW). It would also be necessary to support and encourage the TIs to facilitate access to these treatment services by the IDUs.
Factor Related to Performance	**Recommendations to Improve the Performance**
Resources and inputs to the TIs	1. The budgets for the IDU TI program must be reviewed and optimised. In almost all the budget heads there is a need for an increase. Some amount of flexibility is essential to take into account the unique, local needs of the program. Financial systems should also be streamlined to ensure that the flow of funds and supplies continues uninterruptedly. 2. Existing staff composition must be revisited, particularly the expectation of the same individual to be able to double-up as a nurse/counsellor. This must seriously be reconsidered. Similarly, there should be flexibility in deciding the numbers and ratios of ORWs/PEs/Clients. Female outreach workers are urgently required to address female partners/female IDUs. Similarly, the entire TI staff needs to be oriented and trained on addressing these issues. 3. Human resource development at the TI level, in fact at all the levels in the program must receive due importance. SACS must be involved more proactively in finding and recruiting the staff for IDU TIs. For staff retention, specific, incentive-based strategies may be explored. 4. The capacity building systems require a major over-haul. This must take the form of strengthening the STRCs, finding new institutional mechanisms for capacity building at all program levels (beyond TI staff and including the TSUs and SACS as well), revising the training schedules and curricula and expanding the pool of resource materials and resource persons.

Background and Introduction

It is now well established that IDUs are extremely vulnerable to HIV infection. In fact, among various high-risk groups, currently, HIV prevalence is the highest among IDUs in India, as reported in the sentinel surveillance carried out by NACO. The National AIDS Control Program (NACP) has responded by scaling up the TIs for IDUs. As of mid-2011, about 260 TIs have been established in the country, catering to IDUs exclusively.

These TIs are entrusted with providing a variety of services to the IDUs, including, but not limited to Outreach, Behaviour Change Communication (BCC), Peer Education, Needle Syringe Exchange Program (NSEP), Primary Health Care (PHC), and facilitation of referral to various other services. In addition, about 50 odd TIs also provide Opioid Substitution Treatment (OST) to the IDUs with buprenorphine.

However, there are concerns related to the performance of these IDU TIs. In order to respond effectively to the HIV epidemic (keeping in mind the larger goal of halting and reversing the HIV epidemic), service providers would be required to boost up their performances. NACO has ensured that there are systems in place to periodically monitor and evaluate the performance of IDU TIs. However, the issues of 'why some TIs perform better than the others' and 'what are the factors which influence the performance of IDU TIs' have not been addressed adequately till date.

The Global Fund Round 9 HIV/AIDS activity for IDU has been proposed with an aim of filling gaps in training and capacity building of service providers, as well as program monitors and mentors.

Methodology

Objectives

This study was conducted with the following objectives:

1. *To evaluate the factors associated with performance levels of IDU TIs*
2. *To provide recommendation for improving their performance*

Methodological Approach

To achieve these objectives a combination of following methodological approaches were used in the study.

1. Review of existing (secondary) data: This comprised a review of the existing evaluation reports of IDU TIs.

2. Collection and Analysis of Primary data:

i. A email survey was conducted among various levels of functionaries:
   - Service providers (i.e., IDU TI staff)
   - Capacity building officers (STRCs)
   - Program monitoring staff (TSU/SACS)
   - Additional capacity building mechanisms (RRTCs of MSJE)

ii. Using largely qualitative interview methods, trained interviewers (co-lead consultants) collected data on-field, among various levels of functionaries:
   - Service providers (i.e. IDU TI staff)
   - Capacity building officers (STRCs)
   - Program monitoring staff (TSU/SACS)

Tools for data collection

For primary data collection, a set of semi-structured questionnaires were drafted, specific to each category interviewed. The questionnaires then underwent peer review and after discussion among various stakeholders, were finalised. While the full questionnaires have been added as annexure, a brief outline of questionnaires for all categories of respondents follows:

Table 3 Areas covered in the questionnaire

Entity	Areas covered in the questionnaire
SACS	• Profile of SACS • Capacities of SACS officials in monitoring the IDU TIs and managing the IDU TI program • Various areas of TI functioning: Problems and solutions • Perception of SACS about the capacities of IDU TIs • Opinion of SACS on capacity building of IDU TIs • Opinion of SACS on improving performance of IDU TIs
TSU	• Profile of TSU • Capacities of POs of TSU in monitoring the IDU TIs and providing technical support to IDU TIs in the field • Various areas of TI functioning: Problems and solutions • Perception of TSUs about the capacities of IDU TIs • Opinion of TSUs on capacity building of IDU TIs
STRC	• Profile of STRC • Data on training Programs conducted in the recent past • Profile of Training Officers • Training needs of Training Officers • Opinion of STRCs on existing resource materials • Opinion of STRCs on capacity building of IDU TIs • Opinion of STRCs on functioning of STRC
IDU TI	• Profile of IDU TI • Influence of other activities of the parent organisation on IDU TI work • Profile of staff • Capacities and training needs of staff • Various areas of TI functioning: Problems and solutions • Factors influencing the TI performance • Opinion of TI on STRC • Opinion of TI on capacity building • Opinion of TI on improvement of performance

Regarding various areas of TI functioning, a list was drawn and the respondents were asked to list common problems encountered in that activity and the solutions. These solutions may have been found by them or they might expect these solutions to come from sources or stakeholders. The activities for which the matrix of problems and solutions was prepared for each TI and state (in case of responses from SACS and TSUs) have been listed in the following table:

Table 4 IDU TI Activities

	IDU TI Activities
1.	Staff Turnover
2.	Staff Recruitment
3.	Managing the Infrastructure
4.	Ensuring the Supplies
5.	Training of staff [1]
6.	Line-listing
7.	Outreach planning
8.	Conducting outreach / fieldwork
9.	Maintaining regularity of contact / follow-up of clients
10.	Needle syringe exchange
11.	OST
12.	Documentation and reporting
13.	Reaching out to female partners/spouses of IDUs
14.	Reaching out to special population groups of IDUs (females, adolescents, any other)
15.	Community Mobilisation/ Collectivisation/ Formation of SHGs
16.	Advocacy
17.	Ensuring testing (ICTC) of IDUs
18.	Linkage with ART and ART adherence
19.	Other Referral and linkages
20.	Financial management

Additionally, a matrix was prepared of some factors which may potentially influence the performance of the IDU TI, either positively or negatively. Respondents were asked to explain whether these factors apply to their settings and how they influence the performance. For this purpose, a list of six broad performance areas was drawn and a six potential group of factors which could influence the performance was provided. The table on the next page lists the 'areas of performance' (in the top row) as well as 'group of factors' (in the first column).

It must be noted that the basic unit for data collection was not the *individuals* but the *organisations*. Thus in each of the surveyed entities (i.e. above mentioned categories of organisations), the person who usually takes the lead and is likely to be most informed about the IDU TI program was asked to respond to the questionnaires on behalf of and in consultation with the other staff members of the organisation. It is also worth clarifying that this methodology was *not an evaluation of performance* of various entities surveyed.

Additionally the scope of the study extended to the entire IDU TI program. Thus, all attempts to singularly identify a particular NGO/TI/TSU/STRC/ SACS/State have been deliberately avoided. All the responses have been analysed and coded, so that the identities of the respondents are not disclosed.

[1] *A detailed description of training and many-related issues can also be found in the companion report: Ambekar A (2011), capacity Building Needs Assessment (CBNA) in the context of IDU TIs in India, UNODC ROSA, New Delhi*

Table 5 Areas of TI Functioning/Activities where Performance can be influenced

Areas of TI functioning / Activities in which Performance can be Influenced					
Group of Factors which could influence the performance	**Overall Programme management**	**General medical care of IDU**	**Counselling and Behaviour Change**	**HIV Testing and treatment / Referrals and linkages**	**Working with Female IDUs and Partners of Male IDUs**
Staff (Such as, finding appropriate staff during recruitment, staff attitude and motivation)					
Social/Structural/ Geographical/ Climatic Factors (Such as adverse climate, attitude of general community)					
Capacity / Knowledge Related Factors (Inadequate training)					
Technical / Financial Support systems (such as NACO/ SACS/TSU/STRC/ Parent NGO) (Inadequate/ no timely provision of funds)					
Legal/Law Enforcement Related Factors (Harassment by police or anti-social elements, poor law and order)					
Other Factors (please specify)					

Sample Selection

For both the above methods of data collection, an attempt was made to choose a sample which was as representative as possible. It was ensured – to the extent possible – that various geographical regions of the country are proportionately represented, since different regions and states of the country are in different stages of the IDU-HIV epidemic. Thus, each SACS, STRC and TSU was sent a questionnaire. However since there are a large number of IDU TIs in the country (<250), following approach was adopted to select the sample.

- *In states with five or less IDU TIs, at least two IDU TIs were chosen randomly*
- *In states with more than five IDU TIs, at least 50% IDU TIs were chosen randomly*

Thus, about 106 IDU TIs were sent questionnaires, i.e. around 42% of the total IDU TIs in the country. Among these chosen IDU TIs, about a third was visited from which data was collected by the co-lead consultants using specified data collection tools. The basis for selection of sites for field visits was representativeness in terms of geographical region, intensity of IDU-HIV epidemic, as well as, logistic considerations.

Data Analysis

Once the collection was over, data was triangulated and analysed largely using qualitative data analysis techniques. The various items for which numerical data was available were analysed using descriptive statistical tests. However, most of the data was qualitative in nature. This data was entered in the data-entry formats, was coded for common themes, triangulated and then analysed to summarise the findings. The findings were used for drawing up the conclusion and recommendations.

Findings

Response Rate

The following table presents the response rate across various categories of respondents.

Table 6 Sites contacted

Category	No. of organistions who were approached	No. of organisations from whom responses could be obtained (through email/on-field interviews)	Response rate
SACS	25	17	68%
TSU	20	19	95%
STRC	15	15	100%
RRTC	9	7	78%
IDU TIs	106	64	60%

Thus, we were able to obtain responses from a large majority of the respondents. In case of TIs however, despite best efforts, within the stipulated duration of data collection, responses could be obtained from about 60%. Still, these 64 IDU TIs comprise more than a quarter of IDU TIs in the country.
This section on findings has been organised as follows:

- *Initial responses obtained from each category of the organisation have been summarised*
- *Common issues arising out of triangulation of data collected from various sources has been presented*

Data from the SACS

Profile of SACS

Data was collected from 17 SACS through email interviews, out of which officials from 10 SACS were also personally interviewed. The states represented were:

Table 7 List of stated where SACS were surveyed

Andhra Pradesh	Arunachal	Assam	Bihar	Chandigarh	Delhi	Jharkhand	Kerala	Madhya Pradesh
Meghalaya	Mizoram	Nagaland	Punjab	Rajasthan	Sikkim	Uttar Pradesh	Uttarakhand	

Together these states had a total of 180 functioning IDU TIs. Most states had a rather young IDU program; the mean duration since the first IDU TI became functional in these states was 5.5 years (with a range of 2 to 12 years). Still, it was heartening to note that in most of the states surveyed, the extent of coverage of IDU population ranges between 64% to 100%.

Opinion Of SACS Regarding Problems Faced By The IDU TIs

Problem area # 1: Staff turn-over

Most of the SACS officials surveyed expressed concern over frequent turn-over of staff. In their opinion, this has two important implications. Firstly, it represents a loss of significant investments made in a particular staff with respect to resources and efforts gone in recruitment and training. Secondly, this directly influences the performances of the IDU TIs since old contacts made by the staff are lost and it takes time to establish a rapport between the new staff and the clients. This problem appears to be most pronounced in the case of Peer Educators (PEs) but applies to other categories of staff too. One of the most important reasons cited by the TIs for this is 'inadequate salary structure' particularly as compared to other health programs such as NRHM.

Some innovative solutions attempted in certain states to address the problem of high staff (particularly the PEs) turn-over are:

- Provision of incremental salary using an NGO's own resources
- Maintenance of a district-wise rank list/resource pool for immediate appointment of new staff
- Recruitment of ex IDUs as staff member (with the expectation that they will be more committed to working for IDUs)
- Reward schemes in some cases for high performing staff/PEs (using NGO resources)
- Distributing the PE incentive on a daily basis; this has helped in retaining the PEs

However, an overwhelmingly loud and clear demand/ suggestion from the SACS is: revising the salary structure of the staff at all levels.

Problem area # 2: Staff recruitment

Another related problem area was recruitment of appropriate staff. From their responses, most of the SACS officials appeared dissatisfied with the existing procedures for staff recruitment at TIs. While the selection criteria for TI staff were seen as 'too rigid' by many, some SACS also expressed concern over recruitment of under-qualified staff by the NGOs. Additionally, the funds for staff recruitment are being seen as inadequate which hampers the process of advertisements and consequently attracting the appropriate candidates. Stigma associated with working with drug-using populations was also cited as a reason for which advertisement for a post in the TI does not appear attractive for potential candidates. It was also said that "NGOs generally have the practice of recruiting their relatives as project staff and do not follow the selection guidelines and hence the project suffers (sic)"

Solutions suggested/being practised for these problems are:

- A revision of the budget so that the salaries are made more attractive and there are more funds available for the process of recruitment itself
- Flexible recruitment criteria which would allow an experienced person to be recruited even if under qualified (for example, an experienced PE recruited as an ORW)
- Other than advertisements, personally approaching educational institutions and people known in other areas, are also suggested as methods to explore good candidates
- Centralised staff recruitment (at the state level), where SACS officials will also be part of the selection process. This is suggested as a measure to enhance the efficiency, as well as, to attract a higher number of candidates

Problem area # 3: Managing the infrastructure

There was a concern expressed over the budget for renting out a suitable place for DIC. Additional concern was related to inadequate budgets for furniture. In some cases, additional cost of infrastructure has been managed through NGOs' own contribution. However, as came across from the responses of SACS, inadequate budgets are not the only impediment to hiring a suitable place for DIC. It was also expressed that due to the stigma associated with drug use, "people are not ready to give the space to open a DIC for IDUs (sic)".

Solutions suggested by SACS include revision of budgets by NACO for infrastructure support advocacy with general public to sensitise them to IDU issues, and adequate provision of budget for 'sub'-DICs.

Problem area # 4: Ensuring the supplies

Compared to the other problem areas, very few responses were generated on this issue. Many SACS explicitly denied having concerns in this area. However, interruption in the supply of STI kits and condoms figured as one of the concerns. One important issue which surfaced here was the limit of Rs. 1.5 lakh for procuring needles/syringes for distribution. Beyond this limit, the NGOs cannot

procure as per the existing regulations. Consequently, this involves central procurement by the SACS and the resulting "delay is unavoidable in procuring the things in a government setting (sic)."

