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### 1. ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Anti Retroviral Therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>BSS</td>
<td>Behavioural Surveillance Survey</td>
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<tr>
<td>CB</td>
<td>Capacity Building</td>
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<tr>
<td>CBO</td>
<td>Community Based Organisation</td>
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<td>CM</td>
<td>Community Mobilizer</td>
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<td>CSO</td>
<td>Civil Society Organizations</td>
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<td>CSS</td>
<td>Community Systems Strengthening</td>
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<td>DIC</td>
<td>Drop in Centre</td>
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<tr>
<td>DPHO</td>
<td>District Public Health Office</td>
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<tr>
<td>EDP</td>
<td>External Development Partner</td>
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<td>FGD</td>
<td>Focused Group Discussions</td>
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<td>FHI</td>
<td>Family Health International</td>
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<tr>
<td>FIDU</td>
<td>Female Injecting Drug Users</td>
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<td>Hep B</td>
<td>Hepatitis B</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HRB</td>
<td>High Risk Behaviour</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>IBBS</td>
<td>Integrated Bio-Behavioural Survey</td>
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<td>IDU</td>
<td>Injecting Drug Users</td>
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<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
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<td>IPP</td>
<td>Information Procurement Plan</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring &amp; Evaluation</td>
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<td>MARP</td>
<td>Most at Risk Population</td>
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<tr>
<td>N&amp;S</td>
<td>Needle and Syringe</td>
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<td>NGO</td>
<td>Non Governmental Organisation</td>
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<tr>
<td>NSEP</td>
<td>Needle and Syringe Exchange Program</td>
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<td>OI</td>
<td>Opportunistic Infections</td>
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<tr>
<td>ORW</td>
<td>Outreach worker</td>
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<tr>
<td>OST</td>
<td>Opiod Substitution Therapy</td>
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<tr>
<td>PE</td>
<td>Peer Educator</td>
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<tr>
<td>PEP</td>
<td>Post-exposure prophylaxis</td>
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<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
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<tr>
<td>PPTCT</td>
<td>Prevention of Parent to Child Transmission of HIV and AIDS</td>
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<tr>
<td>SCM</td>
<td>Syndromic Case Management</td>
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<tr>
<td>SS</td>
<td>Social Security</td>
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<tr>
<td>SSH</td>
<td>Secondary Stakeholder</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TI</td>
<td>Targeted Intervention</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Program on HIV/AIDS</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Program</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children`s Fund</td>
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<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>VCTC</td>
<td>Voluntary Counselling &amp; Testing Centre</td>
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<tr>
<td>VDC</td>
<td>Village Development Committee</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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2. STRUCTURE OF TI OPERATIONAL GUIDELINE

VOLUME 1
- Introduction

VOLUMES 2
- Implementation and Scale up

VOLUME 6
- Project Management System

- ANNEXURE - TOOLS AND CHECKLIST

- RATIONALE
- PRINCIPLES
- NATIONAL MANAGEMENT STRUCTURE
- NGO SELECTION GUIDELINE

- PROJECT SET UP
- PACKAGE OF SERVICES - IDU
- STAFF STRUCTURE
- BUDGET

- PLANNING
- STRATEGIC INFORMATION
- HR AND CAPACITY BUILDING
- FINANCE AND PROCUREMENT
3. GLOSSARY OF TERMS AND DEFINITIONS

3.1 GLOSSARY OF TERMS

1. Most at Risk Population:

Persons, who are at the risk of contracting HIV, due to risk behaviours (unprotected non-regular-partner sex, sharing injecting equipment) that these groups are exposed to or engage in. For the purpose of HIV focused prevention programming in Nepal, four MARPs have been prioritized. These are Female Sex Workers (FSW) and their Clients, Male having Sex with Male (MSM), Injecting Drug Users (IDUs) and Migrants.

2. Targeted Interventions:

Targeted Intervention is a cost effective HIV prevention model for reaching people who are most at risk of HIV infection\(^1\). The program provide prevention services that include information focusing on behavior change (through educative sessions, peer education, counseling etc), treatment services for STIs, Condom services or Needles and Syringe program for IDUs and facilitation of enabling environment. Beyond these traditional components, most of the Targeted Interventions world over are now focusing also on community system strengthening, care and support services through linkages and focus on vulnerability reduction through addressing other needs of MARPs that are indirectly linked to the risk of HIV infection.

