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Ministry of Health & Family Welfare, Government of India
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OUTREACH
FOR INJECTING DRUG USERS

STANDARD OPERATING PROCEDURE

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

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Standard Operating Procedure
Outreach
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 the 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 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 Outreach 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 Outreach is the third 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 outreach planning, outreach planning tools, steps in conducting outreach, services to be provided during outreach, formats for documentation and challenges during outreach.

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 National AIDS Control Organisation (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
ART	Anti Retroviral Therapy
ARV	Anti Retroviral
BBV	Blood-Borne Virus
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CBO	Community Based Organization
CM	Community Mobilizer
CRT	Crisis Response Team
CSO	Civil Society Organization
CSS	Community System Strengthening
DDRC	Drug Demand Reduction Centre
DIC	Drop-In Centre
DOTS	Directly observed Treatment Short-Course
FGD	Focus Group Discussion
FIDU	Female Injecting Drug User
FSW	Female Sex Worker
Hep B	Hepatitis B
Hep C	Hepatitis C
HIV	Human Immunodeficiency Virus
HRG	High Risk Groups
HR	Harm Reduction
HSS	HIV Sentinel Surveillance
IBBS	Integrated Biological and Behavioural Surveillance
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug User
IEC	Information, Education and Communication
MSJE	Ministry of Social Justice and Empowerment
M & E	Monitoring and Evaluation
NACO	National AIDS Control Organisation
NGO	Non Governmental Organization
NACP	National AIDS Control Program
NS	Needles and Syringes
NSEP	Needle Syringe Exchange Program
OI	Opportunistic Infection
ORW	Outreach Worker
OST	Opioid Substitution Therapy
PE	Peer Educator
PEP	Post-Exposure Prophylaxis
PLHA	People Living with HIV/AIDS
PLHIV	People Living with HIV
PM	Project Manager
PPB	Puncture Proof Box
PPTCT	Prevention of Parent To Child Transmission
PWID	Person Who Injects Drugs
RCH	Reproductive and Child Health
RNTCP	Revised National Tuberculosis Control Program
SACS	State AIDS Control Society
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TI	Targeted Intervention

Contents

1. Introduction

1.1 Background and Purpose

There are an estimated 2 million to 3.1 million people living with HIV/AIDS in India and the adult HIV prevalence is approximately 0.36%[1]. HIV in India is not a generalized epidemic, but it is concentrated among certain groups practicing high risk behaviours. Injecting Drug Users (IDUs) form such a group, which is vulnerable to the spread of HIV infection and other blood-borne viruses. The practice of injecting drug use and unsafe sex among IDUs is associated with an increase in HIV prevalence rates among IDUs. As per the recent sentinel surveillance exercise, HIV prevalence among IDUs is 9.2% at the national level.

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). NACO has responded by scaling up the targeted interventions for IDUs and presently more than 260 TIs are catering to 76 per cent of the estimated IDUs.

The services currently provided for IDUs under the NACP can be divided into three tiers.

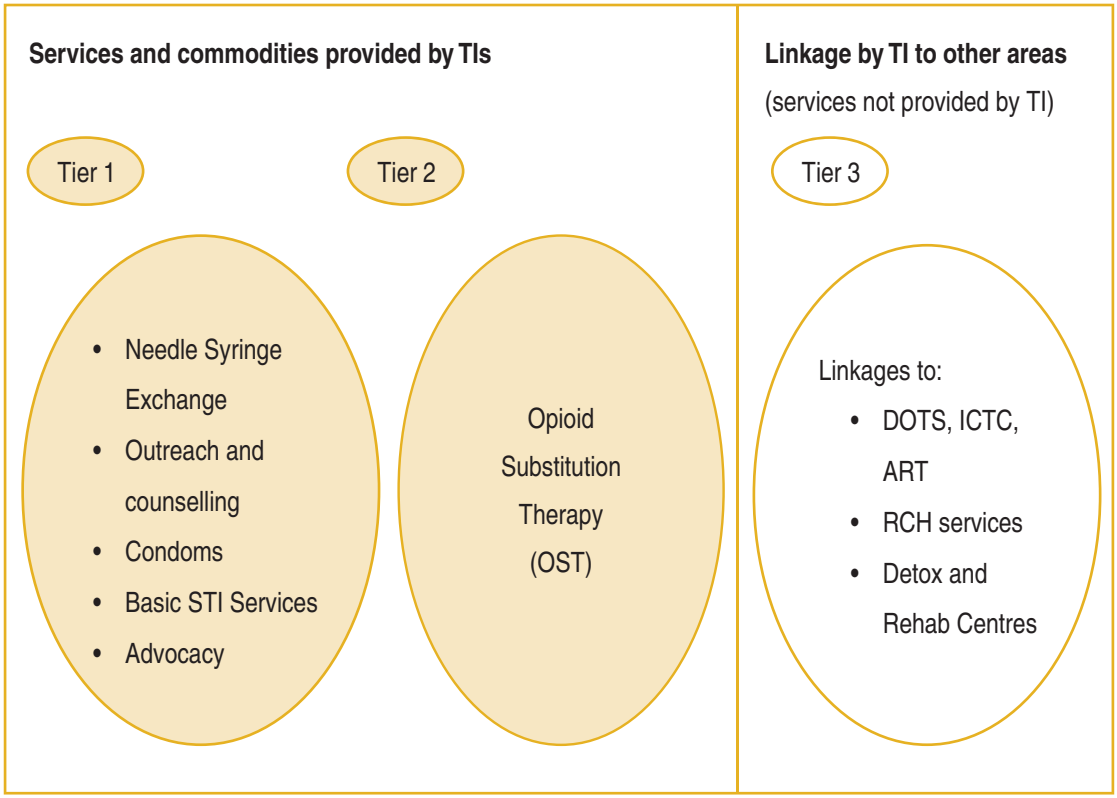


Figure 1. Tiers of Harm Reduction

[1](NACO 2008)

Tier 1: Services Provided Directly by IDU TIs

- Needle Syringe Exchange Program (NSEP).
- Outreach, Information Education and Communication (IEC), Behaviour Change Communication (BCC).
- Free distribution and social marketing of condoms.
- HIV counselling for IDUs and their sex partners.
- Primary health care (sexually transmitted infection treatment, abscess management).

Tier 2: Opioid Substitution Therapy (OST)

- Provided through:
  - NGO TIs.
  - Government hospitals, in collaboration with IDU TIs.
- Currently, involves provision of buprenorphine.
- Plan to initiate methadone as another option.

Tier 3: Services through Referrals and Linkages

- **Linkages with key health services:** Directly Observed Treatment, Short-Course (DOTS), Opportunistic Infection (OI) management, Sexually Transmitted Infection (STI) clinics, Integrated Counselling and Testing Centres (ICTC), Antiretroviral Therapy (ART), Prevention of Parent to Child Transmission (PPTCT), People Living with HIV and AIDS (PLHA) networks for home based care and support, linkages with the MSJE supported centres and other private detoxification and rehabilitation centres.
- **Other linkages and referrals:** psychiatric services within government settings and NGOs, agencies providing shelter, nutrition and vocational support
- Linking with programs for PLHIV as well as other drug user networks, including Narcotic Anonymous, etc.

While the services listed in tiers 1 and 2 are provided directly through NGOs or through government healthcare settings in collaboration with the NGOs, those in tier 3 (referral and linkages) are provided by TIs through established referral linkages with the agencies that provide the linked services.

An important strategy employed by the IDU TI is provision of services through outreach settings. Indeed, this is the backbone for service provision by the TIs.

Purpose of the Standard Operating Procedure (SOP)

This Standad Operating Procedure (SOP) is designed to support organizations providing outreach services under the harm reduction program by building the capacities of TI staff for improving the effectiveness and quality of outreach activities, contextual clarity in planning, conducting and monitoring of outreach activities in the IDU TI settings. It also provides information about essential requirements and detailed process for the development of outreach activity.