To remedy this problem of interruption in supplies, NGOs were reported to be contributing from their own resources to tide over the crisis in some places. At an administrative level, a change in the procurement guidelines so that the upper limit of Rs. 1.5 Lakh is relaxed, has also been recommended as a solution.

Problem area # 5: Training of staff

This particular area generated a lot of responses. The states which do not have a STRC at present, blamed this on the absence of "timely and need-based training". Additionally, in states without a STRC, delays in organising training were reported to occur because "from putting a proposal for the training to the actual sanctioning of funds for training takes time in a government setup (sic)." One major issue identified by the SACS was relative scarcity of resource persons for IDU trainings. This issue is further compounded in the light of the limited capacities of STRCs (as noted by some SACS) and "limitation in providing reasonable honorarium to the experts, if hired from outside (sic)". Training of PEs was mentioned as especially difficult since it has been found difficult to bring PEs to the training site.

While many states recognised the value addition brought by STRC for capacity building of IDU TIs, some did not hesitate to express their blunt opinions - "They are doing trainings just for the sake of training, but are not able to meet the requirements of the TIs and build the required capacities (sic)" or "They just conduct generalised trainings and no needs assessment is done before designing of the training program (sic)".

Solutions adopted by some SACS include training of PEs in the field by the PM or the PO (of TSU). Another recommendation voiced by many SACS was to enhance the pool of trainers/resource persons and capacity building of the STRC. In some states, other 'partner agencies' have assisted in training by making resource persons available.

Problem area # 6: Line-listing

This is a rather technical area and it was heartening to note that most SACS officials could identify some issues here (implying that they had the necessary capacity). Mobility of the IDU population came across as the biggest challenge here. Besides, absence of reliable addresses for most IDUs (particularly for those street-based) was another challenge. The problem appears to be compounded by the lack of a robust, standardised tool for line listing, as mentioned by a SACS official. The mobility of IDUs also resulted in duplication if another TI is functioning in the neighbourhood. Some SACS also raised the issue of targets since some TIs were able to identify more numbers of IDUs for their line-listing than specified in the target.

As solutions (which have been tried in some states), some TIs have tried to update their lists frequently, sometimes through key informants such as drug sellers/peddlers, while some SACS have developed simple tools for tracking using MS Excel and have suggested development of electronic tools for the same. Some SACS have proactively validated the line lists of neighbouring TIs in the same area to address the issue of duplication.

Problem area # 7: Outreach planning

In some states no formal training has been conducted for the TI staff on the issue of outreach planning and even if training has taken place in some areas, it has not resulted in effective implementation at the field level. A related problem is inadequate Information Technology (IT)-related capacities of some of the PMs, which renders them incapable of using certain tools (such as the HRG Master Register).

Suggested solutions are support in the field by the POs and training of TI staff in using IT tools. Involvement of the IDU community itself in the outreach planning has also been suggested.

Problem area # 8: Conducting Outreach/field work

Problems regarding outreach and field work are being experienced in many states according to the SACS. Some of the problems voiced were related to the inherent nature of the drug-use phenomena itself i.e., IDUs being hidden and mobile populations. Some SACS also reported issues related to scattered IDU population, terrain, distance and connectivity and, in this context, the inadequacy of current operational guidelines were pointed out. As per a SACS official "the current guideline is an adaptation of the FSW/MSM in urban setup (sic)" and that is not entirely applicable for IDUs and that too in a non-urban, hilly terrain.

Solutions proposed or adopted include:

- Involving family members of IDUs,
- Involving other stakeholders like peddlers, police, etc;
- Developing non-conventional service delivery outlets,
- Enhancing the capacity of field staff (ORWs and PEs).

Problem area # 9: Maintaining regularity of contact

While this problem is very closely related to the problem area number 8 (outreach/field work), a major issue identified by many SACS was inadequate PE: ORW ratio. Solutions include strengthening the outreach planning, training of PEs through mentorship, and enhancing the numbers of PEs.

Problem area # 10: Needle syringe exchange

In the area of needle syringe exchange, it seems that the community acceptance (the lack of which was perceived to be a problem issue at one point in time) has largely been achieved. Most SACS expressed concerns over a mismatch between demand and supply (i.e. IDUs requiring more needles and syringes than they can be supplied or IDUs preferring a particular brand only), inadequate return rate and waste disposal.

Solutions included training and guidance to TIs in waste disposal and capacity building of TIs in demand analysis.

Problem area # 11: OST

Since OST is present in very few states, SACS from the states without any OST centres appeared to be eager to start OST in their states. SACS from states with OST centres listed problems related to capacities and knowledge of staff, affecting the quality of OST services and inadequate staff at the OST centre. Poor compliance to OST by clients was yet another problem. Solutions as seen by the SACS include enhancing the staff and enhancing the capacities of existing staff at the OST centres.

Problem area # 12: Documentation and reporting

There is clearly a mismatch between the documentation and reporting expectation under the program and the capacities and understanding of the TI staff. Existing reporting formats are seen as too many and too complex for the staff (particularly the PEs) to understand.

Problem area # 13: Reaching out to female partners/spouses of IDUs

Almost all SACS expressed concern over the absence of any specific guidelines or module on this issue. This has resulted in inadequate capacities of the TI staff to handle the issue. It was also reported that many IDUs do not disclose their drug use to their families or do not allow the TI staff to access their families. Absence of female ORWs who could address this issue was raised as a constraint by some, while some SACS have provided a female ORW specifically for this purpose. Most states have demanded guidelines and/or training on this issue.

Problem area # 14: Reaching out to special population of IDUs (like females / adolescents)

Most states did not report presence of significant numbers of female IDUs in their areas and cited the guidelines (which restrict TI services to those >18 years of age) as the factor which hinders reaching out to adolescents. Some SACS officials opined that these special groups must be proactively looked for.

Problem area # 15: Referral and linkages

The issues in this area appear to be related to either logistic factors (distance from TI to various services timings being not suitable for those services) or the capacities and attitude of other service providers than TIs per se, in the opinion of SACS. Suggested solutions too appeared to lie in the domain of NACO taking a more proactive role in making other services friendlier and more suitable for IDUs (change in timing of ICTC centres, training of ICTC counsellors, collection of blood samples for CD4 at ICTC itself, etc.).

Problem area # 16: Formation of SHGs

Most states have not been successful in this area and inherent issues with being IDUs ("De-motivation and lack of bonding among the IDU and their immediate support system [sic]") are seen as a hindrance. The problem is compounded further by lack of proper guidance and absence of specific funds (seed money) for this activity. Example of a Self Help Group (SHG) of wives of IDUs was cited by a state.

Problem area # 17: Advocacy

Poor capacities of SACS and TI staff in conducting advocacy figured as a prominent issue. Need to conduct repeat advocacy (due to frequent change in key stakeholders) was cited as an issue. An interesting response was "IEC division is doing advocacy without much involvement of the TI division thus leaving

nuances of the IDU program unaddressed in these advocacy events (sic)." A need for IEC and TI divisions to work closely was suggested.

Problem area # 18 and 19: Ensuring testing (ICTC) of IDUs and Linkage with ART and ART adherence

Many issues discussed in the area of referral and linkages were echoed here as well. A need for innovative testing solutions such as mobile ICTC vans and testing/counselling at DIC itself was prominently expressed. Provision of accompanied referral and provision of funds for the same was suggested. An interesting suggestion was to actively recruit HIV positive IDUs as staff of "DIC of positives" (sic), presumably suggesting a role for HIV positive IDUs in the Community Care Centres (CCCs).

Problem area # 20: Financial management

Many SACS expressed concern over delay in timely release of funds. The existing financial systems are being seen as rigid, with no provision for allowing fund transfer between various components, which eventually hampers the quality of services. A strong need for capacity building of TI divisions in financial management was expressed by many SACS.

Opinion Of SACS: Role Of TSU In Improving The Performance Of IDU TIs

Most of the SACS have appreciated the role which TSU has played in improving the performance of IDU TIs. TSUs reportedly assist SACS in overall program monitoring, as well as, assist the TIs in support and capacity building in the field. In case of NERO however, there was a mixed reaction. Some states expressed satisfaction with the technical support provided by NERO and others stated that they "do not have access to services provided by NERO as desired (sic)".

SACS: Suggestions/Advice For Improving The Performance Of IDU TIs

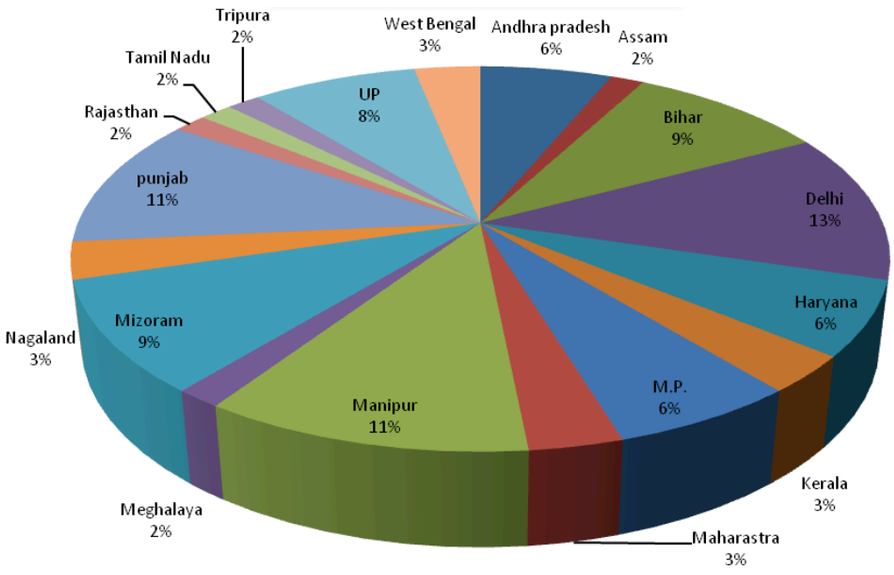
- Better and more intense capacity building at all levels (TIs, STRC and TSU) including exposure visits for all
- Revision of TI operational and costing guidelines, enhanced honorarium for the PEs, enhanced salaries for TI staff, including provision of incentives for the TI staff
- BCC/IEC materials, especially infotainment material be developed
- Revision of SACS budgets to enable them to monitor the TI program more effectively

Data from the IDU TIs

Profile Of IDU TIs

The data was acquired from a total of 64 IDU TIs, from 18 states, spread throughout the country. Out of the total sample of 64 IDU TIs, 18 were from the north eastern region of the country. The mean duration for which these NGOs were implementing IDU TI was 3.5 years, with a range of 0 (just started) to 9 years. The mean target population size was 436 IDUs with a range of 150 to 1000. Out of these 64 IDU TIs, 9 were also providing OST. The mean of 'usual number of IDUs reached on any given day through outreach' was 104. In terms of proportion of total IDUs (target) reached on any average day through outreach, there was a wide variation, ranging from 0.6% to 90% with a mean of 23%. The figures for proportion of clients (out of target) accessing DIC services on any given day were even more dismal. On an average, just about 4% of the target population accesses DIC on any given day (range 0.75% to 17%).

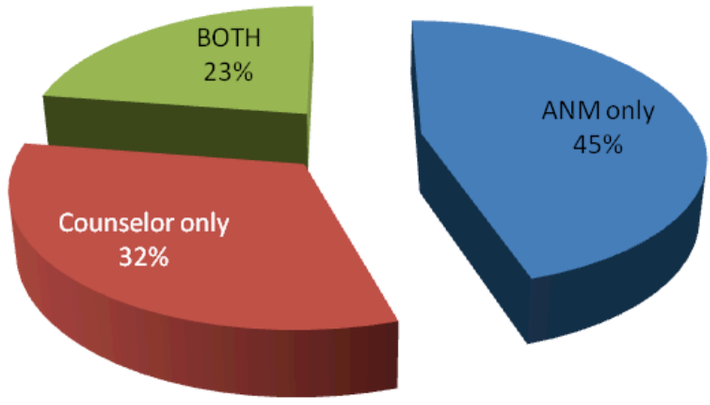
Figure 1 Distribution of TI sample across states



Staff at IDU TIs

All the surveyed TIs reported that they had the necessary staff in position. Regarding availability of ANM and Counsellors, as the chart shows, only a minority 23% of TIs had both in place.

Figure 2 Staff at IDU TIs



Project Managers

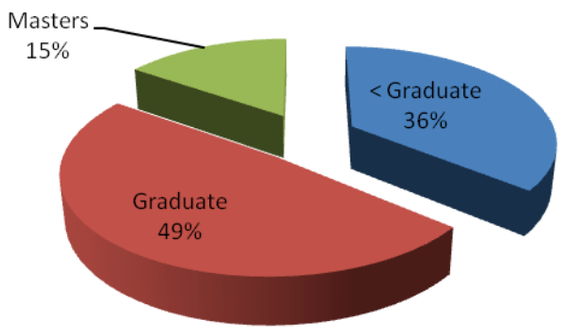
Most TIs had PMs with educational qualifications of masters or above (45 out of 64). About one fourth had PMs with qualifications reported as graduate. The mean duration of experience of work as PM was 1.8 years (with a range of 0-just started to 7 years). Barring a small minority (9%) almost all PMs, reported having received at least some training. However a majority (40 out of 64) had not received any exposure visit to another IDU TI.

Outreach Workers

A surprise finding was the educational qualification of ORWs. As many as 49% of ORWs were reported to be graduates with an additional 15% as having a qualification of Masters or above!

The mean duration of work experience as ORWs was 1.8 years with a range of 0-just started to 7 years. About one fourth ORWs described themselves as 'from the drug use background'.

Figure 3 Educational Qualification of ORWs



Peer Educators

There was a wide variation with regard to the number of peer educators in place. Mean number of PEs was 11, with as many as 7 PEs per NGO recruited within the last one year, reflecting the high turnover. Just about 5 out of 10 PEs on an average were trained by the STRCs. However, almost all PEs were trained in-house. On an average, each TI had about 9 out of 11 PEs who were trained.

Nurses

Among ANMs, about one third had a qualification of Bachelor of Nursing or above while the rest had a qualification of ANM or a diploma in Nursing. The mean duration of experience was about 1.9 years with a range of 0-just started to 10 years.

