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India's voice against AIDS
Ministry of Health & Family Welfare, Government of India
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DROP – IN CENTRE
FOR INJECTING DRUG USERS

STANDARD OPERATING PROCEDURE

Project HIFAZAT: Strengthen the capacity, reach and quality of IDU harm reduction services

Year of Publication: 2012

Published by:

United Nations Office on Drugs and Crime, Regional Office for South Asia

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Standard Operating Procedure
Drop-in Centre
For Injecting Drug Users

"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"

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

Preface

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 a peer based outreach as well as a static premise based approach, i.e., 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 (i.e., 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 series of seven Standard Operating Procedures (SOPs) including the present one on Drop-in Centre (DIC) has been developed. This SOP also feeds into the broader NACP goals and helps strengthen and consolidate the gains of the TIs towards scaling up of critical services.

This SOP on Drop-in Centre is the second in a series of seven SOPs developed. The main purpose of this SOP is to help address the operational challenges of program implementation with specific reference to the functioning and day to day management of a DIC.

This SOP therefore, has also been developed with a vision to serve as an invaluable tool for the service providers engaged in IDU TIs in India and 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 was critical towards articulating and consolidating inputs that went into finalizing this SOP.

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 with leading non-governmental organizations in the countries of South Asia is implementing a project titled "Prevention of transmission of HIV among drug users in SAARC countries" (RAS/H13).

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

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

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANM	Auxiliary Nurse Midwife
BCC	Behaviour Change Communication
CEO	Chief Executive Officer
DIC	Drop-In Centre
DOTS	Directly Observed Treatment Short-Course
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HRG	High Risk Group
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug User
IEC	Information Education and Communication
NACO	National AIDS Control Organisation
NGO	Non-Governmental Organisation
NSEP	Needle Syringe Exchange Program
ORW	Outreach Worker
OST	Opioid Substitution Therapy
PM	Project Manager
PE	Peer Educator
PEP	Post Exposure Prophylaxis
RTI	Reproductive Tract Infection
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections
TB	Tuberculosis
TI	Targeted Intervention
VCT	Voluntary Counselling and Testing

Contents

1. Background and Purpose

The goal of the third phase of National AIDS Control Program (NACP) is to halt and reverse the HIV epidemic in India by 2012. One of the important components of NACP is to provide prevention, treatment, care and support for those at highest risk of HIV through Targeted Interventions (TIs). Injecting Drug Use (IDU) is recognized as an important behaviour, which contributes to the continuing spread of HIV in India. As per the recent sentinel surveillance exercise conducted by NACO, HIV prevalence among Injecting Drug Users (IDUs) is 9.2% at the national level. Additionally, there are many pockets of IDUs, where the HIV prevalence is more than 10-15%. Preventing HIV among this vulnerable group is of utmost importance in the current context.

Most services at the TI level are provided through two broad strategies. Majority of the services to the IDUs are provided through outreach strategy. The outreach strategy involves reaching out to existing as well as potential clients of the TI at places where the IDUs congregate. These may include places where IDUs inject drugs, buy drugs or rest after injecting. Where IDUs do not congregate together at these places, home-based services may have to be provided.

Another strategy of providing services by the IDU TI is through a Drop-In Centre (DIC), which is a static service point. Here, a number of services over and above those provided in the outreach are given. An optimally functioning TI has a DIC which becomes the nodal point for the IDUs as well as the staff of the TI.

About the Standard Operating Procedure

This SOP is designed to support organizations providing DIC services under the harm reduction program by building the capacities of the TI staff for improving the effectiveness and quality of DIC operations. The SOP provides guidance in the establishment of centres, delivery of services within the DIC, roles and responsibilities of staff in maintaining a DIC, processes to be followed in a DIC, and finally operational issues related to management of a DIC.

The SOP is intended for use by all the staff working in the IDU TI. However, specifically, it is for use by project managers and counsellors involved in the day-to-day running of the DIC. Finally, the SOP may also be used by program monitoring agencies/officers to ensure that the TI follows and implements DIC related services in accordance with the SOP.

2. Introduction

The DIC is a community-based facility for drug users including injecting drug users who are at high risk of HIV infection. The drop-in centre caters to individuals at highest risk of HIV and those who have the least access to resources. The harm reduction DIC is client-focused with the goal to reduce the spread of HIV infection. A DIC is a doorway for IDUs and their sex partners to a welcoming and caring environment. It is a hub for all services, which an IDU can access as per his or her need and convenience. The DIC must be within close proximity as daily contact with the client is critical, be it for needle exchange or Opioid Substitution Therapy (OST).

The DIC is a place that addresses the health needs of IDUs. Additionally, it supports the right of people using drugs to treatment and care services that are respectful and non-discriminatory. The DIC also functions as a fixed outlet for a Needle and Syringe Exchange Program (NSEP), wherein IDUs can exchange their used needles for clean new ones. Additionally, other activities necessary for IDUs are also conducted in the DIC. The DIC provides psychosocial support, a space for rest and recreation as well as access to other IDUs and Peer Educators (PEs) for caring through mutual sharing of experiences, etc. In select cases, where the DIC meets the criteria outlined by NACO and is accredited, the DIC can also offer OST to its clients.