3. Harm Reduction:

The emergence of the concept of ‘harm reduction’ in HIV/AIDS prevention programs began with the promotion of condoms among the sex workers. Since involvement in sex work had inherent risk to HIV, it was important to promote the idea of ‘safe sex’ by ensuring use of condom during every penetrative sexual encounter. Studies have proven the efficacy of condoms as an effective tool to control sexually transmitted infections and HIV. The idea is that even if one cannot provide the perfect solution, at least the damage can be controlled and/or reduced.

The same principle of damage control is applied to the practice of injecting drug use and the risk of HIV. Since drug users often shared needles and syringes whilst injecting, increasing their risk to HIV, giving them clean needles and syringes in exchange for the used ones or putting them on Opioid substitution treatment helps in reducing the harm linked to risk of HIV infection due to sharing of needles, untreated abscesses, Hepatitis B and C etc.

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\(^1\) [http://www.searo.who.int/LinkFiles/Publications_NAP_Module_4.pdf](http://www.searo.who.int/LinkFiles/Publications_NAP_Module_4.pdf) (Last accessed on 16 June 2010)
Harm reduction refers to policies, programs and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than primarily on the prevention of drug use itself, and the focus on people who continue to use drugs.\footnote{http://www.ihra.net/Assets/2316/1/IHRA_HRStatement.pdf (last accessed on 8th June 2010)}

4. **Outreach:**

Outreach is one of the key delivery mechanisms within targeted intervention, focused on providing information and services (including BCC) at the convenience of the MARPs – that is reaching out to location where MARPs can be reached and in the timings best suitable for them. Outreach is a process and not a one-time activity. Outreach consists of the following sub-activities - registration, repeat contact, risk assessment and risk reduction inputs through one to one and one to group BCC sessions, Referral for VCT, health care (STI) and to the drop in centre, distribution of condoms and sterile injecting equipments etc.

5. **Risk Assessment:**

Risk assessment is a process of identifying behaviors of MARPs, which are currently risky, or has had a history of such behaviors/habits that contributes towards a risk of acquiring STIs/HIV or transmitting such an infection. This is done with the objective of helping MARPs increase his/her perception of risk and making appropriate behavioral choices.

Risk assessment also includes how consistently a condom is used, alcohol use while at work, involvement in group sex, extent of violence experienced, sharing of needles for injecting drugs and identifying STI symptoms.

6. **Risk Reduction:**

It is a process of decreasing a MARPs risk behaviors from a previous stage of higher/more risks to a stage of lower/reduced risk of contracting HIV infection. It is done using counseling/interpersonal communication/behavior change communication. The intervention is person-centered. Risk reduction can also be accomplished by resetting social or community norms (e.g. “normalizing” condom use, or regular usage of health services). The process of resetting social and/or community norms can occur incidentally, but can also be done through specific outreach and communication strategies.

7. **Site and Hot Spots**

A site is referred to as an “intervention site” which is a contiguous geographical area demarcated by a definite boundary such as a locality. Each site will be in itself independent geography for planning intervention – particularly for outreach planning.
Within a district there could be more than one intervention site depending on number of towns or cities that needs to be covered for reaching out to the MARPs.

Areas within a site where there is significant concentration of HRGs are referred to as “hotspots”. Within hotspots, HRGs may solicit, cruise, and interact with other HRG members or have sex or share injecting equipments and drugs. Therefore there could be many hotspots within a site.

8. Formative Research

When a new intervention is designed, it is important to understand the needs of the community vis-à-vis the intervention objectives. Formative research is carried out before a program is designed or implemented with a focus on understanding the needs of population to be covered through the intervention. Formative research has three stages of action: 1. Mapping location (focusing on identifying risk sites and spots and providing an estimation of MARPs), 2. Situational Assessment (Detailed assessment within the identified risk site on actual intervention needs of the target community) 3. Baseline Study (provides information on status of biological and behavior indicators at the start of the project which will be compared after a period of intervention to assess whether any progress has been achieved through the services provided.)