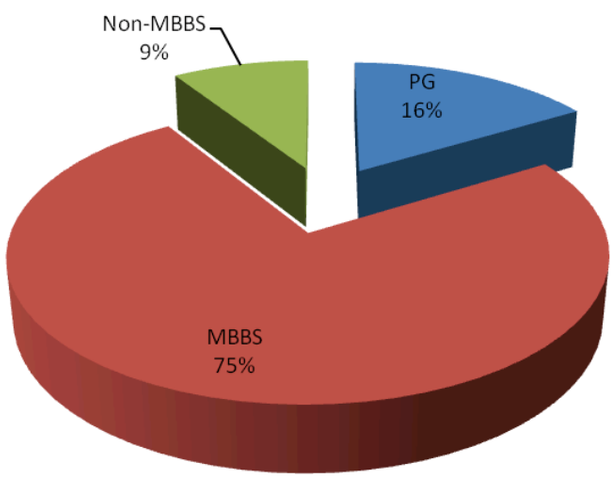
Counsellors

Just about half of the TIs surveyed had a counsellor in place. Among counsellors, about 60% had a qualification of Masters and above while rest were Graduates. Three organisations had counsellors with an under-graduate qualification. The mean duration of experience of counsellors was just about 1 year with a range of 0-just started to 5 years.

Doctors

A majority of doctors had a qualification of MBBS, while some were even post-graduates. Only a small minority reported possessing a non-MBBS medical degree. The mean duration of experience in case of doctors was 2.75 years with a range of 0 -just started to 8 years.

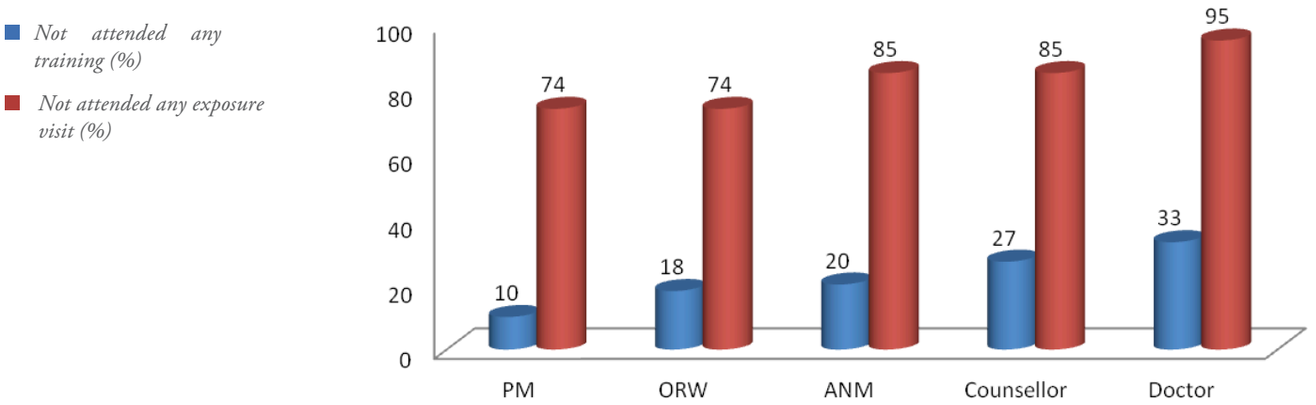
Figure 4 Educational Qualification of Doctors



Training Experience

The following chart shows the proportion of TI staff who reported that they have not had a single training so far. As is evident from the table, only a small minority of staff members were reported to be totally untrained. Interestingly, there was a clear trend visible with lowest proportion of untrained staff among PMs and highest among doctors. As many as one third IDU TIs have doctors who have never been trained.

Figure 5 Proportion of IDU TI staff not receiving training/ exposure visit (in%)



A large majority of all categories of staff however, reported *not having attended any exposure visit*. An attempt was also made to analyse the data on the number of training programs attended by the staff. Interestingly, among those staff who reported having received training, only a small minority reported attending just one training program. In other words, those who attended trainings, tended to receive opportunity of attending more than one training program. Additionally, no clear pattern emerged upon looking at the data on duration of experience vis-à-vis number of trainings attended. There were staff members who had duration of experience of just one year and reported having received as many as four trainings and on the other hand there were some staff members who were in place for three or four years yet reported not having attended a single training program.

Table 8 Themes and areas of IDU TI functioning: Training needs

Theme / area	Proportion of staff reporting having received no training at all* (in %)				
	PM	ORW	ANM / counsellor	Doctors	PEs
Basic knowledge about drug addiction and IDU	8	1	6	12	10
Basic understanding about HIV and Harm reduction	5	3	6	15	16
Outreach planning and conducting	2	6	7	22	25
Running and managing a DIC	5	12	17	20	30
BCC	2	13	15	16	30
Needle syringe exchange including demand analysis	2	5	12	25	15
Condom distribution	1	1	5	15	5
STI detection and treatment	8	25	14	14	30
Abscess management and primary health care	15	25	20	16	33
Waste disposal	20	16	15	25	35
OST	45	60	60	45	60
Overdose management	30	45	40	30	48
Community mobilisation	22	22	16	22	30
Referrals and linkages / Networking	6	10	12	18	25

Advocacy	10	14	21	30	36
Reporting	6	5	15	22	30
Program management	5				
Providing services to Female sex partners	45	60	50	33	50
Providing services to Female IDUs	50	50	60	40	50

[*]All figures have been rounded off.

There are some striking trends apparent from the table. In keeping with the data on prior experience of training, the lowest proportion of staff with training needs in specific areas were the PMs followed by ORWs, ANM, counsellors and PEs. In certain themes however, all the staff categories appear to be not trained and hence require training urgently. While the high proportion of untrained staff on OST is expected (given that OST is not expected to be implemented by a majority of TIs), quite a high proportion of staff have not been trained on overdose management. Similarly, female partners/female IDUs comes across as yet another priority area for the training.

Additionally it is also apparent that the IDU TI staff in general, is trained in the core activities of running a TI – outreach, NSEP, condom distribution, referrals etc. – but need to be trained in issues specific to IDUs such as abscess management, waste disposal and overdose management.

Opinion of IDU TIs: Problems faced and the solutions adopted/suggested

Problem area # 1: Staff turn-over

Most of the TIs surveyed expressed concern over frequent turn-over of staff, particularly the PEs. The reason cited by an overwhelmingly large number of TIs was that of inadequate salaries of the TI staff. Very few specific innovative solutions were in sight. One such solution was to keep a second line of candidates ready who could take over, as soon as, a staff member leaves the organisation. Almost everyone voiced the opinion that the salaries should be raised.

Problem area # 2: Staff recruitment

Like the SACS officials, IDU TIs too appeared dissatisfied with the existing procedures for staff recruitment at TIs. The selection criteria for TI staff were seen as 'too rigid' and the required qualifications too high for the salaries being offered. Moreover, the funds for staff recruitment were considered inadequate, hampering the process of advertisement and consequently attracting unsuitable candidates. Many NGOs reported that they were forced to recruit not fully qualified candidates since it was difficult to get appropriate candidates for the salaries being offered.

Problem area # 3: Managing the infrastructure

Renting out a suitable place for DIC was expressed as a concern. This was because of inadequate budgets and the general community's reluctance to lend space for IDU programs. Additional issue voiced was related to inadequate budgets for furniture as well as related to maintenance of furniture and equipment. In some cases additional cost of infrastructure has been managed through NGOs own contribution. Those NGOs implementing OST program in addition to the IDU TI, appeared more concerned with infrastructural problems (in view of accreditation requirements).

Solutions suggested included the revision of budgets by NACO for infrastructural support, provision of existing government facilities for DIC with assistance/ intervention from SACS and other state government players and advocacy with the general public to sensitise them on IDU issues.

Problem area # 4: Ensuring the supplies

Though in case of SACS – where compared to the other problem areas, very few responses were generated on this issue – a large number of TIs reported irregular supply of various items such as condoms, needles, syringes medicines and others supplies. Concerns about quality of condoms and needle syringes were also expressed by some. Some NGOs have taken "loans from outside in this lean patch to purchase needles/syringes (sic)".

Problem area # 5: Training of staff

This particular area generated a lot of responses. Analysis reveals the following problems faced by the IDU TIs with capacity building of staff (arranged in order of importance, i.e. by number of TIs who have voiced these concerns):

- Lack of timely training of staff: Most TIs have expressed concerns over lack of timely training.

The situation gets aggravated by the next problem, that is

- Frequent turnover of staff: Since the staff, particularly the PEs get replaced very frequently, new staff needs to be trained. Most TIs reported difficulty in organising in-house training for the PEs
- Concerns about resource persons: Many IDU TIs expressed dissatisfaction with the resource persons called in for training by the STRC, exemplified by statements such as "Sometimes resource person talk in high language and using complicated words. Most of the time trainer less talk on drug users issue (sic)". Additionally, language of the training programs also figures as an issue.
- Duration of training programs: Some TIs find it difficult to send all staff members for training at one time since it hampers the routine services
- Distance of the training venue: Training venues are located at long distances from the city/town where the TI is located
- Dissatisfaction with resource material: Some TIs have voiced the need for additional training resources in the form of audio-visual material

Problem area # 6: Line-listing

Like SACS, IDU TIs too found the mobility of the IDU population as the biggest challenge. Additionally, absence of reliable addresses for most IDUs, particularly of those who are street-based, was yet another challenge. Issues regarding duplication (if another TI is functioning in the neighbourhood) were also brought out.

The innovative solutions which were listed by the SACS to address this issue did not appear in the data collected from the IDU TIs.

Problem area # 7: Outreach planning

Lack of capacity of the TI staff on the issue of outreach planning was a major concern. Even if training has taken place, it has not resulted in effective implementation at the field level. Here again, no specific innovative solutions were in sight.

Problem area # 8 and 9: Conducting Outreach/ field work and Maintaining regularity of contact

The problem area number 7, lack of adequate capacity in outreach planning, was found to influence conducting the outreach and field work. Many TIs reported impediments regarding outreach and field work. As in the responses by SACS, some of the problems voiced resemble the inherent nature of the drug use phenomena itself i.e., IDUs being hidden and mobile populations. Issues related to the scattered IDU population, terrain, distance and connectivity were also reported which further compound this problem. Interestingly, some of the responses describing the 'inherent nature of drug use' also point toward the attitude of the IDU TIs (an issue which must be addressed in the training programs). For instance, "The carefree attitude, fickle-mindedness, greed for drugs of PEs…….affects the outreach field activities (sic)". The inadequate number of PEs and lack of adequate budgets were also pointed as problems as were the attitudes of the general community and police. It was also reported by some TIs that the PEs themselves engage in selling needles and syringes meant for free distribution.

Solutions proposed include, involving family members of IDUs and other stakeholders like the police, etc. and advocacy with them, and enhancing the number and capacity of field staff (ORWs and PEs).

Problem area # 10: Needle/ Syringe exchange

Most IDU TIs expressed concern over the low rate of return, which was related to the factors discussed earlier (i.e. outreach planning and conducting). Yet another concern was about a mismatch between demand and supply (i.e. IDUs requiring more needles and syringes then they can be supplied). As a TI reported, "The amount granted by SACS for purchasing Needle/ Syringe is insufficient to distribute as per the demand of our clients. To be exact SACS is providing us Rs 2.36/client/day. So practically on an average we can provide a 2ml syringe to an IDU per day. In a way we are leaving them in a great vulnerable situation for sharing of needle/syringe…….(sic)"

Solutions included training and guidance to TIs in waste disposal and capacity building of TIs in demand analysis. Moreover, some TIs reported increasing their reliance on PEs to collect used needles and syringes from the field.

Problem area # 11: OST

The data on this parameter is not satisfactory since a very small number of TIs surveyed were implementing OST. The very few responses on this issue listed problems regarding retention or drop-outs. As a solution, one of the TI reported that a female ORW has been entrusted with the task of contacting family and ensuring their support with an aim to enhance retention. Clearly, OST is an area of TI functioning, which warrants a separate study of its own.

Problem area # 12: Documentation and reporting

Most TIs criticised the extremely long, complex and inconsistent reporting formats. Moreover the time invested by the staff in documentation adversely impacts the actual field work. Simpler documentation formats, user-friendly software and enhancing the capacity of the staff in using the formats were suggested as solutions.

Problem area # 13: Reaching out to female partners/spouses of IDUs

It was reported that many IDUs do not disclose their drug use to their families or do not allow the TI staff to access their families. Many TIs appeared to think that a female ORW or a female PE could be better suited to perform this task. Besides, on this issue many TIs expressed concern over absence of any specific guidelines or module and demanded the same.

Problem area # 14: Reaching out to special population of IDUs (like females/adolescents)

Most TIs have not registered the significant number of female IDUs in their areas. It also appeared from the responses, that there may be some female IDUs who remain hidden. Some TIs opined that the program needs to have special interventions for these special groups (implying exclusive services for special population groups).

Problem area # 15: Referral and linkages

The problems in this area appear to be related more with logistic factors (distance from TI to various services, timings being not suitable of those services) or the capacities and attitude of other service providers than the TIs per se. Suggested solutions were NACO taking a more proactive role in making other services friendlier and more suitable for IDUs , in the form of changing the timings at ICTC centres, training of ICTC counsellors and collection of blood samples for CD4 at ICTC itself etc.).

Problem area # 16: Formation of SHGs

Most TIs appear to have been unsuccessful in this area because IDUs are seen as more a hindrance, evident from this feedback - "IDUs are not capable to understand the utility of SHGs because most of the time they remain in the influence of drugs [sic]" or "They are every time collect money for drug and they have no interest in Self- Help Groups (SHGs) [sic]"). Lack of capacities and specific funds for this aggravated the problem. One TI from North-East revealed the plan of forming five SHGs in the near future.

Problem area # 17: Advocacy

The need for advocacy with various local stakeholders, specifically the local police, figured as a prominent issue. However, most IDU TIs appear to be struggling on this front. Improper attitude of the stakeholders (to address which we need advocacy in the first place!) is seen as a hindrance in conducting advocacy activities. Interestingly, the TIs look for an official/government intervention to address this: "Direct Order should be given by Govt. to Police Department/MC/MLA of the area for Advocacy meeting with NGO time to time [sic]."

Problem area # 18 and 19: Ensuring testing (ICTC) of IDUs and Linkage with ART and ART adherence

IDUs are generally seen by the TIs as not interested in visiting ICTC. Some TIs have suggested having exclusive testing facilities for IDUs. "Separate ICTC Centres has to be established for HRG's or there will be fixed timings for ICTC testing in govt. hospitals to look after them [sic]." Accompanied referral and funds for supporting IDUs' travel to ICTC centres were some solutions suggested and employed by some TIs.