The main purpose of this SOP is to:

- Assist the outreach team in effective planning and conduct of outreach.
- Ensure better management by Project Manager through effective monitoring and support.
- Set standards for uniform implementation/operation.

Thus, the SOP is intended for all staff working in a TI setting for IDUs. However, specifically, the outreach workers under IDU/TIs should benefit from the SOP.

2. Outreach – General Considerations

Outreach is a systematic approach to deliver harm reduction services to people who inject drugs and to their sex partners/spouses in their own environments.

2.1 Why is Outreach Essential?

Traditionally, the approach to providing services is to set up centres and cater to the clients who visit these centres. However, people who have high risk behaviour and are termed as 'High-Risk Groups' (HRGs) are reluctant to access such centres. This is because:

- Drug use is not a socially approved behaviour. The general community looks down upon people who use drugs. This is especially true for those who inject drugs.
- Drug use is illegal. This affects the ability of IDUs to come forward and seek services. IDUs tend to remain hidden and are not ready to reveal themselves.
- Preconceived notions regarding IDUs, that exist amongst some service providers, also act as barriers to IDUs accessing services from fixed sites.
- The daily life of an IDU centres on finding money, buying drugs and injecting every day. As a result, he/she is not able to focus on other needs or seek help.

As a result of the above, it becomes necessary for service providers to reach out to IDUs at places where they are most likely to be found. This method of service provision is referred to as 'outreach'. Reaching out to IDUs and their sex partners through the PEs and ORWs, with the prime objective of preventing transmission of Blood-Borne Viruses (BBV) by reducing needle, syringe and equipment sharing, is an essential strategy of harm reduction.

Outreach Enables

- Scaling-up provision of services and reaching out to IDUs who are hidden, stigmatized and discriminated against.
- Identifying new IDUs.
- Linking them to appropriate services, such as DOTS, STI, ICTC, ART, which will help them to access other health related services.
- Accessing services like primary healthcare.
- Reaching IDUs who do not want to access services from the DIC.
- Observing and understanding injecting behaviour, drug sharing culture, IDU networks and risk taking behaviours.
- Gathering information from the field which can be used for effective planning, effective outreach, and meeting possible challenges.

2.2 Principles of Outreach

Outreach for IDUs is based on several principles which are interlinked and dependent on each other. If one principle is not followed, the overall outreach objective can be compromised. Effective outreach, that helps in bringing services to the doorstep of IDUs, has to be based on these principles:

- **Respect:** service providers should respect and trust IDUs as individuals.
- **Team work:** delivering outreach is team work. Efficient team work helps in ensuring greater delivery of services.
- **Non-judgmental:** service providers should not have preconceived negative notions about the beneficiaries. Such judgemental attitudes act as impediments for successful service delivery including outreach.
- **Empowerment:** providers of outreach services should empower the IDU clients to take decisions for their own health and welfare. A 'client-generated' demand helps in greater acceptability of services provided by the TI.
- **Do no harm:** the service provider should ensure that clients/beneficiaries are not harmed in his/her attempt to provide services.

2.3 Services through Outreach

An effective outreach strategy should ensure that at least 80%[2] of the estimated IDUs under the coverage area receive the following components as a package and not as stand-alone services.

Services Provided through Outreach

- Education, advice and information either in individual or in group settings on:
  - Risks of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), STIs and means of reducing these risks.
  - Safer injecting and safer sex practices, including prevention and management of overdose.
  - Services for abscess management, STI diagnosis and treatment, HIV testing, ART and TB treatment which may be available at the DIC and/or other facilities.
- Regular distribution of the following, as per need of the IDUs and their regular sex partners:
  - New needles and syringes.
  - Abscess prevention materials – alcohol swabs, cotton swabs, distilled water, etc.
  - Condoms – free as well as socially marketed.
  - IEC materials, as and when required.
- Collection of used/old needles and syringes.
- Referral services to appropriate healthcare and other agencies.

[2]WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users.

2.4 Staff for Conducting Outreach – Roles and Responsibilities

Outreach is conducted as a team with planned services at predetermined sites/routes. Outreach team consists of:

- **Outreach Workers**
- **Peer Educators**

Apart from this, the counsellor/ANM conducts outreach on a need basis. Finally, the project manager also conducts field visits in outreach area to monitor outreach work being delivered. Additionally, he/she is responsible for the overall management and supervision of outreach, including procurement and stock management.

Outreach Workers

Outreach workers should be current or ex-drug users. Apart from conducting outreach, ORWs support and supervise PEs in planning and conducting outreach, monitor the quality of services provided, ensure effective working systems, and consolidate collected data and information from the PEs. At some places, the ORW can also be a non-IDU, but he/she should have an excellent understanding of the geographical terrain, including the local language and customs followed locally. Additionally, the ORW should have a good rapport with the IDU community and should understand the issues and challenges faced by IDUs.

Key roles and responsibilities of the ORW in an outreach setting are to:

- Develop outreach plan in consultation with PEs and IDUs from the hotspots.
- Facilitate weekly work plan for his/her team of PEs.
- Develop a list of target areas with social mapping of each target area.
- Co-ordinate outreach activities and visit hotspots with PEs on a regular basis.
- Supervise outreach and monitor PE activities.
- Ensure regular and uninterrupted supply of harm reduction materials for each outreach visit.
- Provide referral and networking services with other agencies.
- Provide information on HIV/AIDS, hepatitis, STIs, safer injecting, safer sex practices, overdose management, early treatment and services available to IDUs.
- Establish systems of regular contact with secondary outlets.
- Identify stakeholders for advocacy for creating an 'enabling environment'.
- Collect data and consolidate the same from the field/PE.

Criteria for a Good Outreach Worker

- Non-judgmental attitude and willingness to work for IDU community.
- Previous experience of working in IDU TI (desirable).
- Belief in one's ability to lead a team of peer educators and be led by senior TI staff.
- Strong facilitation skills.
- Communication skills.
- Knowledge of local language.
- Ability to document.
- Ability to lead small group discussions.

Peer Educators

A peer educator in an IDU-TI should be a current or ex-injector who works towards influencing attitudes to bring about behaviour change among IDUs. PEs are responsible for providing information on HIV/ STI, hepatitis, harm reduction including overdose prevention, condom promotion and engaging IDUs in group discussions, meetings and events. Each PE will target/cover between 25-40 IDUs. Selection and retention of PEs is an important issue in an IDU TI.

Key roles and responsibilities of the PE in an outreach setting are to:

- Conduct outreach and maintain contact with IDUs – at least once in 15 days.
- Identify new IDUs and contact them.
- Provide dialogue-based inter-personal communication.
- Encourage service uptake (Needle and Syringe, condoms).
- Motivate IDUs to attend DIC regularly.
- Demonstrate safer injection and condom use.
- Invite and organize group discussions.
- Advocate with local level stakeholders.
- Provide referral and networking information.
- Take notes in field diary/note book.
- File reports.
- Attend trainings.
- Attend weekly planning and review meetings.
- Train new PEs (within the project and outside).

The Ideal PE for Various Audiences

Target audience	Who will be the ideal PE
Female injecting drug users.	Female current/ex-injecting drug user.
Female injecting drug users who are also sex workers.	FIDU sex worker – can be current or ex-user.
Male IDU.	Male current/ex-injector.
Spouse of male IDU.	Spouse of current/ex-injectors.
IDU who are also MSM.	MSM IDU.

Selection Criteria for PEs

Qualities to look for in a PE are:

- Ability to give time for the project.
- Acceptability to the target community (IDUs) as a peer – trust, known, language, age, behaviour and gender.
- Knowledge of the local context.
- Tolerance and respect for others.
- Good listening, communication and inter-personal skills.
- Self-confidence and potential to be a leader.
- Good role model.
- Open to learning new things from the field.
- Commitment – gives time and support to the IDUs in crisis.
- Sensitive to the values of the community and maintains confidentiality.