9. Primary and Secondary Stakeholders

Primary Stakeholder – The Most at Risk Populations (MARPs) – FSW, MSM, IDUs and Migrants.

Secondary Stakeholders – Who are engaged with the project indirectly and have influence (positive or negative) on the project deliverables - but are not beneficiaries of the project (Police, Health Care Providers, Local Leaders etc)

3.2 KEY OPERATIONAL DEFINITIONS IN IDU INTERVENTIONS

a. Injecting Drug User – Persons who is using narcotic drugs through injecting mode in the last one year.

b. Needle and Syringe Exchange Program (NSEP) – NSEP is one of the critical components of Harm Reduction program. NSEP involves distribution of sterile and disposable syringes and needles in adequate quantity to the injecting drug users. This should be done on a daily basis as a support in injecting drugs and as a way of preventing HIV infection by minimizing sharing of needles. This also includes collecting back, used needles and syringes from the users.

c. Detoxification - Detoxification refers to the treatment of withdrawal from the opioid or sedatives/Hypnotic over a short period of time by the use of the alternate drug that alleviates the distress in decreasing doses. In Nepal other
methods are also being practiced like cold turkey, acupuncture and homeopathic treatment, which are other options that will be adopted for intervention. The objective of detoxification is to facilitate the patients transition to a drug free state.

d. **Opioid Substitution Therapy (OST):** Substitution therapy ("agonist pharmacotherapy", "agonist replacement therapy", "agonist-assisted therapy") is defined as the administration under medical supervision of a prescribed psychoactive substance, pharmacologically related to the one producing dependence, to people with substance dependence, for achieving defined treatment aims³.

a. **Drop In Centre:** Drop in center is a key service delivery mechanism which is a one stop service centre for IDUs, that provides comprehensive and holistic harm reduction services to the community.

4. RATIONALE

4.1 INJECTING DRUG USE AND HIV IN NEPAL

In Nepal, use of Cannabis (marijuana) has been in existence for centuries. It was in 1960s, that heroin became commonly available among the drug using groups. In the '90s with the introduction of Buprenorphine, injecting behavior emerged. Buprenorphine was replaced by heroin as it was easily available in injectable form and was cheaper. With this, a wide spread shift in culture of drug use emerged in Nepal and injecting became common, as sharing of needle also became a common practice.

There had been several estimation studies of the IDUs that had been undertaken in different parts of the country. But no single figure from one is available in Nepal. In Kathmandu, IDU estimate is around 5200 to 6760 (2007), Pokhara is 600 (2002), Jhapa -Morang -Sunsari - 2300 (2002), 18 Tarai districts – 1200 to 1700 (2004), 26 highway districts – 10400 to 14560 (2007), Far Western Hills – 720 to 1140 (2007) and remaining districts account for 830 to 1660 (2007).

HIV prevalence among the IDUs in Nepal was well below 2% up to 1995. By 1999 the figure rose substantially to 40%. In Kathmandu Valley alone, the prevalence among the IDUs was around 1.57% in 1991 and within a decade it rose to a high prevalence of 68% (2002). Through the focused effort of national program, the NGO interventions and support of various development partners, there is a marked decreasing trend in the infection rate among the IDUs as seen in the graph.

Another key group with increasing vulnerability to HIV but inadequate program focus is the Female Injecting Drug Users. There is no comprehensive study done among the female IDUs to determine the extent of their vulnerability. A study carried out in 2002 among 57 female IDUs, found that 16% were HIV +, showing female IDUs are equally if not more vulnerable to HIV. Several factors increase their vulnerabilities - like sharing of

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5 Ibid. P 17
needles with their sexual partner, involvement in sex work to support injecting behavior and sexual exploitation.