Problem area # 20: Financial management

Many TIs expressed concern over delay in timely release of funds. In general, the demand seems to be for enhancing the budgets but more specific responses on this issue were not forthcoming.

Factors Influencing The Performance of IDU TIs

As described the section on methodology, a list of following program areas was prepared and TIs were asked to describe various factors, influencing there performance in these areas:

- Overall Program management
- Outreach and regular contacts (including NSEP and waste management)
- General medical care of IDU
- Counselling and Behaviour Change
- Referrals and linkages for HIV Testing and other healthcare services
- Working with Female IDUs and Partners of Male IDUs

Overall program management

As reported by the TIs, there are problems in the domain of appropriate staff selection and retention,

and motivation of staff. IDU TIs appear to regard having staff from the drug using background as a very important factor.

Among social factors, stigma came across as a very important theme, forcing IDUs to remain hidden, which hinders delivering services for them, thereby hindering almost all aspects of program management. Many TIs also found their areas of operation to be too large for them to be able to manage the program.
Capacity and knowledge related factors came across as very important for program management. As per some TIs, "Lack of understanding of drug use and drug user behaviour and understanding of drug use patterns influence Program management [sic]."Thus, it is important to build the capacities of cadre in not only the service delivery aspects but also the program management aspects. On the other hand, even trainings focussing on program management issues, must include the basic aspects of dealing with the drug using population.

While some TIs expressed satisfaction over the technical and financial support provided by the various entities such as NACO, SACS and TSU, some TIs had negative feedback. Delay in release of funds came across as a major factor influencing program management. Additionally, the role of TSUs was also perceived by many TIs as too much monitoring and too little technical support.

Outreach and regular contacts (including NSEP and waste management)

Like program management, finding, recruiting, training and motivating appropriate staff members came across as an important issue in this particular aspect of TI functioning. Geographically scattered hotspots make it very difficult for the TIs to conduct outreach and maintain regularity of contacts. While capacities of staff are built in the routinely held training programs, a need of periodic, refresher trainings has been voiced by many TIs. A mismatch between demand at the ground level and the actual supply of needles and syringes affects outreach and NSEP. Waste management still remains an area where many TIs lack adequate guidance and support. The crisis response teams were reportedly formed by only some TIs and responded to issues related to police harassment. Most of the TIs continue to experience police harassment which sometimes hinders the outreach work.

General medical care of IDU

The need for a full-time, adequately trained doctor was expressed by many TIs, since a part-time doctor (most of the times, untrained) was not enough to provide adequate medical care to IDUs. The absence of a full-time doctor is directly linked to the lack of funds.

Counselling and Behaviour Change

Having a trainer and counsellor in place was seen as imperative by most of the TIs (as opposed to the ANM doubling up as a counsellor). Inadequate infrastructure for counselling in the DIC, such as lack of adequate space was reported by some TIs as a hindrance. The existing training curricula for counsellors was reported by some as inadequate since "Counsellors need to understand Denial [sic]" and "Lack of understanding issues around drug use influence counselling and behaviour change [sic]." Harassment by law enforcement agencies is a major hindrance in behaviour change by the IDUs, since it results in frequent change of hotspots.

Referrals and linkages for HIV testing and other healthcare services

Health facilities located at long distances from the TIs/hotspots is a very important issue. Accompanied referrals have not been fully successful in addressing this since there is no adequate provision in the budgets for the same.

Working with Female IDUs and Partners of Male IDUs

Most TIs have strongly voiced the need of appropriate staff (with adequate training) to address this issue. However even after having female ORWs in place and imparting training to them, appropriate program management mechanisms would be required to enable them to deliver the services (such as provision of funds for local travel). As per a TI staff member "The TI had the privilege of having a Female Out Reach Worker (FORW) last year and it strengthened the TI working owing to acceptability by families of IDUs. But of late due to high cost of travel area being scattered [sic]" it has not been possible to deliver services as desired. It would also be difficult to expect that the same facilities (DICs) be available to female IDUs since there are obvious social factors such as stigma, which affect the ability of female IDUs/female partners to access the services. At present, the staff does not have adequate training and capacities to deal with this population group nor do the support structures (SACS/TSU) appear to be geared up for the same.

Opinion of IDU TIs: Role of the TSU

Most TIs appreciate the role of TSUs in providing mentoring and monitoring support. This support is manifested in the form of on-field training (at hotspot level) and particularly in the area of documentation and reporting. However, there were variations in responses on this issue too. When asked about the specific role played by the TSU in improving the performance, a TI responded, "None. Most of the time the TSU members are learning from our TI [sic]."

Suggestions of TIs regarding improving the performance of IDU TIs

Almost all the surveyed TIs had a plethora of suggestions for improving the performance. These are not being reproduced exactly but have been arranged in various themes and listed below:

Table 9 Suggestions of TIs

• A review and revision of the budgets
o To incorporate better salaries for the staff and incentives for the PEs
o More funds for NSEP/waste management and other TI activities
• Additional services in the TIs
o Detoxification (camp/referral to the centres)
o Nutrition support
o Vocational rehabilitation support
o OST
• Linkages and alliances
o Formal linkages with other welfare schemes - Adhaar, Antodya, BPL, Shelter home etc.
o Better linkages with medical and technical colleges
o A more proactive role by the government to ensure that other sectors (hospitals, police, referral agencies) cooperate with the IDU TIs
• Improvement in program management
o Less documentation and reporting load
o Timely release of funds
o Staff number and type to commensurate with the workload
• Capacity building
o Training of staff at all levels
o Improving the capacities of support structures (SACS/TSU)
o Exposure visits to other TIs to facilitate cross learning

Opinion of IDU TIs: Role of STRC

TIs from the states where STRC is not present or functional expressed the need for the same. Many TI from states where STRC is present commended and appreciated the trainings provided by the STRC. Some TIs expressed need to conduct trainings more frequently.

Regarding suggestions for capacity building, most TIs opined that:

- The training methods should be more participatory
- Resource material should also include audio visual material
- Exposure visits should also be a modality for training
- Resource persons should be experts and thoroughly familiar with issues pertaining to IDUs. Additionally, a need for training to be conducted in local languages was also strongly expressed
- Regarding training frequency there was a lot of variations in the responses but most TIs appear to prefer a training program once every quarter
- Training are required not just for TI staff but also for the POs of TSUs

Data from the TSUs

Profile of TSUs

The data was collected from a total of 19 TSUs[2] through email questionnaires and interviews. The states represented were:

Table 10 List of states where TSUs were surveyed

Andhra Pradesh	Arunachal	Assam	Chhattisgarh	Delhi	Jharkhand	Kerala
Madhya Pradesh	Maharashtra	Manipur	Meghalaya	Mizoram	Nagaland	
Punjab	Sikkim	Tamil Nadu	Tripura	Uttar Pradesh	West Bengal	

A close look at the profile of TSUs suggests that most of the TSUs have started working as TSUs for their respective states only recently. The parent organisations of most TSUs do not have any specific experience of working with drug users. Indeed at the moment only one TSU is being run by a parent organisation which has a significant experience of working with drug users.

Opinion Of TSUs regarding problems faced by the IDU TIs

Problem area # 1: Staff turn-over

Like SACS, many TSUs also expressed concern over frequent turn-over of staff, particularly the PEs. Some innovative solutions attempted in certain states to address the problem of high staff (particularly the PEs) turn-over are:

- Parallel batch of volunteers/'shadow workers' prepared and trained by experts
- Provision of incremental salary made using the NGO's own resources
- District wise rank list/resource pool maintained for immediate appointment of new staff
- Distribution of the PE incentive on a daily basis, which has helped in retaining the PEs

In addition, an overwhelming majority of the TSUs have also suggested revising the salary structure of staff at all levels.

Problem area # 2: Staff recruitment

Another related problem area was recruitment of appropriate staff by the IDU TIs. In some cases while new staff is recruited by the NGOs, the SACS and TSUs do not receive the information about the same in time. It was also stated that the "Organisation's preferences dominate in selection process (sic)", insinuating lack of transparency and fairness in the recruitment process.
Solutions suggested or being practised for this problem:

- Revise budget so that salaries are made more attractive
- Approach and orient educational institutions (such as social work colleges) to explore good candidates

Problem area # 3: Managing the infrastructure

The TSUs also talked about the problem of inadequate budget for renting out a suitable place for DIC, particularly in bigger cities. In some cases, additional cost of infrastructure has been managed through NGOs' own contribution. However, inadequate budgets are not the only reason for not being able to rent a suitable place for DIC. Problems related to the stigma associated with drug use also surfaced - "IDU TI DIC has to be shifted frequently due to non-conducive environment in the locality (sic)".

Solutions suggested include revision of budgets by NACO for infrastructure support and advocacy with general public to sensitise them to IDU issues.

Problem area # 4: Ensuring the supplies

Though most SACS explicitly denied any concerns over this area, many TSUs did report interruption in the supply of STI kits and condoms.
As a solution to respond to the issue of interruption in supplies, at some places, NGOs were reported to contribute from their own resources to tide over the

[2] *The North East Regional Office (NERO) functions as TSU for the eight north eastern states*

crisis. "Establishing linkage with Family Planning program / NRHM for procurement of condoms & STI kits (sic)" was also suggested as a solution.

Problem area # 5: Training of staff

As expected, rather than the training process itself, the TSUs are more concerned with the implementation of what has been learnt at the ground level. Consequently, a common response was "In some TI sites, trained staff is unable to translate their learning into practical implementation at the field level (sic)". Lack of IDU specific training was also reported – "IDU staff are trained along with the core group staff.…the resource persons are mostly experts with FSW/MSM population (sic)".

Solutions adopted by some states include training of staff in the field by the PO (of TSU). Some TSUs recommended that the pool of trainers and resource persons be enhanced by involving "Mental Health Institutions / authorities". In some states, other 'partner agencies' have assisted in training by making resource persons available.

Problem area # 6: Line-listing

Though most TSUs reported existence of the line list system, apparently updating the line-list is not taking place with the desired frequency. Mobility of the IDU population came across as a big challenge here as was the absence of reliable addresses for most IDUs. Issues related to duplication of names and overlap with the area of operation of two TIs functioning in the neighbourhood was also mentioned.

Many TSUs reported that their POs are regularly assisting and guiding the TIs in validating the lists.

Problem area # 7: Outreach planning

Despite supervision and on-field guidance by the POs, outreach planning remains a problem area in most states. In some states no formal training has been conducted for the TI staff on outreach planning, and even if training has been conducted, it has not resulted in effective implementation at the field level.

As solutions, most TSUs reported guidance and support in the field by the POs. Some technical solutions were also reported like "…tracking of IDUs to be done not peer wise but area wise..[sic]". Involvement of the IDU community itself and their family members in the outreach planning also figured as one of the suggestions.

Problem area # 8: Conducting Outreach/field work

Problems regarding outreach and field work were reported by many TSUs, as were problems related to IDUs being hidden and mobile populations. Most TSUs also reported that "Field visit by PM and Outreach Workers are not adequate [sic]".
Solutions proposed or adopted include conducting outreach visits by the POs along with the PM and ORWs in order to set up a system for regular field visits by the staff. Doctors and nurses are also asked to conduct outreach as and when needed. "Nonconventional outlets" for needle supply were also suggested.

Problem area # 9: Maintaining regularity of contact

This problem is very closely related to problem area number 8 since a major issue identified by many TSUs was inadequate PE: ORW ratio. Many TSUs opined that the existing target of meeting each client 20 days a month – given existing resources and systems – is practically impossible. One particular TSU suggested revising the definition of regular contact to '"15 days a month" i.e. every alternate day. "Greater involvement of peddlers" was another innovative solution suggested.

Problem area # 10: Needle syringe exchange

A problem area identified by the TSUs (but not so much by the SACS) was that of the return and disposal of used injection equipment. Many TSUs also reported assisting the TIs in tying up with the hospitals where incinerators are present. Most TSUs expressed concerns over a mismatch between demand and supply (i.e. IDUs requiring more needles and syringes than can be supplied).

Setting up a local incinerator and provision of adequate budgets were proposed as a solution as was the need to have more flexibility in deciding the numbers and types of needles and syringes which can be distributed.

Problem area # 11: OST

Since very few states have OST, feedback on them was received from only a few TSUs. From these states, it was reported that in many TIs, "Slot yet to be filled up (sic)" and even in the existing slots, a high number of dropouts remains a concern. Inadequate capacities and knowledge of OST centre staff (such as doctors not providing adequate doses) were also mentioned. Organising training programs was proposed as a solution.

Problem area # 12: Documentation and reporting

The mismatch between the documentation and reporting expected by the program and the capacities and understanding of the TI staff was reported here too. Existing reporting formats are seen as too many and too complex for the PEs to understand.

Problem area # 13: Reaching out to female partners/spouses of IDUs

On this issue, most TSUs reported that "IDU TIs are yet to focus on female partners and spouses coverage which is not the priority focus at this point of time (sic)". While some states do not have any female ORWs, in those that do, they are unable to perform adequately because reaching out to the spouses "requires more time & travel budget for the field level workers, which is not provided to them (sic)".

Problem area # 14: Reaching out to special population of IDUs (like females/adolescents)

Most TSUs did not appear to notice the presence of a significant number of female IDUs in their areas and hence "in the absence of any evidence no intervention has been initiated (sic)".

Problem area # 15: Referral and linkages

As per the responses by the TSUs, there are logistical problems like long distances between TI to various services, non-suitable timings of those services. In addition, capacities of the ANM/counsellor at the TIs (to be able to counsel the IDUs regarding the need for referral) were also reported to be limited. Among suggested solutions, provision of a 'mobile ICTC' figured prominently. Training and orientation of ICTC staff was also suggested.

Problem area # 16: Formation of SHGs

Most states have not been successful in this area. IDUs are not seen as empowered enough to be able to form a SHG of their own. An example of a particular TI was cited where the IDUs can open their account and deposit small sums of money. Exposure visits to other TIs where SHGs are in place were suggested as a solution.

Problem area # 17: Advocacy

It appears from the responses of the TSUs that very limited advocacy-related activities are being conducted in most of the IDU TI sites. Poor capacities of the TI staff (as well as, TSU staff) in conducting advocacy figured as a prominent issue. The need to conduct repeat advocacy (due to frequent changes in key stakeholders) was cited as another issue.