Who will the DIC Serve?

The following persons usually access a DIC and the services provided in the DIC:

- People who inject drugs
- Spouses and sex partners of IDUs
- Other family members of IDUs
- General community (who may visit the DIC to seek information)

What Services are Provided at a DIC?

- Needle and syringe exchange – IDUs can exchange their used needles for clean new ones at the DIC.
- IEC – continued education through leaflets and pamphlets on HIV, HCV, STIs.
- Sharing and caring – access to other IDUs and PEs for sharing information and seeking mutual support.
- Psychosocial support – access to a counsellor who is available to address issues on behavioural change related to high risk behaviour and drug use.
- Wound and abscess management – diagnosis, treatment and management of abscesses by a doctor and nurse.

What Services are Provided at a DIC? (Contd.)

- STI treatment – syndromic treatment of sexually transmitted infections as per established guidelines.
- Condom distribution – access to free condoms.
- Referrals to ICTC, DOTS.
- Waste disposal systems.
- In select cases, where NACO criteria are met, a DIC can offer OST to its clients.

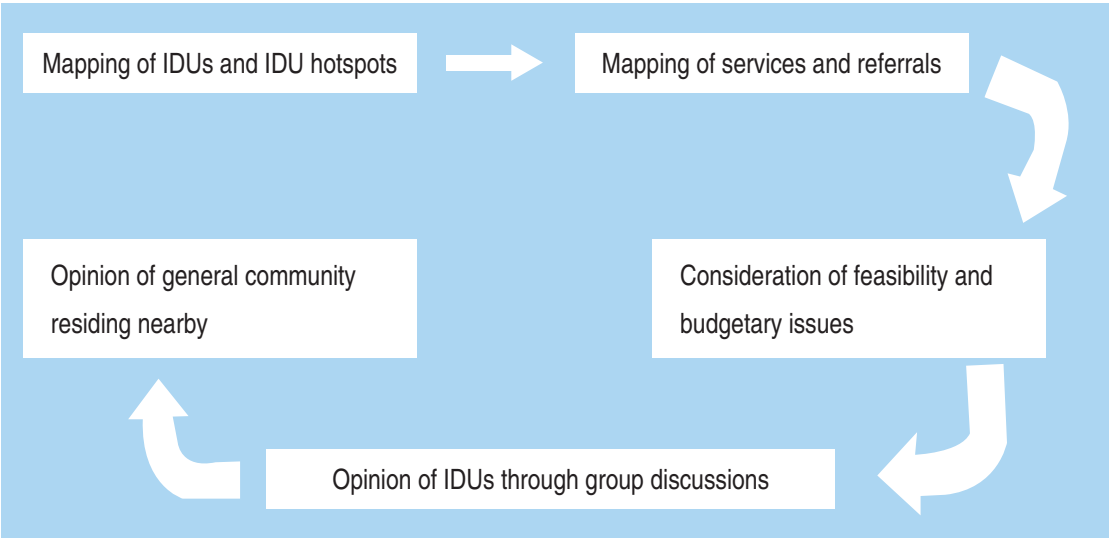
3. Setting-up a Drop-in Centre

The DIC must be located within easy access to congregation points of IDUs. A number of considerations influence setting up a DIC, such as determining the location, infrastructure, and staffing required for the DIC.

3.1 Location

Before choosing a site, it is helpful to keep three "A's" in mind. These are: *Availability* (of services), *Accessibility* (in terms of distance and timings) and *Affordability* (cost of travel to reach the DIC).

The following steps should be undertaken before choosing the location for a DIC:



Extensive mapping of the intervention area must be carried out to identify the IDU community, gain information on the availability of services in the area for networking, collaboration and referrals to local health care service providers, NGOs and social welfare and other local resources. The 'social mapping' exercise, which is conducted as part of outreach activity, helps in identifying the ideal location where a DIC can be set-up. Such a location should be accessible to many, if not majority, of the IDUs. In addition, the IDUs should be able to have easy accessibility to the referral services. About two to three such locations can be short-listed on the basis of the mapping exercise.

Following this, a suitable place should be determined looking at the budgets that are provided to determine the financial viability of hiring a place. Additionally, group discussions with IDU clients should be held to understand their preferences and the location most preferred by IDUs should be chosen.

Finally, the opinion of the local community should be taken into consideration. Initially, many of the local community members residing nearby may oppose having a centre for IDUs in their vicinity. Appropriate sensitisation programs should be conducted to take them into confidence.

3.2 Infrastructure

The DIC must have sufficient space to conduct various activities and provide harm reduction services – at least three to four rooms must be

available. One large room should be designated for rest and recreation as well as for group meetings, while the other smaller rooms can be used for counselling, doctor's room and for providing primary medical care. The centre should be properly ventilated, well lit and must have provision of drinking water and a clean toilet.