Auxiliary Nurse Midwife (ANM)/Counsellor

In addition to DIC related activities, the ANM/ counsellor also has to visit the field to conduct some of outreach based activities. The counsellor also assists the project manager to monitor outreach services being provided in the project area.

Key roles and responsibilities of the ANM/ counsellor in an outreach setting are to:

- Conduct counselling (individual and group), for IDUs who are not able to visit the DIC.
- Motivate IDUs who are not willing to visit DIC.
- Motivate IDUs for HIV testing as well as other referral services.
- Make home-visits to access the partners of IDUs.
- Conduct Focus Group Discussions (FGDs) among the IDUs to understand the adequacy of services being provided by outreach team.
- Interact with the general community, obtain feedback and gain insight into their thoughts and opinions.

Project Manager

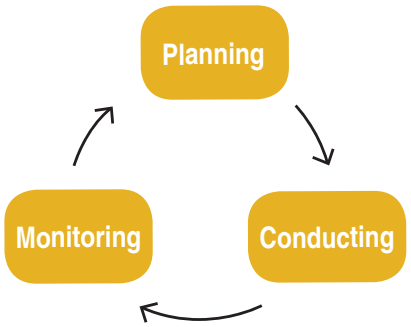
The Project Manager (PM) is the most senior of the TI staff and gives overall direction to outreach as well as other services being provided in the IDU TI. He/ she is responsible for ensuring that outreach activities are being conducted in accordance with the project framework. The PM must understand the challenges faced by outreach team in the field, address them and also keep the morale of outreach staff high.

Key roles and responsibilities of the PM in an outreach setting are to:

- Ensure that outreach team conducts outreach planning before conducting outreach.
- Ensure that outreach team meets each other on a weekly basis to update on the activities conducted in the previous week and plan for the coming week.
- Ensure that sufficient commodities are available at the DIC/Non Governmental Organization (NGO) office for conducting outreach activities.
- Set-up a routine monitoring mechanism for supervision of outreach work.
- Ensure that there is a backup plan for outreach staff taking leave/being absent from providing outreach services.
- Ensure that staff drop-outs are replaced urgently to avoid any lapse in outreach services.
- Monitor outreach activities, through routine field visits, interactions with staff members, general community and beneficiaries (IDU clients) and provide regular feedback.
- Build the morale of the staff to ensure that burnout among the staff is minimized.
- Build the capacity of outreach team through trainings/exposure visits on a regular basis.

2.5 Steps in Outreach

Outreach can be divided into three steps:



All the three steps are interrelated, with each one influencing the other. Though it would seem that conducting outreach is the main step, it should be remembered that planning and monitoring are important steps that need to be carried out regularly to take stock of the changing scenarios in the field. Effective outreach depends on planning and monitoring.

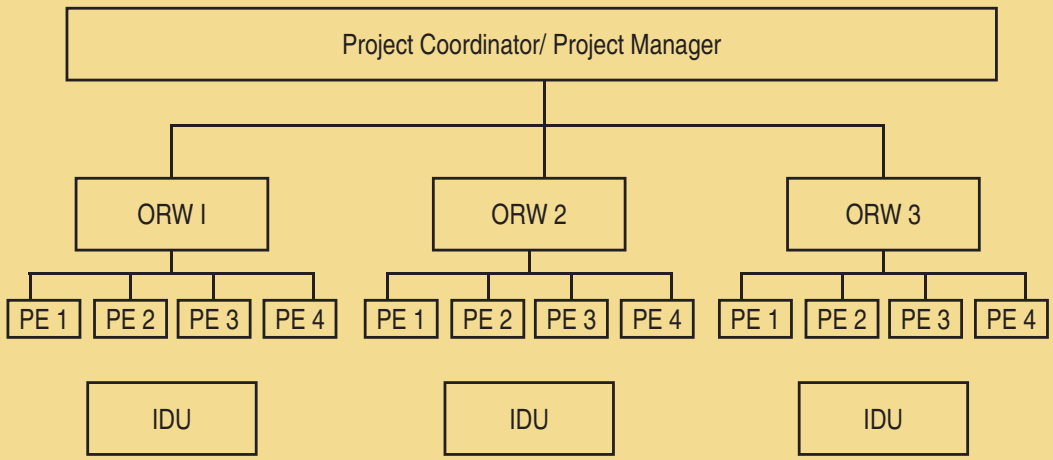
3. Outreach Planning

Outreach planning is a process to facilitate individual level planning and follow-up of service intake, based on high risk and vulnerability. Effective outreach planning will ensure:

- Maximum IDUs are covered in a given period of time.
- Optimal services are provided to every IDU client.
- The existing human resources of the TI project are optimally utilized.

The team for outreach planning consists of the PEs, the ORWs and the PM. The PEs bring in the data/ information from the field and the ORWs process this information by using various tools. PM should supervise and provide inputs when necessary to make the plan robust and practicable.

Outreach planning team



Even before the team sits down for the actual planning, the following should be gathered and kept ready:

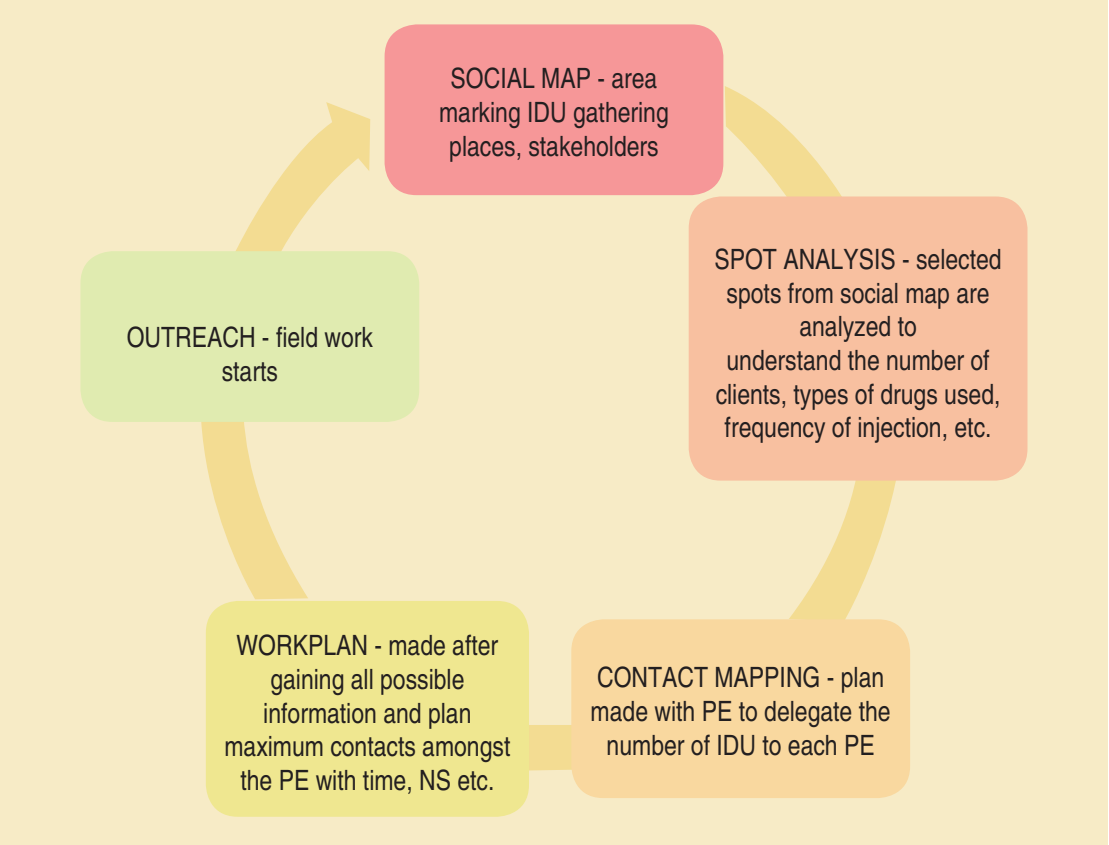
- The geographical maps of the area to be covered under the TI (these can be collected from the local administration – panchayat, municipal corporation, etc.)
- Local high risk group mapping data (can be obtained from the SACS, if available)
- List of hotspots (these can be identified through field visits by the PEs and ORWs)
- Local Behavioural Surveillance Survey (BSS), HIV Sentinel Surveillance (HSS), Integrated Biological and Behavioural Surveillance Survey (IBBS) data (can be obtained from SACS, if under BSS/HSS/ IBBS sentinel surveillance site)
- Information from baseline assessments (if conducted)

The team should gather as many of these resources as possible in order to make the planning easier and more effective.