Problem area # 18 and 19: Ensuring testing (ICTC) of IDUs and Linkage with ART and ART adherence

Many issues discussed in the problem area of referral and linkages were echoed here as well. The need for innovative testing solutions, such as mobile ICTC vans, testing/counselling at DIC itself, was prominently expressed. Accompanied referral and provision of funds for the same were suggested. As per a TSU, "As a protocol, ICTC counsellors are not informing TIs about the positive cases. As a result it is always difficult for the TI staff to link the positive HRG to the ART. ICTC counsellors are supposed to link the positive client with the ART, positive network & other necessary services which is not happening properly (sic)."

Problem area # 20: Financial management

As per the TSUs, basic financial management mechanisms are in place in most of the TIs. Many TSUs expressed concern over delay in timely release of funds. In addition, existing staff was seen by some TSUs as inadequate for attending to financial management needs (one accountant-cum M & E officer). One TSU also lamented the fact that TI audit reports are not shared with the TSU by the SACS.
Most TSUs do see the need to provide guidance and technical support in the field to the TIs, over and above the classroom training provided by the STRC. The areas where such on-field technical support is usually required are:

1. Outreach planning
2. Execution of planning in the field.
3. NSEP
4. Waste disposal management
5. Advocacy and networking.
6. Documentation and reporting

Improving the performance of IDU TIS: opinion of TSUs

- The 'uniform template for all' approach for the TIs must be done away with. Specific needs of IDU population (as opposed to FSW/MSM population) must be taken into account
- Chief decision-makers of the NGO, such as the

project director, must be involved more intensively in the program

- At the moment the IDU TI program is dependent too heavily on the PEs. This must be reviewed and the operational issues related to peer-outreach have to be re-visited
- More intense monitoring by the SACS in the form of Joint TI site visit by PO and JD/DD/AD TI
- Conduct regular review meeting with other component staff directly linked with TI such as ICTC, STI, ART
- Focus should also be on linkages with MSJE programs at a central level
- System for state level coordination meeting should be institutionalised at SACS level for addressing issues identified at the TI level by POs
- Improving the services given by the support centres (such as ICTC, ART etc.)
- To relax the qualification of staff for TI as it is difficult to get people with the essential qualifications, and focus more on recruiting people with good experience and greater commitment towards IDU- related and drug use issues
- The capacity building efforts need to be made in a systematic and synchronised manner. This includes capacity building of all key service providers

Triangulation of data

Since the methodology adopted allowed collection of data from multiple sources, it provides an opportunity to triangulate the data so obtained. Specifically, regarding problems and solutions in the various areas of TI functioning, data was obtained from TIs themselves, SACS and TSUs. Similarly, TIs were asked to identify specific factors which could influence the performance of IDU TIs. Finally, all three types of entities – SACS, TSU and TIs – were asked their opinion on ways to improve performance of IDU TIs. All this data was compared and grouped according to various themes and have been summarised below.

Human Resources: Recruitment, Turnover and Capacities

Finding and retaining appropriate staff remains a challenge for the TIs. Part of the problem lies in the mismatch between qualifications demanded by the program, the job-profile and remuneration offered. All three entities surveyed – SACS, TSU and TIs – found the salary structures in TIs inadequate.

The problem of turnover is most acute in case of PEs. As described in the profile of TIs, the mean number of PEs was 11, with as many as 7 peer educators per NGO were recruited within the last one year, reflecting the high turnover. To address this issue, some states have tried innovative methods like provision of incremental salary using the NGO's own resources or maintaining a district-wise rank list/resource pool for immediate appointment of new staff and distributing PEs incentives or honoraria at more frequent and small instalments.

While data from SACS pointed towards the complexities and challenges involved in recruitment process (besides inadequate salaries), the TIs appeared to attribute the problem of finding appropriate staff largely to the inadequate salaries. Both, SACS and TSUs, suggested some innovative ways to find appropriate staff (such as contacting educational institutions). Overall, it appears that finding and recruiting staff for working in the NGO TIs would require more proactive approaches by government entities like SACS.

Information on concerns or problems regarding capacity building[3] also surfaced from different sources. Almost all the quarters – SACS, STRCs and TIs – expressed dissatisfaction over the unavailability of appropriate resource persons, resource material and training methods. The following issues found resonance in the responses of almost all the categories of respondents:

- The training frequency is not at the optimum level and is unable to keep pace with the frequent turnover of staff
- Resource persons tend to be not fully familiar with IDU issues
- Largely, the trainings are not held in the language most trainees would be comfortable in
- Training methods need to be more participatory and more practical and skills-oriented
- There is a strong need of audio-visual training material
- There is a lack of resource material in the local languages
- Exposure visits are practically non-existent and are perceived as very useful for the TI staff

While capacity building is required on almost all aspects of functioning of IDU TIs, the following themes emerge as burning needs for training:

- Abscess management
- OST
- Overdose management,
- Female IDUs
- Female partners of male IDUs

Program Management: Infrastructure, Supplies, Documentation, Reporting, Monitoring

Problems in hiring suitable place for running a DIC were reported by all the surveyed entities on both counts – inadequate budget for rents, as well as, stigma in the community over establishing a service for drug users. However the 'DIC concept' should also be seen in the light of very inadequate utilisation of existing DICs. Just about 4% of the target population

[3] *A detailed description of training and many related issues can also be found in the companion report: Ambekar A (2011), capacity Building Needs Assessment (CBNA) in the context of IDU TIs in India, UNODC ROSA, New Delhi*

is accessing the DICs. In other words, a TI which is supposed to serve 500 IDUs manages on an average to attract and provide services to just 20 IDUs in its DIC on a given day. Nevertheless, other than a demand for revising the budget for renting out a DIC, advocacy with the general community to address the stigma was also suggested by SACS and TIs.

Supplies on many essentials (STI kits, condoms) remain interrupted as reported by SACS and the TIs. Similarly a mismatch between demand and supply of injecting equipment also figured as a common issue reported by more than one entity. The existing documentation and reporting system, is seen as too complex to be handled by the field level staff. It is in this context that the role of TSU POs (mentioned later) assumes significance. Interestingly some innovative solutions regarding documentation and reporting systems were provided by the SACS (but not by the TIs). Existing capacities for program management appear in need of strengthening at all the levels.

Routine Services Delivered by the TIs: Needle and Syringe Exchange, General Medical Care, Abscess Management and OST Etc.

Similar concerns related to the line-listing of IDUs were reported by the SACS, TSUs and TIs (overlap of areas of operation of neighbouring TIs, duplication, problems in establishing identities etc.). TSUs in addition also reported problems regarding infrequent updating of the lists.

Regarding planning and conducting outreach, in some areas, the geographical factors (unfavourable terrain, scattered and large area of operation) came across as the factors influencing performance. However, more important issues were related to the limited capacities of IDU TIs in planning and conducting field-work, an issue which was noted most prominently by the TSUs. Clearly, the classroom training on these issues remains less than satisfactory, making on-field training all the more necessary.

Most SACS (as well as TIs) remain unsatisfied with the return rates of needles and syringes. More important however is the mismatch between demand and supply of injecting equipment, as voiced by many SACS, TIs and TSUs. SACS and TSUs, in addition, also voiced concerns with inadequate waste management facilities.

Provision of medical care including abscess management, overdose management and STI diagnosis and treatment remains influenced primarily by the capacities of medical staff at TIs. While a large majority of doctors happen to have adequate qualifications, specific training of doctors on IDU TI issues (abscess, overdose etc.) remains a challenge. The existing remuneration package for doctors remains inadequate for even part-time doctors as reported by TIs and SACS. Some respondents believed that the work profile in the TIs would require services of a full-time doctor.

Issues regarding OST remain inadequately explored in the study, primarily due to inadequate representation of OST TIs in our sample (out of 64 IDU TIs surveyed, only 9 were also providing OST). However, combined responses of SACS, TSUs and TIs do not paint a very encouraging picture regarding performance of IDU TIs related to OST services. Existing OST slots remain vacant in many TIs and even clients on OST have less than desired levels of compliance. Inadequate capacities of staff on OST are common. Some problems regarding managing OST and NSEP 'side-by-side [sic]' were also noted.

'Other' Services: Formation of SHGs, Advocacy, Addressing Female Partners/ Female IDUs

These services have been deliberately clubbed as 'other' since in most states, these remain hardly in place. No clear models/examples for any of these issues are in sight. Problems appear to be related to not only the inadequate capacities of the TIs to perform in these areas but at a more fundamental level, realising the importance of these issues. On the issue of community mobilisation/SHGs, many responses of the TIs betrayed their own attitudes towards IDUs ("IDUs are not capable to understand the utility of SHGs because most of the time they remain in the influence of drugs [sic] or "They are every time collect money for drug and they have no interest in SHGs [sic]"). Similarly on the issue of advocacy too, existing efforts of TIs appear to be inadequate and demands are being made for a more structural/official intervention as opposed to local/community-level advocacy initiatives expected of IDU TIs! Female IDUs remain 'out-of-sight' and hence 'out-of-mind'. A realisation of the importance of reaching out to female partners, has taken place, but in the absence of specific intervention models, guidelines and capacities, TIs remain helpless. At places, where female ORWs are in place, some efforts appear to have been made. Clearly these areas – if deemed important – must find more intense focus in the future.

Outside Linkages and Alliances: Referral, Networking

Geographical factors figured prominently in the responses by all the entities, as factors affecting referral and access to other services such as ICTC and ART. However, by the very design of our programs, this is only to be expected. Since the program insists on providing TI services as 'stand-alone' and exclusive services to the IDUs, as close to them as possible, the general health care services are likely to remain at a distance. Here too, many of the responses regarding suggested solutions appeared to lie in the domain of even more exclusivity (mobile ICTCs, provision of testing/sample collection at DICs, sample collection for CD4 at TI etc.) as opposed to fostering more integration. However, some of the suggestions from SACS and TSUs on orienting ICTC/ART staff on IDU specific issues appear relevant. Many TIs, as well as, SACS suggested provisions for accompanied referral and travel money for IDUs.

Conclusions and Recommendations

Methodological issues

The study was conducted as a cross sectional survey, largely qualitative in nature. Any attempt to evaluate the actual performance of an IDU TI and compare the performance of various IDU TIs was deliberately avoided. As the data reveals, there are too many factors which influence the overall performance of an IDU TI. Moreover, there are a variety of areas in which an IDU TI is expected to perform. Thus, reductionist approaches, which grade the performance of IDU TIs, are best avoided.

The data falls in the category of self-report and must be seen with all the potential caveats of such an approach. However, the authenticity of self-report by the respondents gets credibility by the consistency of most of the responses across states and geographical regions. It must also be noted that the responses were obtained through a healthy mix of email questionnaires and interviews conducted by three different interviewers. In spite of these variations, consistency of responses was largely maintained, enhancing the credibility of these responses.

The study attempted to explore almost all the areas of performance of an IDU TIs, as well as, various factors which could influence these areas of performance. The questionnaires were deliberately designed so that even though the study was qualitative in nature, an unstructured, free-flow of thoughts and opinions was intentionally avoided. This helped in collecting data on specific issues and minimised the complexities involved in grouping and categorising the responses, typically associated with qualitative studies.

The TI Approach

The TI approach is the mainstay for prevention of HIV among all the HRGs (FSWs, MSM, and IDUs) in the NACP III. It appears from some of the responses though that for ease of program management at the macro level, a 'uniform-template' style has been adopted and in the process some of the finer nuances related to unique needs of at-risk population groups (in our case, IDUs) have not received the desired level of attention. This is clear from some of the direct responses and from the finding that capacities at many levels are found lacking in issues specific to IDU TIs (such as Needle-Syringe exchange, Abscess management, overdose and OST) as opposed to the more generic issues (condom distribution, managing a DIC etc.). Thus, more attention needs to be paid to IDU specific issues during program designing.

Crucial factors influencing performance of IDU TIs

As per the findings of the study, these can be grouped in factors related to the following:

- Staff: recruitment, retention and capacity building
- Enabling environment in the community
- Resources and inputs to the TIs

Staff: Recruitment, Retention and Capacity Building

Findings regarding problems related to the recruitment of appropriate staff have been described in the preceding pages. As the data indicates, TIs also find it difficult to retain their staff. For instance, the mean duration for which the surveyed TIs were functioning was 3.5 years, while most of the staff had been in place for much less than 2 years on an average. The performance of TIs is seen as directly being affected by the difficulties in recruiting, retaining and training the staff across all categories. Problems seem to be most pronounced for PEs and doctors, though almost all staff categories are affected by it.

Existing capacity building mechanisms do not seem to address all the issues required for optimum performance. Additionally, crucial factors which may affect staff retention – addressing staff motivation, coping with burn out – are not addressed in the existing training systems.

Recommendations

- Revise the budgets to optimise the salary structure of staff at all levels
- Revisit and simplify the staff recruitment procedures at NGO TIs. A more proactive role and support by the SACS is required in staff recruitment.
- Review and strengthen the existing capacity building mechanisms. In addition to STRCs, other institutional support for capacity building must be explored. Similarly the pool of resource persons and resource materials must be expanded. Newer and innovative training techniques must be employed.

Enabling Environment in the Community

The problems related to the performance of IDU TIs, as a result of presence or absence of enabling environment, manifest in diverse forms. These may range from inability to find a suitable place to open a DIC owing to stigma, or harassment of service beneficiaries or sometimes even of the staff at the hands of the police. The physical and geographical characteristics of the environment (scattered population, TIs too far from general health care services) also influence the performance of IDU TIs. Nevertheless, access to other health care services for IDUs must be improved both logistically (e.g. facilitating travel) as well as providing more IDU-friendly services.

Recommendations

- Enhancing the capacity of TI staff in conducting advocacy with various stakeholders is important. A more proactive role on the part of SACS has been suggested as a part of advocacy
- TIs must be supported in their efforts to improve the access of IDUs to other referral and linkage services. The network of such referral services must itself be strengthened. Orientation programs aimed at creating IDU-friendly services are required. However, even more decentralisation and exclusivity (such as testing and counselling at DIC itself) should be avoided
- In order to make the service provision as comprehensive as possible, the element of drug treatment must be highlighted in the program. This can be accomplished through strengthening the linkages at the central level with the Ministry of Social Justice and Empowerment (MSJE) and the Drug De-Addiction Program (DDAP) of the Ministry of Health and Family Welfare (MOH&FW). Both these entities run drug treatment centres through NGOs and government hospitals, respectively. It would also be necessary to support and encourage the TIs to facilitate access to these treatment services by IDUs

Resources and Inputs to the TIs

A wide variety of resources and support structures exist for the TIs. These include SACS, TSUs and STRCs. By and large, the support provided by these entities can be seen as very useful for the program. The STRCs have been building the basic capacities of the staff and the TSUs are providing on-site guidance and monitoring. However, there are gaps in the support provided. Inadequate budgets figured as a prominent performance-influencing factor for almost all the areas of TI functioning. While a detailed financial analysis was out of scope for this work, it can be safely concluded that TIs (as well as, many SACS and TSUs) see the existing budgets as inadequate for the TIs to perform efficiently.