Recreation Room

This should be the entry room with the largest space. The recreation room should be made attractive to the clients by providing recreational materials. In addition, educational materials in the form of posters should also be displayed in the room.

Purpose

- For IDUs to spend time.
- For IDUs to rest.
- For conducting group activities and discussions.
- For entertainment (recreational materials such as a carom board, chess, TV, movies and video games should be provided for this purpose).

Counselling Room

This room would be used to conduct counselling services for IDU clients and their families/spouses/ sex partners. The room must have enough audio-visual privacy to maintain confidentially.

Purpose

- To provide one-to-one counselling to IDUs and their sex partners.
- To provide referral services.

Medical Room

This room would be used to conduct medical examinations, diagnosis and provide treatment, abscess care and wound dressing. Adequate hygiene and sterilization should be ensured in the medical room.

Purpose

- To conduct general history taking and medical examinations.
- To provide treatment of general medical conditions.
- To provide treatment of abscess.
- For management of STI.

Apart from these rooms, space should be available for maintaining records, storage of consumables and drugs. Toilet facilities should be provided and, if possible, kitchen facilities.

3.3 Basic Equipment/Commodities

The DIC must have the following minimum basic equipment, furniture and commodities to operate an optimally functioning harm reduction service:

- Bleaching powder for preparing fresh 1% Na Hypochlorite solution.
- Chairs/carpets for the IDU clients.
- Condoms.
- Disposable gloves.
- Emergency lights.
- IEC material on safe injecting and safe sex.
- Medical equipment: stethoscope, BP apparatus (sphygmomanometer), thermometer, torch, tongue depressor, weighing scales, kidney trays, disposable gloves and masks, hydrogen peroxide solution, antiseptic solution, solvent ether spirit, povidone iodine solution, freshly prepared eusol, cheatles forceps in antiseptic solution, sterile drums with sterile gauze and bandages, sterile packets of catgut, ethylon, prolene, silk, etc., autoclaved linen, sticking plaster, 2% xylocaine without adrenaline, suture cutting scissors.

- Needle destroyer/burner/crusher.
- Needles and syringes for exchange.
- Notice board for display.
- Patient examination table.
- Post exposure prophylaxis (PEP) drugs with visibly displayed instructions.
- Puncture proof containers for collection of used injecting paraphernalia.
- Recreational materials as per the local need such as carom, playing cards, television, newspapers, magazines, etc.
- Steriliser.
- Stool/chair for the clients.
- Stool for abscess management.
- Storage space for drugs.
- Tables and chairs for the staff
- Waste disposal containers

3.4 Extra Requirement for Dispensing OST at a TI DIC

An OST Centre should have additional rooms over and above the medical room and counseling room. These should include:

Dispensing Room

This room is for the nurse to dispense OST medication to the clients. The room should have a table and chairs for the nurse and an office support staff and at least three chairs for clients to sit (a client needs to be seated for three to five minutes, until the medicine dissolves, under direct observation by the nurse while he/she administers medicine to another client).

Secure Storage Space

This is a space to store the OST medicines and other commodities in the centre. Utmost precaution should be taken for storing the medicines safely. The medicine should be stored in a cool and well ventilated room away from direct sunlight in a securely locked cupboard or cabinet. The storage space should not be easily accessible to the clients and visitors.

3.5 Staff Structure, Roles and Responsibilities at a DIC

Various members of staff have individual responsibilities in the functioning of the DIC. One staff member of the IDU TI should be the designated DIC in-charge. This can be the Project Manager (PM), counsellor or in some cases, the Outreach Worker (ORW).

Project Manager

The project manager working for the TI project should visit the DIC almost on a daily basis to oversee its working and ensure that the centre is functioning as per the mandate of the TI. In addition, the PM can also conduct group discussions for the IDU clients in the DIC. The roles and responsibilities of the PM in DIC functioning are to:

- Supervise clinic activities on a regular basis.
- Facilitate advocacy meetings and focus group discussions.
- Develop and monitor the weekly work plan as per the performance indicators for ORWs and counsellors.
- Arrange weekly and monthly meetings to identify shortfalls and to evolve corrective measures/plans of action.
- Build capacity of staff and organization.
- Oversee MIS.
- Develop DIC policies and plans.
- Analyze project activities.

ANM/Counsellor

The ANM / counsellor should be available in the DIC every day, except at times when he/she has to visit the field for outreach related activities. It would be desirable to have a separate ANM and a separate counsellor at the DIC. If the ANM/counsellor is designated as the DIC in-charge, he/she should also manage the DIC on a day-to-day basis.

The key roles/responsibilities of ANM/Counsellor at the DIC:

- Patient management, ensuring partner notification, ensuring follow-up of cases and one-to-one counselling of STI cases.
- Pre and post-test counselling (which would be in addition to that provided in the ICTC).
- Family counselling.
- Capacity building of ORWs.
- Coordinating creation of linkages/ networking
- Maintaining registers
- Condom promotion, demonstration and distribution
- Assisting the project coordinator in team building

Doctor

A part-time doctor, having a basic MBBS qualification, should visit the DIC on five days every week. The doctor should provide general medical care to the IDU clients as well as their sex partners.