Outreach Planning Tools

Outreach planning is made easier by the use of a number of aids, called planning tools. The tools used in the context of IDU TIs are:

- Social mapping.
- Spot analysis.
- Contact mapping.
- Work plans.
- Outreach activities.



3.1 Social Mapping

A social map is a rough diagram of the intervention area showing an overview of the sites where IDUs gather/come together. It is a visual illustration of the sites/areas where IDUs gather (hotspots) as well as service points such as hospitals, NGO, clinics, referral centres, etc.

The social map should be updated as per the local situation. For example, if there is frequent movement of hotspots, the social map may be updated once every two to three months. At places, where the hotspots do not change frequently, the social maps may be updated once every six months.

Who should draw the map?

IDUs, PEs led by ORW

How is the map to be drawn?

Arrange chart paper, pencils, colour pens, scale, etc. Divide the participants, PE and IDUs into groups and ask them to draw the map showing all the places which are important for them. Give them 20 minutes to draw.

An ORW would normally have one social map but if the area is too large, it may be subdivided and social maps can then be drawn separately for each sub-area. Mapping can be conducted either in the field or at the DIC by PEs and ORWs. The IDU clients should be involved in the mapping; overall the process should be facilitated by a senior staff member, preferably the PM.

What is important in a social map?

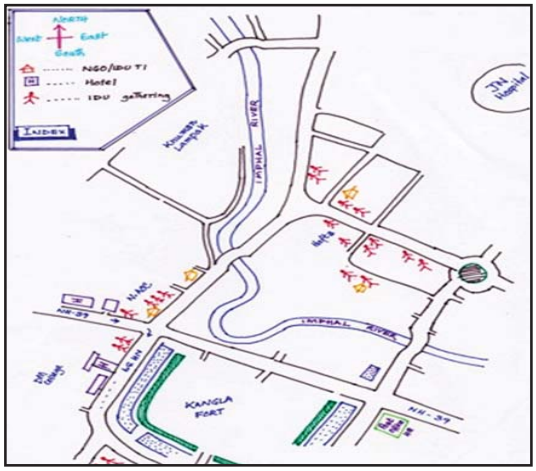
The key principle of drawing a social map is to provide a visual overview of the area. This enables creation of an effective outreach plan for PEs. Direction coordinates, i.e., North South, West and East (NSEW), IDU gathering place, peddling areas, temples, cemeteries, NGOs, hospitals, churches, and other relevant services that IDUs can access or avail should be marked. An index or legend should

be provided In each social map. This index is the main indicator of the signs/drawing, that help in reading and understanding the map.

Why is it important to analyze spots?

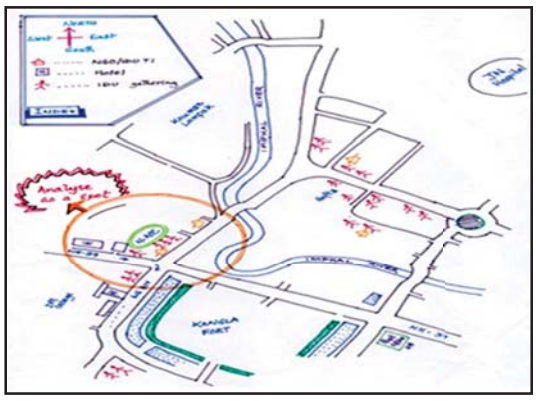
In each social map, there are spots where IDUs congregate at certain times of the day. This spot becomes important to analyze. This is done through 'Spot Analysis' for effective outreach planning.

Sample maps are given below:



Sample 1

After drawing the social map, one hotspot (for e.g., North AOC (Imphal) in the above sample) is selected from the social map. A detailed analysis of the hotspot is then conducted. In the next map (sample 2) the yellow circled site/spot will be analysed for best outreach services.



Sample 2

3.2 Spot Analysis

A hotspot is extracted from a social map by identifying common places where IDUs gather at certain times of the day. The objective is to find the right time to meet maximum IDUs, and provide services and referrals to them. The information collected during needs assessment, related to each high risk spot/site in their respective project areas, is then compiled.

Each spot is different from the other and a project site will usually have more than one site or hotspot. Spot analysis should give the break-up of IDUs in a particular spot according to their:

- Time of availability–IDUs may frequent the particular hotspot to buy drugs, inject, or rest after injecting. The time at which they are available should be recorded, and may be divided into morning, afternoon, evening and night.
- Age of the IDU.
- Type of drugs injected.
- Volume of injecting – This is a rough calculation of the number and frequency of injecting episodes. Classically, it is divided into high volume (more than three episodes per day), Medium volume (one to three episodes per day) and low volume (less than one injecting episode per day).

  Another simple way of calculating the injecting episodes is to divide the IDUs into two categories – daily injectors (at least one injecting episode per day) and non-daily injectors (less than one injecting episode per day). This manner of division is easier and helps the program to prioritize individuals who have to be provided NSEP services on a daily basis.

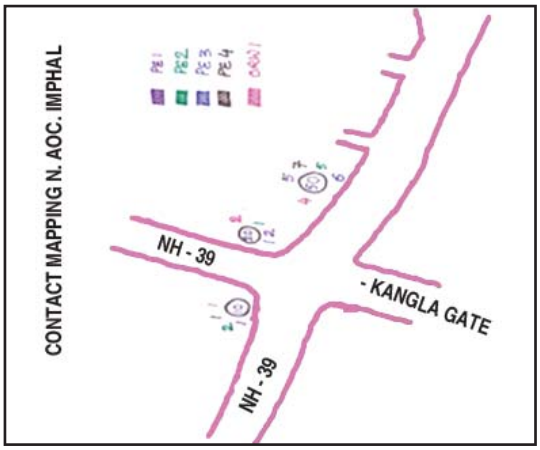
The spot analysis format is provided as Annexure 1.

Who: ORWs and PEs along with IDU clients, facilitated by senior staff.

How: through a group discussion with IDUs engaged in needs assessment, facilitated by senior staff. Explain the link between the social map and spot analysis. Follow the steps or questions:

- What is learned during the situation and needs assessment process?
- What information is required about IDUs operating in a spot? (E.g. volume of clients, typology of drugs, age groups, frequency of injection per day/week.)
- When to go? This will help in establishing the time of operation and frequency of operation required per week, etc.
- Divide the participants as per taluka or ward number to complete the analysis exercise.
- After completion of the exercise, each group presents and discusses the process that they adopted to do this analysis.
- What is the analysis for the spot and what is the plan?

Spot analysis should be done every time there is a change in the spot. If there are no changes, then once every six months is suggested.



Example : Spot Analysis

After spot analysis the potential client (PWID) names and code numbers are written down in another format "contact mapping". In the above diagram numbers circled are estimated total IDU population and numbers in different colors represent each PE and ORW. For example out of 50 estimated IDU, only 6+5+7+5+4 = 27 IDU are known and rest 33 are not known. The outreach team will plan how to increase contact to all 50 IDU in one small spot.