Recommendations

- The budgets for the IDU TI program must be reviewed and optimised. In almost all the budget heads there is a need for an increase. Besides a fixed template for the budgets, some amount of flexibility is essential to take into account the unique, local needs of the program. Financial systems should also be streamlined to ensure that the flow of funds and supplies continues uninterruptedly.
- Existing staff composition must be revisited. Particularly the expectation that the same individual should be able to double-up as a nurse or counsellor must be seriously reconsidered. Similarly there should be flexibility in deciding the numbers and ratios of ORWs/PEs/clients. Female outreach workers are urgently required to address female partners/female IDUs as is the orientation and capacity building of the entire TI staff on these issues.
- SACS must be involved more proactively in finding and recruiting the staff for IDU TIs. For staff retention, specific, incentive-based strategies may be explored. Human resource development at the TI level and in fact, at all the levels in the program must receive due importance. This may take the form of addressing issues such as staff burn-out and stress-and-coping during the training programs. The PMs and the project directors of the parent NGOs, as well as, the TSU POs must be sensitised on human resource management issues.
- The capacity building systems require a major over-haul [5]. This must take the form of strengthening the STRCs, finding new institutional mechanisms for capacity building at all program levels (beyond TI staff and including the TSUs and SACS as well), revising the training schedules and curricula and expanding the pool of resource materials and resource persons.

[4] *A detailed description of training and many-related issues can also be found in the companion report: Ambekar A (2011), capacity Building Needs Assessment (CBNA) in the context of IDU TIs in India, UNODC ROSA, New Delhi*

Annexure

A. QUESTIONNAIRES USED IN THE STUDY

Factors Influencing Performance of IDU TIs
Questionnaire for Service Providers (IDU TIs)

A. ORGANISATION PROFILE (to be filled by Project Director of NGO / Program manager of TI)		
1. Name of NGO		
2. Address Office with phone number and email		
3. Address DIC		
4. Duration since working as IDU TI		
5. Current Target		
6. Providing…(Tick • one)	IDU TI services only	IDU TI services + OST
7. Current coverage (in %, IDUs covered / target)		
8. Average number of contacts made through the outreach on any given day:		
9. Average number of clients coming on any given day to receive OST:		
10. Average attendance in DIC on any given day		
11. Number of IDU TI staff in place (as of today)	11.1 PM	
	11.2 ORWs	
	11.3 PEs	
	11.4 ANM	
	11.5 Counsellor	
	11.6 Doctor	
	11.7 Any Other (specify)	
'Peer educators'		
12. Total number of peer educators in place as of today		
13. Total number of NEW peer educators placed till date in the last one year		
14. Total number of peer educators trained (in a formal training conducted by STRC) till date in last one year		
15. Total number of peer educators trained (in-house) till date in last one year		
16. Total number of trained peer educators in place as of today		

17.Other activities of the parent NGO (if any) Tick ✓ as many as applicable	☐ Drug treatment / rehab centre
	☐ Vocational rehab / counselling / training
	☐ Educational activities
	☐ Microfinance / SHGs
	☐ Shelter homes
	☐ Other TIs (FSW, MSM, Migrant etc.)
	☐ Any other (specify)
18. If the parent NGO conducts some other activities, do they influence (either positively or negatively) your work with IDUs in any way? Describe how.	

B. Implementing an IDU TI

1. Provided below is the list of some of the activities you regularly conduct.

For each of the activity listed below, mention the problems you encounter or have encountered in the past. Also list the possible solutions to these problems. These solutions may include some of the measures which you have already taken or some measures you expect other stakeholders (SACS / NACO / TSU / STRC etc.) to take.

Activity / Area	Problems encountered (now or in the past)	Solution (adopted by you or you expect others to provide these solutions)
1.1. Staff turnover		
1.2. Staff Recruitment		
1.3. Managing the infrastructure		
1.4. Ensuring the supplies		
1.5. Training of staff		
1.6. Line-listing		
1.7. Outreach planning		
1.8. Conducting outreach / fieldwork		
1.9. Maintaining regularity of contact / follow-up of clients		
1.10. Needle syringe exchange		
1.11. OST (Leave blank if you are not implementing OST. For those TIs implementing OST, there is a set of additional items towards the end)		
1.12. Documentation and reporting		
1.13. Reaching out to female partners / spouses of IDUs		
1.14. Reaching out to special population groups of IDUs (females, adolescents, any other)		
1.15. Community Mobilisation / Collectivisation / Formation of SHGs		
1.16. Advocacy		
1.17. Ensuring testing (ICTC) of IDUs		
1.18. Linkage with ART and ART adherence		
1.19. Other Referral and linkages		
1.20. Financial management		

2. Below is the list of some factors, which potentially influence the performance of your IDU TI, either positively or negatively. Please see which of these apply to your setting and also briefly mention how they influence performance in the activities and areas indicated below.

Please note that we would like to know about following areas:

2.1. Overall Program management
2.2. Outreach and regular contacts (including NSEP and waste management)
2.3. General medical care of IDU
2.4. Counselling and Behaviour Change
2.5. HIV Testing and treatment / Referrals and linkages
2.6. Working with Female IDUs and Partners of Male IDUs

For instance at some places, finding appropriate staff is difficult, while at others, the geographical area is such that the IDU population is scattered making outreach difficult. Some TIs may have noted that having people with the drug-use background on the staff (PM/ORW/PE) helps them to form a better rapport and deliver services to the IDUs. In some places there are some anti-social elements which hamper the functioning of IDU TI, while at certain others, it is the local police. Some TIs may have found that a police force sensitised and oriented to IDU issues through advocacy is a great help in delivering services. Please describe for each of the areas, how do factors related to staff, social/structural/climatic factors, capacity-related factors, technical support related factors and law-enforcement related factors influence the performance of IDU TI.

Factors related to	2.1 Overall Program management
2.1.1. STAFF (such as, finding appropriate staff during recruitment, staff attitude and motivation etc.)	Which STAFF related factors influence Overall Program management and how?
2.1.2. SOCIAL / STRUCTURAL / GEOGRAPHICAL / CLIMATIC FACTORS (such as adverse climate, attitude of general community etc)	Which SOCIAL / STRUCTURAL / GEOGRAPHICAL / CLIMATIC FACTORS influence Overall Program management and how?
2.1.3. CAPACITY / KNOWLEDGE RELATED FACTORS (Inadequate training etc)	Which CAPACITY / KNOWLEDGE RELATED FACTORS influence Overall Program management and how?
2.1.4. TECHNICAL / FINANCIAL SUPPORT SYSTEMS (SUCH AS NACO / SACS / TSU / STRC / PARENT NGO) (inadequate / not timely provision of funds etc)	Which TECHNICAL / FINANCIAL SUPPORT SYSTEMS (SUCH AS NACO, SACS, TSU, STRC, PARENT NGO) related factors influence Overall Program management and how?
2.1.5. LEGAL / LAW ENFORCEMENT RELATED FACTORS (harassment by police or anti-social elements, poor law and order etc)	Which LEGAL / LAW ENFORCEMENT RELATED FACTORS influence Overall program management and how?
2.1.6. OTHERS FACTORS (please specify)	Which OTHER FACTORS influence Overall Program management and how?

Factors related to	2.2 Outreach and regular contacts (including NSEP and waste management)
2.2.1 STAFF (such as, finding appropriate staff during recruitment, staff attitude and motivation etc.)	Which STAFF related factors influence Outreach and regular contacts (including NSEP and waste management) and how?
2.2.2 SOCIAL / STRUCTURAL / GEOGRAPHICAL / CLIMATIC FACTORS (such as adverse climate, attitude of general community etc)	Which SOCIAL / STRUCTURAL / GEOGRAPHICAL / CLIMATIC FACTORS `influence Outreach and regular contacts (including NSEP and waste management) and how?
2.2.3 CAPACITY / KNOWLEDGE RELATED FACTORS (Inadequate training etc)	Which CAPACITY / KNOWLEDGE RELATED FACTORS influence Outreach and regular contacts (including NSEP and waste management) and how?
2.2.4 TECHNICAL / FINANCIAL SUPPORT SYSTEMS (SUCH AS NACO / SACS / TSU / STRC / PARENT NGO) (inadequate / not timely provision of funds etc)	Which TECHNICAL / FINANCIAL SUPPORT SYSTEMS (SUCH AS NACO / SACS / TSU / STRC / PARENT NGO) related factors influence Outreach and regular contacts (including NSEP and waste management) and how?
2.2.5 LEGAL / LAW ENFORCEMENT RELATED FACTORS (harassment by police or anti-social elements, poor law and order etc)	Which LEGAL / LAW ENFORCEMENT RELATED FACTORS influence Outreach and regular contacts (including NSEP and waste management) and how?
2.2.6 OTHERS FACTORS (please specify)	Which OTHERS FACTORS influence Outreach and regular contacts (including NSEP and waste management) and how?
Factors related to	2.3 General medical care of IDU
2.3.1 STAFF (such as, finding appropriate staff during recruitment, staff attitude and motivation etc.)	Which STAFF FACTORS influence General medical care of IDU and how?
2.3.2 SOCIAL / STRUCTURAL / GEOGRAPHICAL / CLIMATIC FACTORS (such as adverse climate, attitude of general community etc)	Which SOCIAL / STRUCTURAL / GEOGRAPHICAL / CLIMATIC FACTORS influence General medical care of IDU and how?
2.3.3 CAPACITY / KNOWLEDGE RELATED FACTORS (Inadequate training etc)	Which CAPACITY / KNOWLEDGE RELATED FACTORS influence General medical care of IDU and how?

2.3.4 TECHNICAL / FINANCIAL SUPPORT SYSTEMS (SUCH AS NACO / SACS / TSU / STRC / PARENT NGO) (inadequate / not timely provision of funds etc)	Which TECHNICAL / FINANCIAL SUPPORT SYSTEMS (SUCH AS NACO / SACS / TSU / STRC / PARENT NGO) influence General medical care of IDU and how?
2.3.5 LEGAL / LAW ENFORCEMENT RELATED FACTORS (harassment by police or anti-social elements, poor law and order etc)	Which LEGAL / LAW ENFORCEMENT RELATED FACTORS influence General medical care of IDU and how?
2.3.6 OTHERS FACTORS (please specify)	Which OTHERS FACTORS influence General medical care of IDU and how
Factors related to	2.4 Counselling and Behaviour Change
2.4.1 STAFF (such as, finding appropriate staff during recruitment, staff attitude and motivation etc.)	Which STAFF FACTORS influence Counselling and Behaviour Change and how?
2.4.2 SOCIAL / STRUCTURAL / GEOGRAPHICAL / CLIMATIC FACTORS (such as adverse climate, attitude of general community etc)	Which SOCIAL / STRUCTURAL / GEOGRAPHICAL / CLIMATIC FACTORS influence Counselling and Behaviour Change and how?
2.4.3 CAPACITY / KNOWLEDGE RELATED FACTORS (Inadequate training etc)	Which CAPACITY / KNOWLEDGE RELATED FACTORS influence Counselling and Behaviour Change and how?
2.4.4 TECHNICAL / FINANCIAL SUPPORT SYSTEMS (SUCH AS NACO / SACS / TSU / STRC / PARENT NGO) (inadequate / not timely provision of funds etc)	Which TECHNICAL / FINANCIAL SUPPORT SYSTEMS (SUCH AS NACO / SACS / TSU / STRC / PARENT NGO) FACTORS influence Counselling and Behaviour Change and how?
2.4.5 LEGAL / LAW ENFORCEMENT RELATED FACTORS (harassment by police or anti-social elements, poor law and order etc)	Which LEGAL / LAW ENFORCEMENT RELATED FACTORS influence Counselling and Behaviour Change and how?
2.4.6 OTHERS FACTORS (please specify)	Which OTHERS FACTORS influence Counselling and Behaviour Change and how?

Factors related to	2.5 HIV Testing and treatment / Referrals and linkages
2.5.1 STAFF (such as, finding appropriate staff during recruitment, staff attitude and motivation etc.)	Which STAFF FACTORS influence HIV Testing and treatment / Referrals and linkages and how?
2.5.2 SOCIAL / STRUCTURAL / GEOGRAPHICAL / CLIMATIC FACTORS (such as adverse climate, attitude of general community etc)	Which SOCIAL / STRUCTURAL / GEOGRAPHICAL / CLIMATIC FACTORS influence HIV Testing and treatment / Referrals and linkages and how?
2.5.3 CAPACITY / KNOWLEDGE RELATED FACTORS (Inadequate training etc)	Which CAPACITY / KNOWLEDGE RELATED FACTORS influence HIV Testing and treatment / Referrals and linkages and how?
2.5.4 TECHNICAL / FINANCIAL SUPPORT SYSTEMS (SUCH AS NACO / SACS / TSU / STRC / PARENT NGO) (inadequate / not timely provision of funds etc)	Which TECHNICAL / FINANCIAL SUPPORT SYSTEMS (SUCH AS NACO / SACS / TSU / STRC / PARENT NGO) FACTORS influence HIV Testing and treatment / Referrals and linkages and how?
2.5.5 LEGAL / LAW ENFORCEMENT RELATED FACTORS (harassment by police or anti-social elements, poor law and order etc)	Which LEGAL / LAW ENFORCEMENT RELATED FACTORS influence HIV Testing and treatment / Referrals and linkages and how?
2.5.6 OTHERS FACTORS (please specify)	Which OTHERS FACTORS influence HIV Testing and treatment / Referrals and linkages and how?
Factors related to	2.6 Working with Female IDUs and Partners of Male IDUs
2.6.1. STAFF (such as, finding appropriate staff during recruitment, staff attitude and motivation etc.)	Which STAFF FACTORS influence Working with Female IDUs and Partners of Male IDUs and how?
2.6.2. SOCIAL / STRUCTURAL / GEOGRAPHICAL / CLIMATIC FACTORS (such as adverse climate, attitude of general community etc)	Which SOCIAL / STRUCTURAL / GEOGRAPHICAL / CLIMATIC FACTORS influence Working with Female IDUs and Partners of Male IDUs and how?
2.6.3 CAPACITY / KNOWLEDGE RELATED FACTORS (Inadequate training etc)	Which CAPACITY / KNOWLEDGE RELATED FACTORS influence Working with Female IDUs and Partners of Male IDUs and how?