The key roles/responsibilities of the Doctor at the DIC:

- Assessment for common physical and mental health problems.
- Treatment (general, STI, abscess management).
- Advice for investigation and referral.
- Motivation of patients for follow-up, partner notification.
- Training staff on medical issues.

Outreach Workers

One of the outreach workers from the pool can be stationed at the DIC on a rotational basis. A roster of ORWs can be drawn up for DIC duties. The outreach worker would assist the DIC in-charge in managing the DIC on a day-to-day basis and ensure that activities of the DIC are conducted as per plan. The ORW, if capable, can also be designated as the DIC in-charge.

The key roles/responsibilities of an ORW at the DIC:

- Making IDUs comfortable in the DIC.
- Ensuring IDUs' involvement in DIC activities.
- Maintaining rules and regulations at DIC.
- Conducting group discussions.
- Encouraging IDUs to visit the DIC and access services.
- Facilitating formation of committees and self-support groups in the DIC.
- Ensuring the concerns and voices of IDUs reach TI management staff.
- Ensuring a respectable environment for IDUs.

Peer Educators (PE)

The peer educators assist the outreach worker in managing the DIC on a day-to-day basis and ensure that activities of the DIC are conducted as per plan. One of the peer educators from the pool can be stationed at the DIC on a rotational basis.

The key roles/responsibilities of a PE at the DIC:

- Identifying and enrolling clients.
- Disseminating message and information about program services.
- Distributing IEC materials at the DIC.
- Distributing needles/syringes/condoms.
- Motivating IDUs to access STI treatment and adopt safer sex practices.
- Conducting group discussions with IDU clients.
- Creating support groups in the DIC.
- Ensuring that rules and regulations of the DIC are followed.
- Motivating IDU clients to utilize referral services to ICTC, DOTS and other healthcare services
- Reporting to the concerned ORWs

Staff Skills Needed for a Drop-In Centre

- Thorough knowledge and training in harm reduction, information on drug use, safe sex.
- Thorough understanding of social mapping, the capacity to conduct group discussions with High Risk Groups (HRGs) and conduct brief assessments of drug users.
- Knowledge on waste management, especially for used syringes and needles.
- Ability to provide client support and assistance where appropriate.
- Ability to understand the community and community dynamics.
- Ability to promote harm reduction within the community.
- Ability to conduct health promotion activities with clients and the community.
- Ability to carry out administrative tasks such as stock management, collecting data, following organizational policies and procedures.
- Ability to liaise with hospitals and emergency services to deal with any untoward medical incidents.
- Ability to liaise with the local police station office to create an enabling environment.

4. Programs and Services at DIC

4.1 Processes and Procedures for Service Provision

Usually, the IDU client visits the DIC upon referral from outreach. In such cases, the concerned PE or ORW must accompany the client to the DIC for the first time. In rare cases, the client may come to the DIC on his/her own without being referred from the outreach unit.

Upon arrival at the DIC, the IDU must meet the staff member who is the DIC in-charge. During this first interaction, efforts must be made to make the client as comfortable as possible. The client should not be overloaded with information and services in his/her first visit.

Upon Repeat Visits

During repeat visits, the client must be made to feel that he/she is a part of the DIC. The client should be introduced to the various services offered at the DIC. Efforts must be made by the TI staff to ensure that the IDU client receives the following services:

- **Assessment and diagnosis:** the doctor, nurse or counsellor must record:
  - Basic medical history.
  - Information on the type of drug, mode and patterns of use.
  - Abstinence attempts in the past, help/ treatment sought earlier.
  - History of exposure to contaminated blood and other risk behaviours.

During the First Visit

- The accompanying outreach staff introduces the client to the DIC in-charge.
- The DIC in-charge meets the client and provides information on the basic services available at the DIC.
- The immediate service needs are identified and provided.
- If commodities such as needles/syringes and condoms are required, they should be provided to the client.
- The dos and don'ts at the DIC are clearly explained to the IDU client.
- The follow-up needs are identified.
- The client IDU is encouraged to visit the DIC regularly.

He/she should also glean information about the client's knowledge and attitude towards diseases like TB, STIs, HIV and AIDS, hepatitis B and C.

- **Referral to HIV related services:** the IDU client should be referred to the nearest ICTC for HIV testing after proper pre-test counselling. If the client is detected as HIV positive, referral to an ART centre should be made.
- **Referral to other services:** based on the need, the client may be referred to a TB centre, centres providing nutritional support, shelter home, vocational centre or detoxification-cum-rehabilitation centre.
- **Counselling:** one-on-one counselling should be provided on safe injection, safe sex, importance of regular access to NSEP, safe disposal, abscess prevention, HIV, hepatitis B & C and prevention of other blood-borne infections.
- **Group discussions:** the client should be involved in group discussions where various issues pertaining to drugs, HIV, hepatitis, STIs and other related information are being discussed. The group discussion should be organized and moderated by the outreach worker or the counsellor. The doctor can lead some of the topics, especially those related to co-morbid conditions such as hepatitis B & C, abscess care, HIV related issues, etc.