3.3 Contact Mapping

Contact mapping helps participants to map their contacts with IDUs in each spot and helps in analysing their needs. After the spot analysis is completed, the names of the potential IDU clients are written down in the contact mapping format.

Who: PEs facilitated by ORWs

How: the group (of PEs and ORWs) should be divided as per taluka, ward or site and the following steps undertaken:

- Each group draws a map of the town or site with estimated number of IDUs in each spot.
- Use a colour code — assign a different colour to each ORW and PE in marking the number of IDUs each PE and ORW knows.
- Using colour coding will simplify the process of identifying which (PE) is most suitable for each spot.
- Also answer the following questions – where is the contact limited; what is the reason for the limited contacts; what can be done in each specific area/spot to increase the contacts.

Analyze who reaches whom and who are left out. One contact may be known to more than one ORW/PE (common contacts by ORW/PE) and overlapping can be avoided through this exercise.

risk and vulnerability profiles of each IDU (Annexure 2). Field level environment and setting can change very quickly, hence some sites may need planning to be done weekly, but mostly sites would need monthly planning and revisiting of work plans.

Example: Contact Mapping

Contact Mapping

District Imphal Taluk Name of Town N. AOC Date of exercise

Estimated number of IDU in the town 80 IDUs.

Contacted number of IDU in the town 30

SL No	Name of Spot	Peer 1 Name of contacts	Peer 2 Name of contacts	Peer 3 Name of contacts	Peer 4 Name of contacts
1	N. AOC.	Raju	Babbloo	Ramesh	Dhanraj
2	"	Suresh	Lolikanta	Subash	Kanta
3	"	Tomba	Bobio	Akimbo	Mobi
4	"	John	Jyotin	Jackie	Michael
5	"	Bobby	Dinesh	Vikash	Pappu
6	"	Naresh	Amitab	Rajen	Bijen
7	"	Manoj	Surinder	Tom	Naoba
8	"		Parijat		Neelakanta
9					
10	Total.	7	8	7	8

Geographic networks and social networks of peers enable better outreach planning. Similarly risk and vulnerability exercise is also covered by spot analysis.

3.4 Work Plan

This is the output of the entire outreach planning process. It provides a work plan to regularly reach out to individual IDUs with requisite services based on

Who: PEs and ORWs can make the work plan to cover and address the needs of IDUs.

How: using the spot analysis, social mapping, contact mapping and gap analysis, the team can develop weekly target plans for outreach to cover each area. The weekly plan for each PE can be different as per the variation in needs, spots, risks and vulnerabilities.

Planning a meeting

4. Conducting Outreach

Following are the steps in conducting outreach:

Step 1: Building rapport with the IDU and general community

This is a critical prerequisite to conduct street/ community outreach. Good rapport will enable the outreach team to deliver services effectively without interference.

Step 2: Delivering services in the field; referrals to DIC and other services

The outreach plan discussed in the earlier section should be completed before systematically delivering services in the field. This helps in ensuring that all the IDUs are optimally covered with services in a timely manner.

Step 3: Creating an enabling environment

An enabling environment is required for effective delivery of and access to services. IDUs being stigmatized and discriminated against are more hidden and fear accessing services. The outreach team should understand the barriers in service delivery by talking to IDUs and PEs so that an appropriate advocacy campaign can be conducted.

Step 4: Documentation and analyses

Services provided should be documented and collected and data should be analyzed for re-planning or re-strategizing outreach. Re-planning is done after understanding the gaps in consultation with PEs and IDUs. Documentation should focus on coverage of target and regularity of accessing services. Senior staff or PM should be consulted when certain gaps or issues cannot be addressed.

Where should outreach be done?

Outreach should be done at identified hotspots or locations where IDUs inject drugs or gather:

- Places where IDUs and sex partners congregate (buying drugs, shooting galleries, if any, or common places where they gather regularly).
- Space near locations where other medical and social support services are located.
- Mobile outreach units – e.g. mobile vans.

What should be the outreach hour?

Outreach should happen at a time when IDUs gather (e.g., to buy drugs). This can be in the evening or early morning. Appropriate measures should be taken to ensure safety of staff (PE and ORW) engaged in outreach.

Who leads outreach?

The PE should lead the outreach – each PE should interact with individual IDUs on a one-to-one basis and distribute needles, syringes, condoms, etc. Outreach workers should supervise and provide support as and when required.

How many clients can be served in a single day?

The number of contacts in a single day depends on the target and plan considering site, average gathering of IDUs, risk, vulnerability, and frequency of injection. Spot analysis and contact mapping help in making plans for single day. A single PE has 25-40 IDUs as part of the outreach target. However, in some cases, all the IDUs may not be met by a PE in a single day. In such cases, the PE should plan in such a way that he/she is able to meet all the targets every alternate day. Alternatively, the ORW should cover for the PE, wherever the PE fails to meet the target allotted to him/her.

What needs to be carried during outreach?

- Identity card for security reasons. Some NGOs also carry a copy of the district SP's letter acknowledging the NGO's work and field area.

- IEC materials.
- Needles – 26 and 24 gauge.
- Alcohol swabs, distilled water.
- Syringes – 1 ml, 2 ml and 5 ml.
- Disposable gloves for collecting used needles and syringes.
- Puncture proof container to receive used/ returned needles and syringes.
- Tongs for picking up used needles and syringes.
- Condoms for distribution and a penis model for condom demonstration.
- Scissors, betadine ointment and lotions, bandage, spirit, plaster.

4.1 Services Provided through Outreach

a. Needle Syringe Program

NSEP[1] facilitates safe injecting practices by providing clean injecting equipment and ensuring safe disposal options for used equipment.

- Clean needles and syringes are the tools to prevent HIV and other blood-borne diseases. Hence, providing needles and syringes whenever needed is essential to make each injection safe from diseases.
- Needles and syringes should be provided according to the need of the individual IDU. This is to be calculated based on the information available from the need assessment conducted with individual IDUs in the field.
- The distribution of needles, syringes and medi-swabs should be supplemented with information on safer injecting practices. On-site demonstration of safer injecting skills should be performed by the PEs.

Collection and removal of used needles and syringes from circulation is important to reduce re-use. PEs should encourage returning of used needles and syringes. They should follow proper guidelines for collection and safe disposal of used needles and syringes.

The procedure to be followed for collection of needles and syringes is laid out in the *'Guidelines on Safe Disposal of Used Needles and Syringes in the Context of Targeted Intervention for Injecting Drug Users - NACO, 2009'*. Adherence to these guidelines is essential.

b. Behaviour Change Communication (BCC)

What: BCC is an interactive process with communities to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours.

Why: behaviour change is one of the essential elements to reduce harm in each client. Normally people resist changing in spite of knowing facts and information. Therefore, a well-planned strategy to regularly engage IDUs with different communication methods allows change to happen and be sustained.

Target group	Objective of BCC
IDU	Motivate/sustain safer injecting practices and safer sex.
Spouses, regular sex partners of IDUs	Assist in acquiring knowledge on self-care, life skills to enable safer behaviour with their partners and also seek reproductive health care as and when needed.

[1]The details can be found in the SOP on NSEP developed by UNODC as part of the GFATM Round 9 program.

How:

- One-to-one: using tools like flip books/ charts, IEC materials. It is done to motivate safer injecting practices and safer sex. Details on how to inject safely are provided in the SOP on abscess prevention and management.
- Group education: a group of more than two and less than eight is appropriate. Group education is done to share knowledge, information and skills.
- Counselling: can be done in the field but is more effective at the DIC.
- IEC: includes brochures, posters, street plays, flip charts. IEC should be developed by assessing the behavioural risk.