2.6.4 TECHNICAL / FINANCIAL SUPPORT SYSTEMS (SUCH AS NACO / SACS / TSU / STRC / PARENT NGO) (inadequate / not timely provision of funds etc)	Which TECHNICAL / FINANCIAL SUPPORT SYSTEMS (SUCH AS NACO / SACS / TSU / STRC / PARENT NGO)FACTORS influence Working with Female IDUs and Partners of Male IDUs and how?
2.6.5 LEGAL / LAW ENFORCEMENT RELATED FACTORS (harassment by police or anti-social elements, poor law and order etc)	Which LEGAL / LAW ENFORCEMENT RELATED FACTORS influence Working with Female IDUs and Partners of Male IDUs and how?
2.6.6 OTHERS FACTORS (please specify)	Which OTHERS FACTORS influence Working with Female IDUs and Partners of Male IDUs and how?

3. Can you describe the specific ways in which the TSU / NERO (in case of northeast states) has helped you improve the performance of your TI?
4. Do you have any other suggestions / advise about improving the performance of IDU TIs?

C. Staff (To be filled in by the PM or the respective staff themselves)			
PM			
1. Qualification			
2. Duration of Experience as PM of IDU TI			
3. Any other work experience (provide details)			
4. Whether would like to describe himself / herself as 'from the drug use background'?			
5. Number of training programs attended as PM			
6. Details of training Programs *Mention, for each training attended*	Year of training,	Program conducted by	Main topics covered
7. Exposure visits to other IDU TIs and their details Mention, for each exposure visit –year, place/site where exposure visit was made, visit organised by			
8. Has there been a staff turnover in the last one year (staff leaving the project in the last one year)?	No		Yes

9. If YES, Please mention the cadre of staff and the number against the cadre who have left in the last one year	Cadre	Number of staff who have left	
	PM		
	ANM/Counsellor		
	Doctor		
	ORW		
	PEs		
ORW 1(senior most) (To be filled in by the PM or the respective staff themselves)			
10. Qualification			
11. Duration of Experience as ORW of IDU TI			
12. Any other work experience (provide details)			
13. Whether would like to describe himself / herself as 'from the drug use background'?			
14. Number of training Programs attended as ORW			
15. Details of training Programs *Mention, for each training attended –*	Year of training,	Program conducted by	Main topics covered
16. Exposure visits to other IDU TIs and their details *Mention, for each exposure visit –year, place/site where exposure visit was made, visit organised by*			
ORW 2 (Junior most) (To be filled in by the PM or the respective staff themselves)			
17. Qualification			
18. Duration of Experience as ORW of IDU TI			
19. Any other work experience (provide details)			
20. Whether would like to describe himself / herself as 'from the drug use background'?			
21. Number of training programs attended as ORW			
22. Details of training programs *Mention, for each training attended –*	Year of training,	program conducted by	main topics covered

23. Exposure visits to other IDU TIs and their details *Mention, for each exposure visit –year, place/site where exposure visit was made, visit organised by*			
ANM / Counsellor (To be filled in by the **PM** or the respective staff themselves) (to be filled in separately for both, in case the **TI** has both - an **ANM** and a counsellor. see below)			
24. Qualification			
25. Duration of Experience as ANM / Counsellor of IDU TI			
26. Any other work experience (provide details)			
27. Whether would like to describe himself / herself as 'from the drug use background'?			
28. Number of training programs attended as ANM / Counsellor			
29. Details of training Programs *Mention, for each training attended –*	Year of training,	Program conducted by	Main topics covered
30. Exposure visits to other IDU TIs and their details *Mention, for each exposure visit –year, place/site where exposure visit was made, visit organised by*			
ANM / Counsellor (To be filled in by the **PM** or the respective staff themselves) (to be filled in separately for both, in case the **TI** has an **ANM** and a counsellor. If the **TI** has just one person as **ANM / Counsellor**, skip this)			
31. Qualification			
32. Duration of Experience as ANM / Counsellor of IDU TI			
33. Any other work experience (provide details)			
34. Whether would like to describe himself / herself as 'from the drug use background'?			
35. Number of training programs attended as ANM / Counsellor			

36. Details of training Programs *Mention, for each training attended –*	Year of training,	Program conducted by	Main topics covered
37. Exposure visits to other IDU TIs and their details			
Mention, for each exposure visit –year, place/site where exposure visit was made, visit organised by			
Doctor (To be filled in by the PM or the respective staff themselves)			
38. Qualification			
39. Duration of Experience as Doctor attached to IDU TI			
40. Any other work experience (provide details)			
41. Number of training programs attended as Doctor attached to IDU TI			
42. Details of training Programs *Mention, for each training attended –*	Year of training,	Program conducted by	Main topics covered
43. Exposure visits to other IDU TIs and their details			
Mention, for each exposure visit –year, place/site where exposure visit was made, visit organised by			
D. Staff and their training needs Please see the table below. Which of the following aspects of TI functioning you think the staff needs training in? Feel free to elaborate.			
Note: Ideally the following table must be filled by the individual staff. However, in case it is difficult, program managers may also – as per their understanding of staff training needs – respond to the following table.			

Legend:

Fill '1', if Trained and feel fully confident; no further training required
Fill '2', if Trained; but may benefit from further training
Fill '3', if Not received any training at all

	PM	ORW (applies to ORWs in general)	ANM / Counsellors	Peer educators	Doctor	M & E officer (if applicable)
1.Basic knowledge about drug addiction and IDU						
2. Basic understanding about HIV and Harm reduction						
3. Outreach planning and conducting						
4. Running and managing a DIC						
5. Counselling / BCC						
6. Needle Syringe exchange including demand analysis						
7. Condom distribution						
8. STI detection and treatment						
9. Abscess management, and general medical care						
10. Waste disposal including Post Exposure Prophylaxis (PEP)						
11. OST						
12. Overdose prevention and management						
13. Community mobilisation						
14. Referrals and linkages / Networking						
15. Advocacy						
16. Reporting						
17. Program management (only for PM)						
18. Providing services to Female sex partners						
19. Providing services to Female IDUs						
20. Any other topic / theme 1						
21. Any other topic / theme 2						
22. Any other topic / theme 3						
23. Do you have any resource material in the TI,(such as operational or practice guidelines or manuals etc) to which the staff can refer to? If yes, please mention the names.						
24. In what way the STRC has contributed to functioning and capacity-enhancement of your TI? Describe briefly.						

25. Do you have any specific suggestions to improve the training systems (process or manner of training) for staff of IDU TIs? Please provide details. *To be filled in by the PM. Specific suggestions from individual staff may be obtained by the PM.*
a) Training methods
b) Training frequency
c) Training language
d) Resource material
e) Trainers / resource persons
f) Any other
E. Only For those IDU TIs which are implementing OST too
1. In your opinion, how does OST influence your other activities with IDUs?
2. In your opinion, how do other TI activities influence OST?
Regarding OST, in which of the following areas you think your staff needs training.

Fill '1', if Trained and feel fully confident; no further training required
Fill '2', if Trained; but may benefit from further training
Fill '3', if Not received any training at all

	PM	ORW (applies to ORWs in general)	ANM / Counsellors	Peer educators	Doctor	M & E officer (if applicable)
3.Deciding which IDU clients are suitable for OST						
4. Diagnosing Opioid Dependence						
5. Explaining the benefits of OST to clients / motivating them for OST						
6. Deciding about appropriate dose of OST						
7. Dispensing of OST medications						
8. Managing stock related to OST						
9. Record Maintenance related to OST						
10. Understanding Drug interactions between buprenorphine and other drugs						
11. Counselling of clients on OST / ensuring regularity of treatment						
12. Follow-up and reaching out to clients who have dropped out						
13. Any other topic / theme						

- End of Survey - Thank You very much for your time and patience.

Factors Influencing Performance of IDU TIs

Questionnaire for State AIDS Control Society

Profile of SACS (to be filled by JDTI / DDTI / ADTI any other official familiar with functioning and training needs of IDU TIs)	
1. Name of SACS	
2. Address Office	
3. Number of IDU TIs currently functional in state (only core, not composite)	
4. In which year did the FIRST IDU TI became functional in your state?	
5. Current, approximate coverage of IDU population (in %)	
6. Whether STRC present in state?	
7. Whether TSU present in state?	
8. What is the number of training Programs held for IDU TIs of your state, in last one year?	
9. What is the number of exposure visits held for IDU TIs of your state, in last one year?	
10. Number of IDU TIs for whom, there has been NO INDUCTION TRAINING (on IDU specific issues) till date	
11. Number of IDU TIs for whom, there has been just an induction training but NO FURTHER / REFRESHER TRAININGS till date	

Capacity of SACs for Monitoring the IDU TIs			
One of the important activities of the SACS is to monitor the functioning of IDU TIs. In your assessment / opinion, in which of the following areas, SACS officials in your state need capacity building in order to be able to effectively monitor the IDU TIs? *Note: There may be variations among SACS staff with some officials more in need of capacity building, than others. Please provide response to this questions in terms of what you think applies to most of the SACS staff.*			
	1. Fully capacitated to monitor the IDU TI program; no further training required	2. Can manage to monitor the IDU TI program, but may benefit from further training	3. Not received any training or do not have the capacity to monitor the program
12. Basic knowledge about drug addiction and IDU			
13. Basic understanding about HIV and Harm reduction			
14. Outreach planning and conducting			
15. Running and managing a DIC			
16. BCC			

	1. Fully capacitated to monitor the IDU TI program; no further training required	2. Can manage to monitor the IDU TI program, but may benefit from further training	3. Not received any training or do not have the capacity to monitor the program
17. Needle Syringe exchange including demand analysis			
18. Condom distribution			
19. Abscess management and primary health care			
20. Waste disposal			
21. OST			
22. Overdose management			
23. Community mobilisation			
24. Referrals and linkages / Networking			
25. Advocacy			
26. Reporting			
27. Providing services to Female sex partners			
28. Providing services to Female IDUs			
29. Any other topic / theme 1			
30. Any other topic / theme 2			
31. Any other topic / theme 3			

Capacity of IDU TIs			
In your assessment / opinion, in which of the following areas, IDU TIs in your state need capacity building? *Note: There may be variations among TIs with some TIs more in need of capacity building, than others. Please provide response to this questions in terms of what you think applies to most of the IDU TIs.*			
	1. Trained and fully capacitated to implement the program; no further training required	2. Trained and can manage to implement the program, but may benefit from further training	3. Not received any training or do not have the capacity to implement the program
1. Basic knowledge about drug addiction and IDU			
2. Basic understanding about HIV and Harm reduction			
3. Outreach planning and conducting			
4. Running and managing a DIC			
5. BCC			
6. Needle Syringe exchange including demand analysis			
7. Condom distribution			
8. Abscess management and primary health care			
9. Waste disposal			
10. OST			

	1. Trained and fully capacitated to implement the program; no further training required	2. Trained and can manage to implement the program, but may benefit from further training	3. Not received any training or do not have the capacity to implement the program
11. Overdose management			
12. Community mobilisation			
13. Referrals and linkages / Networking			
14. Advocacy			
15. Reporting			
16. Providing services to Female sex partners			
17. Providing services to Female IDUs			
18. Any other topic / theme 1			
19. Any other topic / theme 2			
20. Any other topic / theme 3			
21. Please list briefly, the challenges, which you think are faced by SACS, regarding training of IDU TIs			

22. Please list briefly your suggestions and recommendations for improving the capacity building program for IDU TIs

23. Provided below is the list of some of the activities IDU TIs regularly conduct. For each of the activity listed below, mention the problems IDU TIs encounter / or have encountered in the past. Also list the possible solutions to these problems. These solutions may include some of the measures which IDU TIs have already taken or some measures you expect other stakeholders (NACO etc.) to take.

Activity	Problems encountered (now or in the past)	Solution (adopted by the TIs or you expect other stakeholders to provide these solutions)
23.1. Staff turnover		
23.2. Staff Recruitment		
23.3. Managing the infrastructure		
23.4. Ensuring the supplies		
23.5. Training of staff		
23.6. Line-listing		
23.7. Outreach planning		
23.8. Conducting outreach / fieldwork		
23.9. Maintaining regularity of contact		
23.10. Needle syringe exchange		
23.11. OST		
23.12. Documentation and reporting		

Activity	Problems encountered (now or in the past)	Solution (adopted by the TIs or you expect other stakeholders to provide these solutions)
23.13. Reaching out to female partners / spouses of IDUs		
23.14. Reaching out to special population groups of IDUs (females, adolescents, any other)		
23.15. Referral and linkages		
23.16. Formation of SHGs		
23.17. Advocacy		
23.18. Ensuring testing (ICTC) of IDUs		
23.19. Linkage with ART and ART adherence		
23.20. Financial management		
24. Can you describe the specific ways in which the STRC has helped in the state to improve the capacities and performance of IDU TIs?		
25. Can you describe the specific ways in which the TSU / NERO (for northeast states) has helped in the state to improve the performance of IDU TIs?		
26. Do you have any other suggestions / advise about improving the performance of IDU TIs?		
27. Do you have any suggestions about improving the capacities of monitoring officers from SACS, related to the monitoring of IDU TIs?		

- End of Survey - Thank You very much for your time and patience.

Factors Influencing Performance of IDU TIs

Questionnaire for Training Officers from STRCs

(To be filled preferably by the STRC coordinator. Most of the responses would require extensive knowledge of functioning of this STRC)

Note: If a single organisation is responsible to function as STRC for more than one state, separate questionnaires should be filled for each of the states.