4.2 Other Operational Issues

- The DIC follows standard business hours (9 a.m. to 5 p.m.).
- Staff must open the centre on time and be ready to provide services to clients as needed.
- An intake form should be filled-out for a client visiting the DIC, their basic information should be recorded and clients should be registered at the DIC.
- The client should be made aware of the various harm reduction services available at the DIC.
- An information leaflet of activities such as NSEP, OST, meetings, group discussions related to harm reduction are provided to clients. A client can then avail of services available at the centre.
- The client, after accessing specific services, can relax at the DIC and read a paper, book or magazine; watch T.V.; play games such as chess, carom, etc.; listen to music; play an instrument (e.g. guitar); interact with the staff or other clients; or rest in the recreation room.
- A client may participate in group discussions, training or education classes, talk to peers, and seek counselling services on personal problems and other social issues.
- A client may also access referral services through the DIC such as medical referrals, HIV testing, and ART services from other medical facilities/centres.
- The client may attend counselling, peer counselling, groups meetings and sharing of experiences.
- Clients who are homeless or those without a permanent address may use the centre as a mailing address.
- Stock checks, inventories, reports and all other DIC records should be finalized at the end of each day.

4.3 Medical Care and Services

Amongst IDUs, there is a high incidence of abscesses, wounds, cellulites, vein collapse, drug overdose that results in physical discomfort or pain often affecting normal duties and chores. The DIC therefore must make basic medical care services available. Such services cater to the needs of IDUs and serve as a critical point to initiate risk reduction services especially with registered clients.

The following basic minimum care services must be made available at the DIC:

- **Abscess and wound management:** the centre must provide treatment of abscesses, primarily for removing pus and cleaning and dressing wounds. Medicines must also be provided. The staff and clients must be trained in prevention and management of abscesses and self care.
- **Drug overdose management:** the centre must be equipped with relevant medicines and medical equipment to manage a case of drug overdose. The staff must be trained in detection of early signs of overdose and its management. The ORWs and PEs must be provided hands-on training on first aid and basic emergency care. Education and information on drug overdose must be made available through signages and pamphlets.
- **Psychiatric treatment support:** the doctor and nurse must be able to identify psychological changes in behaviour of clients and provide necessary treatment referrals.
- **Hepatitis B and C:** the doctor and the counsellor should be able to provide information on hepatitis B and hepatitis C, including on prevention and management related aspects. Those clients who wish to undergo testing for these conditions should be referred to the appropriate laboratory services.

4.4 Information, Education and Communication materials

In order to complement the Behaviour Change Communication (BCC) efforts, adequate IEC materials should be developed and stocked in the centre for distribution and display. IEC materials on HIV, drugs, injecting related behaviour, condoms, STIs and other health hazards should be readily available. Most of these IEC materials are centrally developed by National AIDS Control Organisation and made available to the State AIDS Control Society (SACS)/NGOs for adaptation and reprinting. The types of IEC materials and methods used in a DIC may consist of brochures, posters, flip books/ handbooks and banners.

4.5 Client's Involvement

The program management must involve the clients in planning activities of the centres. Clients should be involved in designing the program activity plan. A group discussion for this purpose can be initiated with the clients, and the clients can plan the activities. The PE and ORW play a very important role in this exercise. Clients must be made to feel more involved in the program by these activities. A group (committee) must be formed among the clients to help manage the day-to-day functioning of the DIC. Various sub-groups (sub-committees) may be formed from this group, which can take care of various activities such as ensuring the rules of the DIC are followed, cleaning of DIC, conducting various recreational activities of the DIC, etc. Additionally, teams can be formed for redressal mechanisms, violence prevention and action. These activities go a long way in ensuring that the IDU community accepts the DIC as their own and the clients feel a sense of ownership and responsibility towards the DIC.

A case study on community involvement in DIC activities given in the Avahan publication 'From Hills to Valleys: Avahan's HIV Prevention Program among Injecting Drug Users in Northeast India' is shared here.

Case Study: Community Mobilization and a Learning Site at Kumbi

Kumbi lies in a remote and troubled area in the south of Bishnupur district in Manipur. Avahan's local implementing NGO in Kumbi is the Dedicated People's Union (DPU), founded by a group of former injecting drug users and professionals who started to implement harm reduction for injecting drug users in the area. Program staff provided services, and mobilized and organized the community by using their own experience and knowledge as former drug users. DPU ensured that community members were involved in each element of the program, from the initial needs assessment to monitoring and evaluation. As services developed, support groups and committees comprising injecting drug users were founded to address their needs and give them ownership of the program. For example, the drop-in center committee facilitated a feedback process from the injecting drug users to the NGO staff. This led to a change in the center's opening hours and other facilities to meet the community's requirements. Community members also started income-generating activities, such as producing handicrafts and decorative items. A community-run barbershop at the site generates income for the staff and DPU, and is also used to motivate members to access clinical services: they receive a free haircut if they have visited the STI clinic.