Behaviour change communication should focus on:

- Drug related harm.
- Ways to reduce harm.
- Safer injecting practices such as NSEP, prevention and management of overdose, etc.
- Safer sex, negotiation skills.
- Accessing available health services.
- Ways to prevent and manage abscess.
- Capacity building of IDUs on correct condom use, safer injecting practices.
- Advocacy among key stakeholder for creating a supportive environment.

Additional topics for group discussion should be planned in discussion with the IDUs and sessions should be planned accordingly. For example, a site may have frequent drug overdose. In such a case, education should be provided about how drug overdose happens, how to avoid overdose, and how to manage overdose. Information should be provided on naloxone, an emergency lifesaving medicine for opioid drug overdose.

Focus group discussion at the hotspot

A focus group discussion with current IDUs to understand the causes and issues related to drug overdose was done at one of the hotspots in Imphal, Manipur. The team developed a set of probing/leading questions and one of them facilitated the whole discussion. The criterion for attending was overdose in the last one month. The focus group discussion lasted for about an hour, and the facilitator was able to impart education to the IDUs on reasons for occurrence of overdose, apart from understanding the factors associated with overdose.

Similar FGDs can be done to understand more about other issues, challenges which may hamper intervention programs, e.g., why IDUs are not keen to get HIV tested, how IDUs share injecting equipment, use of condoms, fear of HIV/ART, etc.

c. Condom Promotion

What: to promote safer sex by encouraging proper condom use, providing skills to use condoms and information on the purpose of condoms. Also ensure regular supply of condoms as per requirement.

Why: to ensure consistent use of condoms among IDUs and their sex partners. The TI should focus on regular sex partners as it is important to prevent both receiving and onward transmission of STIs, HIV and other blood-borne diseases through the sexual route.

Ensuring availability, accessibility and, correct and consistent use of condoms by the HRGs is the key to HIV prevention.

How: strategies to be followed are -

- **Primary strategy:** free supply of condoms to male as well as female IDUs, some of whom may also be sex workers and spouses/ partners of male IDUs.
- **Secondary strategy:** social marketing done through TIs or Community Based Organizations (CBOs) in collaboration with social marketing agencies.

Distribution channels

- **Direct:** condoms given directly during field visits or at DIC.
- **Indirect:** distribution done though condom outlets like public toilets, paan shops, lodges, etc.

d. Referrals

All services required for IDUs and their sex partners cannot be provided through outreach. Thus, referral for suitable services will be needed to suit the requirements of the IDUs and their sex partners. The IDUs and their sex partners may not always be comfortable accessing these services through referral. Accompanied referral, with ORWs/PEs accompanying the IDUs or sex partner to various services at least in the initial stages, should be provided.

e. Creating an Enabling Environment

What: harm reduction services require a supportive environment from community, families, society and law enforcement agencies including pressure groups (in certain places).

Why: IDUs often face stigma and harassment because of a number of reasons making access to services a challenging task for IDUs. The PE and ORW, in consultation with other staff, need to create a good environment for accessing services. Effectiveness of the program is enhanced by having a supportive environment.

How: at the onset of the intervention, meetings should be organized with law enforcement personnel and community leaders on the issues of IDUs.

- **Advocacy with law enforcement agencies** – gaining support for harm reduction

services is essential to avoid harassment of IDU clients or the field staff by the police while providing/receiving services.

- **Senior police officers**

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

- **Get support for the TI project**

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

- **Educate police officers on drug use issues and risks**

  After gaining trust, explain the risk involved to the police while frisking the IDU clients. Explain the risk that the police may face due to accidental needle stick injury resulting in infection with Blood Borne Viruses (BBV). Additionally the police should be educated on Post-Exposure Prophylaxis that are available in the near by health centres. Focus should be on changing the attitude of the police by reinforcing the message that drug dependence/addiction is a health problem and a number of harms can be prevented by providing appropriate services.

- **Use supportive police to do more advocacy**

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

- **Periodic visits to the police station**

  In consultation with the district officer, arrange regular visits, preferably monthly, by the NGO team to update on program achievements and issues

Case Study – Advocacy Meetings

Some of the TI partners conducted an advocacy meeting by inviting a high-ranking police officer to attend a meeting focused on issues related to drug policy and the work being done by NGOs in preventing HIV among IDUs. The meeting was organized by a group of NGOs working in an IDU TI. Many lower level police officers also accompanied the senior officer to the meeting. A month after conducting the meeting, two staff members of the IDU TI were detained in the police station as they had been helping an IDU who had developed OD and subsequently died. However, when the TI NGO project director visited the police station, the station house officer immediately recognized him and the work being done by the organization. He offered the TI staff members tea and the detained staff was released. This relationship helped in maintaining a cordial working environment between the police and the IDU TI NGO.

faced by the field staff in service provision. Avoid disclosing identity of the clients which may break the trust between the NGO team and the IDU. If the IDU suspects that the NGO is helping police in their activities, he/she may stop taking services from the NGO.

- Ask all of them to help, assist and participate in wider consultations.

Build community (IDU) ownership of the TI by:

- Collectivization: making a collective, united effort by IDUs.
  - Creation of space for community events.

Community awareness meeting in progress

  - Building capacity of IDUs and their sex partners to assume ownership of the program.

- **Drugs, HIV events, meetings with police and community**

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

- **Working with the IDU community** – Involving the community, IDUs, spouses, FIDUs, in designing services makes the harm reduction services more acceptable to the IDU clients and increases the uptake of these services.
  - Identify supporters and opponents, and work accordingly.
  - Identify the key decision makers and opinion leaders.

- **Raising public awareness amongst general population** – Advocacy with general population is also needed on harm reduction, how stigma leads to more challenges in the whole public health works, etc.General population needs:
  - Awareness on drug use facts and issues to decrease stigma.
  - Information on "harm reduction" as it is new and many will not know the benefits.
  - Clarify that HR does not promote drugs and sex it helps to reduce risks. There is always misconception or misunderstanding that HR encourages antisocial and illegal practices.

5. Documentation

Documentation of regular outreach activities is important for keeping track of the changing scenario at the field level. Thus, improved planning, monitoring of the activities and performance of the PEs and the ORWs is required.

5.1 Individual PE Tracking

What: information of day-to-day outreach and other services provided is recorded in the PE log book or diary. On returning from the field, the PE can transfer the record/data on to the individual PE tracking sheet (see Annexure 2).The main services recorded are:

- One page for each PE.
- Name and code of IDUs met during the month.
- Their risk and vulnerability assessment.
- Number of needles and syringes distributed.
- Number of condoms distributed.
- Number of IDUs who attended clinic, were referred to ICTC/ART/Revised National TB Control Program (RNTCP), etc.
- Report of experience of violence or harassment especially by pressure groups and police.
- Number of BCC contacts.
- Number of referrals made during the month.

Who: PE and ORW transfer daily notes/data within two days' time for maintaining quality of the data.

How: Use formats (Annexure 2) to update individual tracking grids weekly.

This helps in weekly review meetings to update the target achievement, re-prioritize IDUs who need to be reached in the following week, etc.

5.2 Other Formats – PE

- Outreach planning tools: contact mapping, spot analysis, social mapping. These tools are essential for making weekly plans and ORW and other staff can monitor the effectiveness of a PE by using these tools.
- Field observation/daily notes: should be maintained daily.
- Weekly planning and activity sheet (Annexure 2): this is maintained weekly and submitted to the ORW. PE activity can be checked weekly and sometimes the ORW can make field visits.

5.3 Records/Formats for ORWs

- IDU/HRG registration contains information of the IDU, profile e.g., name, age sex, address, etc.
- Monthly summary sheet (Annexure 3).
- Weekly meeting register (planning) to be maintained by ORW.
- Field diary of ORW.
- ORW weekly report (Annexure 4).

6. Monitoring and Management Issues

6.1 Monitoring Outreach

What: the following activities should be monitored weekly:

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

Monitoring should also be done fortnightly to see whether:

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

Who: monitoring is conducted at two levels:

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

How: at the field level, the ORW should regularly observe the PEs and their interactions with the IDUs and local people.