State_____

Profile of STRC	
1. Name of STRC	
2. Address Office	
3. Duration since working as STRC	
4. Other activities of the parent organisation (if any)	
5. Do other activities of the parent organisation influence your work as STRC – specifically in the context of training for IDU TIs – in any way? If Yes, how?	
6. Total Number of Training Programs conducted for TIs in last one year (ANY type of TIs)	
Number of Training Program conducted for IDU TIs in last one year	
7. Number of Training Programs conducted Exclusively for IDU TIs	
8. Number of Training Programs conducted in which IDU TIs were also trained	
9. Please provide details of training programs conducted by you for the IDU TI staff in past one year: (if a document / report exists summarising this information, it may kindly be attached) *Please mention for each training:* *Month,* *Main Topics,* *Duration in days,* *Number and type of participants*	
10. The language in which the training programs are usually conducted is..	☐ English ☐ Other ☐ (Specify)_____

11. In most of the training programs FOR IDU TIS where do you get resource persons from?	☐ ☐ ☐ ☐	ONLY In-house resource persons (among STRC officials) In-house + outside resource persons (within state) In-house + outside resource persons (including those from outside the state) Outside resource persons only (within or from outside the state)
12. Total number of resource persons which you have used for IDU TI trainings till date, in last one year.	☐ ☐ ☐	In-house resource persons (among STRC officials) Resource persons outside STRC (but within state) Resource persons from outside the state
13. Besides in-house resource persons, do you have a roster of resource persons from outside (for any type of training)?		
14. Total number of resource persons in the roster…		
15. Total number of resource persons in the roster, who are specific for IDU related training …		
16. Do you have an academic committee in place?		
17. Total number of members in the academic committee…		
18. Total number of members in the academic committee who could be regarded as IDU experts…		
19. Please Mention the names of TRAINING MANUALS you use for training of IDU TIs (Title and publishing agency / organisation's name)		
20. Mention the names of other resource materials – such as practice guidelines or operational guidelines – you use for training of IDU TIs (Title and publisher's name)		
21. Are you aware of any other training manuals / resource materials which could be used for training of IDU TIs? Though you may not be using them. (you can include both national as well as international publications in your responses)		

22. Has your STRC developed / translated in local language, any training / resource material specific for IDU TIs? Please mention names.			
In your opinion, for which of the following areas of functioning of IDU TI, the EXISTING TRAINING MANUALS are inadequate? (Tick ✓ one) *Note: Please DO NOT consider operational or practice guidelines here*			
Topic / Area	Existing Manuals / training material ADEQUATE	Existing Manuals / training material INADEQUATE	Can't say since we have never conducted training on this issue
23. Basic knowledge about drug addiction and IDU			
24. Basic understanding about HIV and Harm reduction			
25. Outreach planning and conducting			
26. Running and managing a DIC			
27. BCC			
28. Needle Syringe exchange including demand analysis			
29. Condom distribution			
30. Abscess management and primary health care			
31. Waste disposal			
32. OST			
33. Overdose management			
34. Community mobilisation			
35. Referrals and linkages / Networking			
36. Advocacy			
37. Reporting			
38. Providing services to Female sex partners			
39. Providing services to Female IDUs			
40. Any other topic / theme 1			
41. Any other topic / theme 2			
42. Any other topic / theme 3			
In your opinion, for which of the following areas of functioning of IDU TI, the existing resource materials (such as practice or operational guidelines) are inadequate? (Tick ✓ one)			
Topic / Area	Existing resource materials (such as practice or operational guidelines) ADEQUATE	Existing resource materials (such as practice or operational guidelines) INADEQUATE	Can't say since we have never conducted training on this issue
43. Basic knowledge about drug addiction and IDU			
44. Basic understanding about HIV and Harm reduction			

Topic / Area	Existing resource materials (such as practice or operational guidelines) ADEQUATE	Existing resource materials (such as practice or operational guidelines) INADEQUATE	Can't say since we have never conducted training on this issue
45. Outreach planning and conducting			
46. Running and managing a DIC			
47. BCC			
48. Needle Syringe exchange including demand analysis			
49. Condom distribution			
50. Abscess management and primary health care			
51. Waste disposal			
52. OST			
53. Overdose management			
54. Community mobilisation			
55. Referrals and linkages / Networking			
56. Advocacy			
57. Reporting			
58. Providing services to Female sex partners			
59. Providing services to Female IDUs			
60. Any other topic / theme 1			
61. Any other topic / theme 2			
62. Any other topic / theme 3			

63. What is your opinion on the language of Training Manuals? (Tick ✓ one)	
☐	Training manuals in English are fine, though the training delivery should be largely in local language
☐	Training manuals should be available in local languages
64. What is your opinion on method of training? (Tick •one)	
☐	A typical classroom training only is adequate
☐	A combination of class room training with practical exposure which is delivered in classroom setting / training venue itself
☐	A combination of classroom training with a field visit to a functioning TI site

Please see the matrix below. There is a list of certain activities which an IDU TI is supposed to conduct / know. On which of the following aspects of IDU TI functioning you think the training officers in your STRC need more TOT / exposure?

Note: Ideally the following matrix must be filled after consulting the training officers. It is quite possible that there is variation among Training officers, with some of them fully trained and comfortable, while others may not be fully trained and comfortable. The responses should pertain to the 'largely' felt need of the STRC.

	1. Training officers Trained and feel fully confident in training the TI staff; no further TOT required	2. Training officers Trained and can manage somehow to train the TI staff, but may benefit from further training	3. Training officers have Not received any training or do not feel comfortable in training the TI staff
65. Basic knowledge about drug addiction and IDU			
66. Basic understanding about HIV and Harm reduction			
67. Outreach planning and conducting			
68. Running and managing a DIC			
69. BCC			
70. Needle Syringe exchange including demand analysis			
71. Condom distribution			
72. Abscess management and primary health care			
73. Waste disposal			
74. OST			
75. Overdose management			
76. Community mobilisation			
77. Referrals and linkages / Networking			
78. Advocacy			
79. Reporting			
80. Program management			
81. Providing services to Female sex partners			
82. Providing services to Female IDUs			
83. Any other topic / theme 1			
84. Any other topic / theme 2			
85. Any other topic / theme 3			

Profile of Training Officers (to be filled by any three training officers)	
Training Officer -1	
1. Qualification	
2. Duration of Experience as Training officer of STRC	
3. Any other work experience (provide details)	
4. Any other experience / exposure with drug users / IDUs? (mention briefly)	
5. Number of training programs facilitated / co-facilitated as Training officer of STRC (for any type of training)	
6. Number of training programs facilitated / co-facilitated as Training officer of STRC - SPECIFICALLY FOR IDU TIs	
7. Number of TOT programs attended as Training officer of STRC	
8. Number of TOT programs attended as Training officer of STRC SPECIFICALLY ON IDU issues	
9. Details of TOT Programs *Mention, for each TOT attended –year, duration of program in days, program conducted by, main topics covered*	
10. Number and details of exposure visits (related to IDU TI) attended, if any *Mention, for each exposure visit–year, duration of visit in days, visit conducted at, main topics covered*	
Training Officer -2	
11. Qualification	
12. Duration of Experience as Training officer of STRC	
13. Any other work experience (provide details)	
14. Any other experience / exposure with drug users / IDUs? (mention briefly)	
15. Number of training programs facilitated / co-facilitated as Training officer of STRC (for any type of training)	
16. Number of training programs facilitated / co-facilitated as Training officer of STRC - specially for IDU TIs	
17. Number of TOT programs attended as Training officer of STRC	
18. Number of TOT programs attended as Training officer of STRC SPECIFICALLY ON IDU issues	

19. Details of TOT Programs *Mention, for each TOT attended –year, duration of program in days, program conducted by, main topics covered*		
20. Number and details of exposure visits (related to IDU TI) attended, if any *Mention, for each exposure visit–year, duration of visit in days, visit conducted at, main topics covered*		
Training Officer -3		
21. Qualification		
22. Duration of Experience as Training officer of STRC		
23. Any other work experience (provide details)		
24. Any other experience / exposure with drug users / IDUs? (mention briefly)		
25. Number of training programs facilitated / co-facilitated as Training officer of STRC (for any type of training)		
26. Number of training programs facilitated / co-facilitated as Training officer of STRC - specifically for IDU TIs		
27. Number of TOTs attended as Training officer of STRC		
28. Number of TOTs attended as Training officer of STRC S specifically on IDU issues		
29. Details of TOTs *Mention, for each TOT attended –year, duration of program in days, program conducted by, main topics covered*		
30. Number and details of exposure visits (related to IDU TI) attended, if any		
Mention, for each exposure visit–year, duration of visit in days, visit conducted at, main topics covered		
31. Do you have any specific suggestions to improve the training systems for staff of IDU TIs? (provide details)		
32. Do you have any specific suggestions to improve the way the STRCs function? (provide details)		

- End of Survey - Thank You very much for your time and patience.

Factors Influencing Performance of IDU TIs

Questionnaire for Technical Support Unit (TSU) / NERO (in case of North-eastern states)

Note: If a single organisation is responsible to function as TSU for more than one state, separate questionnaires should be filled for each of the states. (For instance NERO is responsible for many states)

Profile of TSU / NERO in case of North east (to be filled by Team Leader – TI or any other official familiar with issues related to IDU TIs)	
1. Name of TSU	
2. Address Office	
3. Any other activities conducted by the parent organisation?	
4. Does the activities of the parent organisation influence in any way, your work as a TSU with the IDU TIs? Whether positively or negatively? Please describe briefly	
5. Total number of program officers in the TSU	
6. Number of IDU TIs currently functional in state (only core, not composite)	
7. In which year did the FIRST IDU TI became functional in your state?	
8. In which year, did the first TSU become functional in your state?	
9. In which year, did your organisation start working as a TSU in this state?	
10. Current, approximate coverage of IDU population (in %)	
11. Whether STRC present in state?	
12. What is the number of trainings held for IDU TIs of your state, in last one year?	
13. What is the number of exposure visits held for IDU TIs of your state, in last one year?	
14. Number of TIs for whom, there has been No Induction Training (on IDU specific issues) till date	
15. Number of TIs for whom, there has been just an induction training but NO FURTHER / REFRESHER TRAININGS till date	

Capacity building needs of TSU			
To be filled by the senior most PO or team leader – TI The program officers of TSU are expected to provide technical assistance to IDU TI staff for many activities. In you assessment / opinion, for which of the following activities, the program officers of your TSU need their own capacity building? Note: There may be variations among program officers with some program officers more in need of capacity building, than others. Please provide response to this questions in terms of what applies to most of the POs.			
	1. The POs are Trained and fully capacitated to assist the IDU TIs; no further training required	2. The POs are Trained and can manage to assist the IDU TIs, but may benefit from further training	3. Not received any training or do not have the capacity to assist the IDU TIs
16. Basic knowledge about drug addiction and IDU			
17. Basic understanding about HIV and Harm reduction			
18. Outreach planning and conducting			
19. Running and managing a DIC			
20. BCC			
21. Needle Syringe exchange including demand analysis			
22. Condom distribution			
23. Abscess management and primary health care			
24. Waste disposal			
25. OST			
26. Overdose prevention and management			
27. Community mobilisation			
28. Referrals and linkages / Networking			
29. Advocacy			
30. Reporting			
31. Providing services to Female sex partners			
32. Providing services to Female IDUs			
33. Any other topic / theme 1			
34. Any other topic / theme 2			
35. Any other topic / theme 3			

Problems encountered by IDU TIs and their solutions		
36. Provided below is the list of some of the activities the IDU TIs are expected to conduct. For each of the activity listed below, mention the problems IDU TIs encounter / or have encountered in the past. Also list the possible solutions to these problems. These solutions may include some of the measures which IDU TIs (with or without assistance from the TSU) have already taken or some measures you expect other stakeholders (SACS / NACO etc.) to take.		
Activity	Problems encountered (now or in the past)	Solution (adopted by TIs or you or you expect others to provide these solutions)
36.1. Staff turnover		
36.2. Staff Recruitment		
36.3. Managing the infrastructure		
36.4. Ensuring the supplies		
36.5. Training of staff		
36.6. Line-listing		
36.7. Outreach planning		
36.8. Conducting outreach / fieldwork		
36.9. Maintaining regularity of contact		
36.10. Needle syringe exchange		
36.11. OST		
36.12. Documentation and reporting		
36.13. Reaching out to female partners / spouses of IDUs		
36.14. Reaching out to special population groups of IDUs (females, adolescents, any other)		
36.15. Referral and linkages		
36.16. Formation of SHGs		
36.17. Advocacy		
36.18. Ensuring testing (ICTC) of IDUs		
36.19. Linkage with ART and ART adherence		
36.20. Financial management		
37. Please list briefly, the challenges, which you think are faced by TSU, regarding capacities of IDU TIs		
38. Please list briefly those areas where you think that the TSU program officers have to provide on-site / on-field training for the IDU TI staff, over and above the class-room training?		
39. Please list briefly your suggestions and recommendations for improving the capacity building program for IDU TIs		
40. Please list briefly your suggestions and recommendations for improving the performance of IDU TIs		

Factors Influencing Performance of IDU TIs

Questionnaire for RRTC

(To be filled preferably by the RRTC coordinator. Most of the responses would require extensive knowledge of functioning of this RRTC)

Profile of RRTC		
1.Name of RRTC		
2. Address Office		
3) Duration since working as RRTC		
4) List names of the States for which the RRTC is responsible		
5) Other activities of the parent organisation		
6) Total Number of Training Programs conducted for NGO drug treatment centres in last one year?		
7) Have you EVER conducted training programs for IDU TIs (working under the National AIDS Control Program)?	Yes	No
8) Have you EVER conducted Training Programs EXCLUSIVELY for IDU TIs?	Yes	No
9) Do issues pertaining to 'Injecting Drug Use and HIV' figure in the training curriculum for NGO drug treatment centres?	Yes	No
10) The language in which the training programs are usually conducted is..	☐	English
	☐	Other
	☐	(Specify)_____
11) In most of the training programs where do you get resource persons from?	☐	ONLY In-house resource persons (among RRTC officials)
	☐	In-house + outside resource persons (within state)
	☐	In-house + outside resource persons (including those from outside the state)
	☐	Outside resource persons only (within or from outside the state)
12) Please Mention the names of TRAINING MANUALS you use for training (Title and publishing agency / organisation's name)		
13) Has your RRTC developed / translated in local language, any training / resource material specific for IDU and HIV issues? Please mention names.		

14) What is your opinion on the language of Training Manuals? (Tick ✓one)	
☐	Training manuals in English are fine, though the training delivery should be largely in local language
☐	Training manuals should be available in local languages
15) What is your opinion on method of training? (Tick •one)	
☐	A typical classroom training only is adequate
☐	A combination of class room training with practical exposure which is delivered in classroom setting / training venue itself
☐	A combination of classroom training with a field visit

- End of Survey - Thank You very much for your time and patience.