The Kumbi Learning Site was developed to demonstrate community mobilization of injecting drug users to other implementing groups, by sharing practical program experiences and practices. Kumbi offers a comprehensive overview of the skills required for outreach and community mobilization, including outreach planning, documentation, capacity building, and strategies for meaningful community organization. Each visitor receives integrated presentations, case studies, field visits, and discussions with community members. Trainee groups are typically comprised of 80 percent community members and 20 percent NGO staff. While induction training activities were initially conducted at the Kumbi Learning Site, the Kumbi staff and community members now provide capacity building support to other communities and NGOs in their own locations.

*Accessed at *http://www.gatesfoundation.org/avahan/Documents/injecting-drug-users-hiv-prevention.pdf* on 11th January 2012.

5. Management and Housekeeping Issues at DIC

5.1 Standards of Conduct for Staff

The code of conduct is a set of guidelines for ethical and professional conduct to be followed by the DIC staff. The code of conduct should clearly state what is expected of the staff as professional workers in the TI project. It must be strictly followed by all staff members regardless of levels of experience or job title.

The code of conduct outlines expectations of behaviour based on aims and objectives of the drop-in centre. The code of conduct ensures that all staff respect and protect the rights of clients and maintain confidentiality at all times and under all circumstances. The staff must pledge to uphold the code of conduct to maintain the integrity of the program.

Code of Conduct for DIC Staff

- Every staff member will respect the confidential nature of his or her work.
- All staff members will respect and maintain the confidentiality of clients.
- No staff member will violate the legal rights of the clients or the program.
- Staff members will not accept any personal gift or money for services from a client.
- No staff member will sell to or purchase any item from a client.
- No staff member will sell any drugs at the centres or in hot spots.
- Staff members will not promote personally held views about any religion or any type of therapy.
- Staff members will act as role models to clients.
- Staff members must receive permission from the project manager to conduct interviews or speak to the media.
- Under no circumstances will staff carry out their jobs at the office or on outreach under the influence of alcohol or illicit drugs.
- Staff members must always provide an explanation to a client when they refuse a client's request.
- Staff members must demonstrate respect to clients and to each other at all times.

5.2 Standards of Conduct for Guests

The DIC must prominently display a signage of the 'Standards of Conduct' in the centre. The following are not acceptable behaviours at the centre:

- Buying or selling drugs in or around the centre.
- Displaying any rude force or weapons such as guns, knives, blades, etc.
- Harassment of any type including emotional, sexual, physical, badgering, hounding, or nagging.
- Stealing.
- Using drugs or alcohol or being in an intoxicated or inebriated condition.
- Disrespecting a person's disabilities, gender, religious beliefs, interests or chosen work.
- Bad-mouthing, swearing or cursing peers or staff.
- Borrowing without returning, handling others' bags and property.
- Indulging in malicious gossip about clients.
- Being noisy and failing to be quiet or leave another person alone when asked to do so.

Additionally, the DIC must maintain a board highlighting important information of the organization, also called the 'citizen's charter'. The main objective of such a citizen's charter is to improve the quality of services offered to clients.

Information Displayed in Citizen's Charter

- Brief information about the organization.
- Organogram of the organization.
- Information regarding staff and contacts.
- Service area.
- Timings/hours.
- Helpline numbers.
- Emergency helpline numbers.
- Details of grievance redressal mechanism and how to access it.
- Services provided.
- Area wise hotspots and the total target for the project.
- Number of clients registered.
- Number of clients on NSEP.
- Number of clients on OST.

5.3 Cleaning Rules

The DIC in-charge or designated staff is responsible for ensuring that cleaning tasks are completed at the end of each shift or event at the centre. He or she must initial and record the daily cleaning log.

Cleaning at End of Day

- Clean and mop the bathrooms.
- Clean carpets, if any.
- Return furniture and appliances to their original places, if moved during the day.
- Organize magazines and pamphlets that are on table tops and the front desk.
- Sweep and mop floor.
- Take out trash and replace trash bags.
- Wipe all surfaces with a wet cloth using cleaning liquid.
- ALWAYS wear gloves when cleaning.