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

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

He/she should also discuss issues related to IDU's drug use, injecting and sexual practices, new IDUs, emerging hotspots, etc.

The ORW should conduct weekly meetings for each hotspot with the relevant PEs and discuss the following:

- Coverage
- Contacts made
- Needle and syringe supply
- Other provisions

- Condom supply
- Referral to DIC
- BCC at the field level
- Follow-up

Record/documentation review: the ORW should also check the relevant sections of the PE diary, tracking sheet to check for contacts with clients- (both 1-1 & 1-group), number of needles, syringes and condoms distributed, referrals and follow ups and check if they are matching.

At the TI level the PM should monitor the outreach at least on a fortnightly basis. The PM should visit the hotspots two to three times a week. He/she should make a plan for regular visits to all the hotspots. There should also be some surprise visits conducted.

During the visits the PM should be meeting:

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

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

- Outreach plan, including spot analysis.
- Needle and syringe stock register (this will provide the situation of the stock and also the number of needles and syringes received by individual PEs and ORWs).
- DIC registration records (number of clients who have been referred from the outreach).
- DIC service utilisation registers (abscess management, counselling, STI treatment, referral etc.).
- PE weekly planning and activity sheet (Annexure 2) and PE-wise individual HRG compiled sheet for IDU intervention (by ORW) (Form C).
- Monthly CMIS report.

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

- Field visits.
- Record/documentation review.

6.2 Managing PEs

Outreach workers should directly supervise the PEs. The supervision should be supportive in nature, keeping in mind PE's strengths and weaknesses.

- Review performance of PE every six month. This is done by reviewing the records maintained by the PE, observation of the work done by the PE in the field and the field level monitoring conducted by ORW.
- Each PE should be given a 12-month agreement and the agreement should be renewed based on performance.
- Weekly meetings with PEs help bring focus to challenges faced by the PEs in the field. ORWs and the PM should ensure discussion regarding these challenges and plan to address them.
- Rotation of PEs after completion of the contact list is also preferred to get new users or new contacts.
- Current IDUs working as PEs may not be able to perform effectively if his/her daily drug use is becoming unmanageable. Providing counselling with proper focus on work as a reminder is always helpful.

Provide support and encouragement to PEs to get on OST as OST makes the PE's life more stable and he/she and improves ability to work more effectively.

6.3 Managing ORWs

ORWs are supervised by the project manager who should:

- Review performance of ORW with the output, contacts and monitoring of outreach. This requires review of the performance of the PE also, as the main role of ORW is to manage PEs.
- Attend the weekly meetings to understand the work activities, processes and plans. This enables immediate attention to be focussed on addressing the gaps and misunderstandings between staff and also external challenges.
- Ensure opportunity is given to ORWs to attend relevant trainings (internal or external).
- Follow NGO rules when dealing with ORWs who are ex-users and have relapsed. At the same time support should be provided to the ORW.

7. Challenges

What	Suggestion or Option
Inability to carry needles and syringes by IDU	• This may happen in certain areas. PEs and ORWs should always carry their ID cards. The crisis response team should make advocacy efforts to reduce police harassment and allow IDUs to bring back used needles and syringes for proper disposal.
Pregnancy and heroin use	• A pregnant woman who uses heroin puts her foetus at risk of being aborted. There may be complications for the mother as well. Hence, it is advisable to refer pregnant FIDUs to OST for the safety of the foetus and the mother.
Addressing burnout	• Burnout may be related to psychosocial states; chronic emotional strains; lack of experience; role conflict and confusion; workload; misunderstanding between staff or with IDUs; organizational demands • It can be prevented through use of clear job descriptions, realistic expectations of ORWs/PEs and supportive supervision.
Relapse	• Relapse can be caused by stress and exposure to high risk situations. PEs and ORWs are vulnerable to relapse due to their psychological states; proximity to drug use; physical pain; inability to manage large amounts of cash; etc. • It can be prevented through organizational rules, individual preparation for outreach work, by appropriate supervision and assistance from other outreach workers. • As a basic rule PEs and ORWs should never go to the field alone. Pairing them up greatly reduces chances of relapse due to exposure to drugs. • Regular counselling and sharing in group meetings can further reduce chances of relapse. • Clear guidelines regarding relapse of PEs and ORWs should be developed at the organizational level with emphasis on seeking treatment in case of relapse and providing opportunities to re-join service upon treatment completion. This helps the PEs and ORWs have greater confidence in the system and continue work with reduced apprehensions regarding relapse.
Police arrest of PEs and/or ORWs	• Senior staff of the TI project should provide necessary help to the PE/ORW in case they are apprehended by the police while on duty or for reasons of distribution of needles and syringes. • Regular advocacy with law enforcement is necessary if such arrests occur frequently.

What	Suggestion or Option
Police arrest of IDU	• If the IDU is on ART/OST the individual will suffer without medication. • Crisis response team (CRT) in the TI should be made aware of such a crisis and should be empowered to deal with the issue of access to health/services. • If the arrest is related to some 'crime' committed, CRT may not be able to help much but should ensure that the IDU receives his/her medications as required. • Advocacy meetings should be held with the law enforcement agencies to ensure that the treatment is not affected and the health of the IDU is not compromised.
Home based IDU	• Initial contacts can be made through a link person, but the PE should clearly state his/her identity, name of the NGO and the services offered. • Contact details including phone numbers should be shared to enable the IDU to contact outreach staff as and when needed. • Such IDUs should specially be assured of confidentiality and all efforts should be made to ensure that it the confidentiality is not breached. Some IDUs can be sick at home and may not be in a position to move out to seek services. They may need to be linked to the ANMs/doctors and requisite services to help tide over the crisis period

Annexure 1: Spot Analysis

District : **Targeted Intervention (TI) area :** **Location :** **Spot :** **Date of analysis :**

High Volume	Typology																						
	Street						Home						Brothel						Lodge				
	Age						Age						Age						Age				
	>20		20-30		30-40		>20		20-30		30-40		>20		20-30		30-40		>20		20-30		30-40	
	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly
	Time		Time		Time		Time		Time		Time		Time		Time		Time		Time		Time		Time	
	M A E N																							
Medium Volume	Typology																						
	Street						Home						Brothel						Lodge				
	Age						Age						Age						Age				
	>20		20-30		30-40		>20		20-30		30-40		>20		20-30		30-40		>20		20-30		30-40	
	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly
	Time		Time		Time		Time		Time		Time		Time		Time		Time		Time		Time		Time	
	M A E N																							
Low Volume	Typology																						
	Street						Home						Brothel						Lodge				
	Age						Age						Age						Age				
	>20		20-30		30-40		>20		20-30		30-40		>20		20-30		30-40		>20		20-30		30-40	
	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly	Daily	Weekly
	Time		Time		Time		Time		Time		Time		Time		Time		Time		Time		Time		Time	
	M A E N																							

M - Morning A - Afternoon E - Evening N - Night

Annexure2: PE Weekly Activity Plan

PE Weekly Planning & Activity Sheet (IDUs)

Name of the PE		District		Name of the hot spot/s		Week	1	2	3	4
Name of the supervising ORW		For the month				Date: (end of the wek)				

Sl. No.	Name of the HRB Groups	000000 000	PE's Symbol for Identifying HRB Groups	Referral due/Over due		Risk Assessment									Services										
						Risk				Vulnerability					# of contacts					# of referrals (STI & others centers) Report access by HRB Groups					
		UID Number		STI	ICTC	High number of drug using partners > 3 per month	Sharing of needles/syringes (Yes/No)	Injecting > 3 times a day	STI reported in last three months	Use of Alcohol & other drugs apart from injections	Unsafe sex (sex with non regular partner)	Mobility from one hotspot to another	Condom requirement per week	# of condom distribution	1-1	1-Group	Needles/syringes requirement per week	# of syringes distributed	# of syringes returned	STI referrel visited	Abscess treatment	ICTC	ART	Condom use during last sex	Needle/syringe not shared during last injecting episode
1.																									
2.																									
3.																									
4.																									
5.																									
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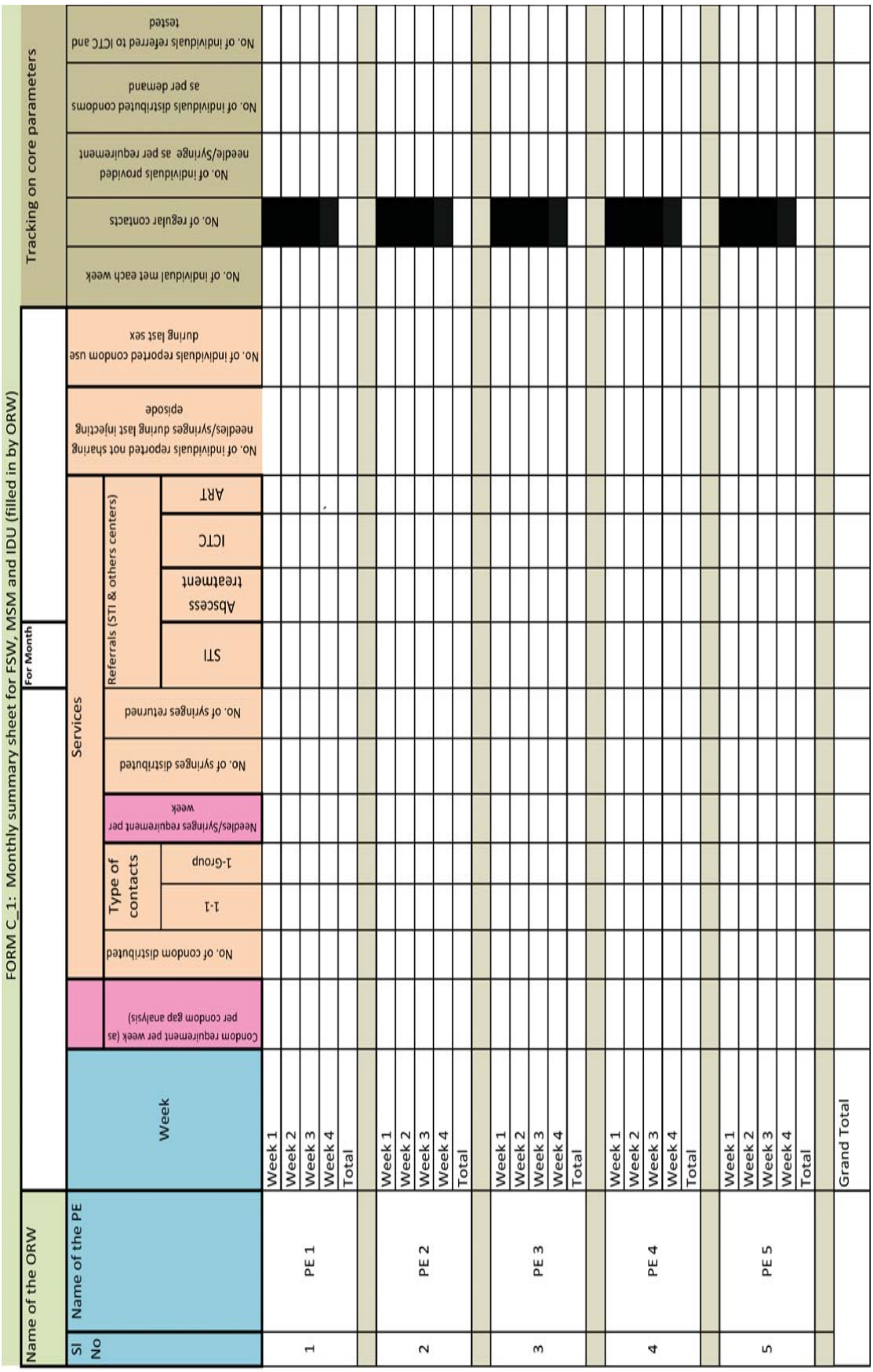
18.																									
19.																									
20.																									
21.																									
22.																									
23.																									
24.																									
25.																									
	Total													Total distributed through 1-5											

Annexure 3: Monthly Summary Sheet



Annexure 4: ORW Weekly Report

FORM D: ORW WEEKLY REPORT

Name of ORW		Date	Reporting for the WEEK:	For the Month:

Number of PE working with ORW:		No. of ICTCs in ORW area		No. of police stations in ORW area	

Sl No	Activities	PE 1	PE 2	PE 3	PE 4	PE 5	Guidance
1	PEs met to review outreach for week ended; and to plan outreach for next week by prioritizing KPs to be given services						For each PE, pls write if PE was met. If yes, pls write a paragraph about the outreach /referral challenges faced by the PE and the support you will provide him/her for the next week. Pls also indicate if a clear risk based outreach plan plan has been prepared for next week (which lists the HRGs to be prioritzed for outreach next week)
2	PEs met to review condom distribution and condom sold						Pls review condom distribution / sold for each PE last week against requirement, and strategy /support you will provide to the peer to ensure adequate condoms are available and distributed.
3	Sites were visited during the week for supportive supervision.						Pls indicate the nature of site visited, and the support provided to resolve any problem (e.g. in explining MIS system, in improving skills of peers in IPC, in building rapport with stakeholders (e.g. gatekeepers,, local leaders etc). The ORW during the visit meets 10% of the HRGs in a given site to know on the feedback on the services given by the project for improving.
4	Number of new HRGs registered.						Indicate whether all the HRGs estimated /mapped are being registered with the program
5	Number of HRGs declared as dropped out during the month						For any KP that has not received program services for 6 months, pls understand from the peer the reason (e.g. migration) and make "inactive" after adequate efforts made to trace her. This has to be documented in the weekly minutes and shared with the PM
6	Coordination meeting with ANM/Counselor to list STI/ICTC visits made during the last week and due next month.						by HRGs during the previous week and ensure that peers have a list of KPs due or overdue for clnic /ICTC visits. Pls also report no. of ICTC /STI visits due this month
7	Group meetings with HRGs in DIC (For review and community issues)						Pls, summarize key issues faced by community and action proposed to address their issues
8	Meeting for Developing linkages						
	ICTC						Pls summarize nature of the meeting and action taken to develop linkages and improve coordination
	ART						
	POLICE						
	GATE KEEPERS						
	Other stakeholder						

8. References

1. National AIDS Control Organisation, Ministry of Health & Family Welfare, Government of India. 2007. Targeted Interventions Under NACP III. Volume I. Core High Risk Groups. http://www.nacoonline.org/upload/Policies&Guidelines/NACP-III.pdf
2. National AIDS Control Organisation, 2009. Guidelines on Safe Disposal of Used Needles Syringes in Context of Targeted Intervention for Injecting Drug Users. http://www.nacoonline.org/upload/NGOTargeted/wastedisposalguidelineforIDUTI.pdf
3. National AIDS Control Organisation. A Manual on Working with Injecting Drug Users. A Training manual. http://www.nacoonline.org/upload/NGO & Targeted/Capacity Building/Training Module/Training Package for working with IDU/A manual Working with Injecting Drug Users a Trainers Manual.pdf
4. United Nations Office on Drugs and Crime, 2012. Staying safe A manual to train Outreach workers in IDU TI interventions (Draft stage).
5. United Nations Office on Drugs and Crime, 2012, Staying Safe. A Manual to Train Peer Educators in IDU TIs (Draft stage).
6. United Nations Office on Drugs and Crime, 2011, Counselling in Targeted Interventions For Injecting Drug Users. www.unodc.org/documents/southasia//trainingmanuals/A_counsellors_handbook.pdf

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