5.4 Safety Measures

The DIC must have safety measures in place to handle any eventuality. In the event of a disaster, violence, active drug use or drug sales on the premises, any member of the DIC staff may request that the centre be temporarily closed for the safety of the staff, volunteers or participants. In the event of a threat to the safety of the staff, volunteers or participants or in the case of a medical emergency, staff should call the emergency department. Any available supervisor should be contacted immediately and informed of the circumstances surrounding the closure of the centre or the need to call the emergency department or ambulance. Inform the relevant authority of the incident.

a. Addressing violence at the centre

Any incident of violence at the DIC must be reported to the management. There should be clear written procedures on managing violence at the centre. Staff who have a good relationship with the client concerned should try to intervene. Failing this:

- The person must be told that the police will be called.
- Those who are not involved must be moved out of the area.
- The police may be called in to help handle the situation.
- The centre may be temporarily shut down in an emergency.

b. Security and avoiding thefts

The police can only come into the centre if they are pursuing someone who runs in; or they see the person just before he or she entered the DIC; or if they have a warrant and the registered client uses the centre as a legal address to receive mail and correspondence. The DIC staff and volunteers must not divulge whether the client gets mail or accesses any service at the centre to the police.

c. Maintain an incident log

The staff must maintain a simple logbook and record details of any incident at the DIC. The first column has the client's name and date, the second column records what the client did and lists the witnesses and the third column records and shows actions taken by the staff handling the incident.

The project manager must make sure all key staff read and initial the incident log weekly. If such a situation arises where the individual's behaviour does not improve or change, the detailed records in the logs will be the evidence to act upon – to perhaps ask him or her not to visit the DIC in the future. If such individuals complain against the centre for refusing him or her services, the logbook provides the details that justify this action. The incident log should be kept locked in a secure cabinet at the end of the day.

5.5 Waste Disposal at DIC

All waste generated at the DIC must be handled as bio hazardous material and securely stored in approved waste disposable bins. The used needles and syringes and other bio hazardous materials, such as dressing materials, must be sent to private waste management agencies, approved government hospitals or to be incinerated. In places, where TIs do not have access to incinerators, or where there are no private waste management agencies, a concrete pit should be dug and used needles and syringes buried. Additional details on waste disposal are available in NACO's guideline on waste disposal (Guidelines on Safe Disposal of Used Needles/ Syringes in Context of Targeted Intervention for Injecting Drug Users, NACO 2009).

5.6 PEP

The DIC staff are prone to receiving needle stick injuries which often occur when collection and disposal activities are done in a careless, hurried manner and when due precautions are not taken. A strict protocol to prevent needle stick injury must be in-place. In case of needle stick injury:

Dos

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

Don'ts

- Do not panic.
- Do not put the pricked finger into the mouth.
- Do not use alcohol, chlorine, bleach, betadine, iodine, or any other antiseptic on the wound.

Steps to be followed in case of injury and for PEP:

- Immediately inform the management about the injury.
- HIV tests should be done immediately.
- Drugs for PEP should be made available to any staff member or caregiver who is accidentally exposed to HIV in all facilities as early as two hours and within 24 hours of the accidental exposure but not later than 72 hours.

The protocol for administration of PEP drugs is available on the NACO website.

5.7 Local Community Engagement

The DIC staff must advocate with the authorities and other stakeholders to secure an enabling environment. These local efforts are supported by advocacy efforts at the state and national levels. The DIC staff must plan regular sensitisation meetings with law enforcement agencies and local communities on drug use, harm reduction and stigma and discrimination. The process of engaging the local community is described in Annexure 1.

5.8 Legal Issues and Advocacy

The IDU community constantly faces stigma and discrimination and are often harassed by law enforcement authorities because of past criminal behaviours and possession of injecting equipment or small quantities of drugs. Incidents involving NSEP, including community objections or concerns, law enforcement incidents, and potential legal action against programs and persons, must be reported, addressed and documented by DIC staff.

Law enforcement has a unique role to play to achieve supply reduction, demand reduction and other harm reduction approaches. The police traditionally have a fundamental role in supply reduction and in supporting demand reduction and harm reduction strategies.

The DIC staff's efforts at advocacy and securing an enabling environment at the local level are supported by advocacy efforts at the state and national levels. The DIC must conduct regular sensitisation meetings with law enforcement agencies, lawyers and local communities to advocate for harm reduction and sensitize clients on human rights and drug laws.

Protocol for Staff Interacting with Law Enforcement Authorities, Pressure Groups and Community Watchdogs:

- Calmly inform clients that the police/ pressure group/community watchdog is in or around the building.
- Identify yourself as staff and ask if there is a problem and if you can be of assistance.
- Get statements from the police, as appropriate.
- Never antagonize the police.
- Let the police know that the centre is an approved DIC and must be respected as a health care facility and not a place to look for criminals.
- Always try to record the names and phone numbers of the police officer in charge and the witnesses to the incident. First, get the staff and volunteers' details recorded and remember that other clients may not want to get involved. Remember that it is the job of the DIC staff to protect the clients' confidentiality and ensure safety.
- Contact the immediate supervisor and let him/her know what has happened.
- Remember to write the incident down in the incident log.

Incidents related to the DIC, community or law enforcement must be immediately reported to the project manager or management, verbally and in writing. The incident is notified as soon as possible, but no later than 24 hours from the time of the occurrence. The purpose of these reports is to ensure documentation of incidents in order to identify and address potential problems. All subsequent actions taken by the organization to address the community or law enforcement concern must be reported to the relevant authorities.

The DIC staff has to implement strategies to prevent and address such incidents with law enforcement authorities and the local community before establishment of the program. The topics of discussion should include possible interventions and timetables for follow-up discussions and further activities. Interventions may include meetings or presentations to community boards, community groups, civic associations, and law enforcement authorities.

5.9 Tips for Improving DIC Attendance

A number of issues affect attendance at the DIC. These include staff related issues, activities conducted at the DIC, proximity of the DIC to the clients and finally, services available at the DIC.

- The staff at the DIC has to maintain a friendly relationship with clients and should never be disrespectful or judgemental.
- The DIC should be properly run with consistent opening and closing times, basic rules of conduct, follow up of rules and consistent availability of services.
- The availability of entertainment and recreational services, such as TV, movies, video games, carom, chess, musical instruments, etc., in addition to the harm reduction services, add to the attraction of the DIC.
- The DIC should have provisions for tea, coffee, snacks, etc., if funds are available. Such refreshments further attract attendance at the DIC.
- Provision of nutrition increases attendance at the DIC. Due to prolonged use of drugs and neglect of personal hygiene and health, many drug users are malnourished and nutritionally weak. They require good nutritional supplementation for improved physical and mental health. The DIC must be linked-up with existing and applicable government schemes for nutrition. Efforts must also be made to leverage support for free supply of food from religious places such as, churches, temples and *gurudwaras* in the vicinity of the DIC.
- Other facilities like spaces for rest and relaxation, bathrooms and washing machines at the centre encourage more clients from the street to make regular visits and access the services provided at the DIC.
- The availability of additional professional services such as family counselling, medical treatment and care facilities for both clients and their families improves DIC attendance.
- Involving clients in day-to-day functioning of the DIC, including setting up and following the rules and regulations of the DIC, also positively impacts attendance.
- Prompt redressal of grievances helps in instilling faith of the clients in the DIC.

5.10 Record Keeping and Maintenance

The records of activities and relevant data should be preserved in the record room for record keeping to be used for both internal and external monitoring and evaluation. Strict confidentiality must be maintained at all times. All DIC staff must fill reports on the officially prescribed monthly formats. The formats for record keeping are designed according to the needs and are provided by NACO. They clearly delineate the role and responsibilities of the staff in-charge of records. The project manager should conduct periodic reviews of the records and analyze them to assist and improve the functioning of the centre.

5.11 Checklist for Supervisors Supervising at a DIC for IDU

The project manager has to supervise the drop in centre and see that quality services are provided by staff and appropriate systems are in place. To supervise all the activities and systems of the DIC, the project manager has to develop a checklist in the following manner:

- Cleanliness of surroundings.
- Daily and regular review of DIC registers.
- Display of IEC materials.
- Display of rules of the DIC.
- Maintenance of job responsibilities of staff.
- Outreach kit.
- Proper maintenance of stock register.
- Proper security system.
- Proper waste disposal and management systems.
- Protocol maintenance by outreach, NSEP and OST staff.
- Regular data checking by the supervisor.
- Regular field visits.

Other officers involved in supervision of the DIC/TI project can also use this checklist:

Conclusion

DICs are a safe space where IDUs can come together and find a 'common voice'. DICs serve to meet unmet needs, as all services that IDUs require cannot be provided by outreach alone. The purpose of the DIC is to provide services through user-friendly centres that are easily accessible to IDUs. DICs may be accessed by IDUs, spouses and sex partners of IDUs; family members of IDUs; and general community. DICs are useful venues for service providers to address their clients – IDUs and partners – as a group. DICs provide various products and services, including outreach, NSEP, IEC dissemination, psychosocial support, ulcer and abscess management, STI treatment, condom programming, referrals and recreation and rest facilities. A well functioning DIC can act as an effective centre-point for harm reduction and HIV prevention efforts.

Annexure 1: Process for Local Community Engagement

First step: Define/identify the problem

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

Understand community needs and problems:

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

Second step: What are we trying to achieve?

Any response to harm reduction and drug use requires a clear understanding of what is to be achieved. The aims and objectives will differ depending on the stakeholders that are being addressed. For e.g., advocacy with law enforcement would help enable outreach staff to function without being arrested. The local area where the DIC is situated may need to be sensitized on the services being provided in the TI. The aims and objectives should be clearly defined beforehand to understand how various stakeholders can be engaged in soliciting support for the TI activities.

Annexure 1: Process for Local Community Engagement

(Contd.)

Third step: Who will be involved?

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

Fourth step: What are the options for engagement?

Depending on the aims and objectives and the stakeholders to be engaged, various options can be used. These may include:

- Health education program
- Group meetings with community
- Advocacy with law enforcement personnel and the local business community
- Involving the local community in observing important drug/HIV related days

Fifth step: How do we know if it is working?

Reflection on the successes and failures, the positive and negative outcomes of programs, is essential for refining and strengthening existing and planned responses. After conducting the programs, the aims and objectives should be revisited to assess if these have been met. The success in meeting the objectives should encourage the team to continue with the strategies adopted for engagement. In case, the objectives have not been met, the strategies adopted should be revisited.

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