4.2  CHALLENGES AND HIV PROGRAMMATIC GAPS FOR IDUS IN NEPAL

There are several challenges and programmatic gaps in Nepal as far as the IDU component is concerned. These challenges are either related to contradictory law, availability of resources or capacity. Following are some of these challenges and constraints:

- Current Policy environment of HIV among injecting drug users in Nepal is favourable, however, there care contradicting drug control law, that hinders implementation of HIV prevention programs in the country
- Lack of policy dialogue between sectors of government responsible for responses to HIV and drug use
- Economic, social and political dislocation, leading to increases in drug injecting, needle sharing and, consequently, HIV
- Injecting drug users, especially women, being ‘demonised’ for their drug use, rather than supported, placing them at particular risk of both human rights abuses and HIV infection
- Lack of standard Intervention protocol and guidelines for IDU community
- Donor agencies and countries alike failing to recognise the long-term threat to development posed by HIV and injecting drug use. This has led to absence of any effective primary prevention efforts especially among children in the school.
- Programmatic gaps include the following:
  - Inadequate number of Peer Educators and ORWs
  - Poor focus on sexual health needs of IDU
  - Poor program focus on the female IDU
  - Some of the critical needs of the IDUs like abscess management, Hep B and C etc are not adequately focused
  - Drug users inject drug anywhere in the community and leave the needles and syringe all over. This has resulted in greater threat to the community, particularly children who move around playing in the same area.
  - Poor capacity building efforts focusing on the community
This section details out key steps to be followed in setting up Targeted Intervention for Injecting Drug Users (IDU). The section is more relevant to NGOs/CBOs who are starting a new targeted intervention, while it will still be useful for the existing TIs to use this as guide during preparation of Project Annual Plan (PAP).

The diagram given summarizes the key steps and process involved in setting-up TIs. It is to be kept in mind that, though these are independent steps, they could be implemented simultaneously. (While formative research is initiated, infrastructure and some of the systems could be brought into operation.)

Following paragraphs describe briefly the key project set up steps leading to effective project operations.

**STEP 1: FORMATIVE RESEARCH:**

Formative research will focus on generating information and data about estimates of IDUs, identify key high risk spots, needs of IDUs (both male and Female) relevant to the intervention, baseline on level of awareness related to HIV, current skills, practices, barriers for service uptake, field level challenges, etc. Formative research will employ tools such as, Mapping and Needs Assessment. (Details on the tools and process is given in Volume 6 of this TI Operational Guidelines)

**STEP 2: PLANNING PHASE:**

Based on the evidence generated from the formative research, the NGO partner along with IDUs and ex user representatives will prepare the implementation plan. The team will evolve key objectives, strategies, process, outputs and outcomes. The plan so evolved will contain clear design and direction for delivery of services, roles of all project staff and inform key stakeholders about the intent of the project.

During the planning phase, Micro Planning tools will be used for - Outreach plan, plan to engage stakeholders, service delivery plan and risk mitigation strategies. (Details on the tools and process in Volume 6 of this TI Operational Guidelines)
STEP 3: SETTING UP INFRASTRUCTURE FOR MANAGEMENT AND SERVICE DELIVERY:

This is focused on setting-up and operationalizing key infrastructure such as office space and Drop in Centre (DIC) facility including STI clinic, VCTC, condom depot, Needle and Syringe Program, OST services, Rehabilitation Services etc.

The Implementing partners as part of project set-up will have to establish administrative offices and service delivery infrastructure such as DICs, VCTCs, Rehabilitation centre etc. This section details out the process to be followed:

**Office Set-up:**
The NGO partner may or may not have an existing administrative office in the locality where intervention is being set up. In case the NGO partner does not have an office it is important to locate the office in the project area. Options can be explored whether to co-locate the office within or in and around DIC for better management and optimizing resources. If NGO partner has an existing office in the project area, needs to make necessary modification to accommodate additional staff and other requirement of the project.

**Drop In Centre (DIC) Set-up:**
DIC and other service infrastructure is lifeline of any prevention projects often providing ‘safe place’ for IDUs to seek information, treatment, advice and to advocate for their rights and dignity. Such an infrastructure should cater to the needs of the intended group and be responsive to their changing needs.

One DIC should ideally be set up to cater to a population of 500 to 1250 IDUs. This will also be finalized based on the density and distance. DIC should be accessible to a beneficiary within 20 to 30 minutes by road.

**Branding:** DIC branding strategy needs to be developed. National TI Division will take the initiative to develop the branding strategy for all DIC across the country which will have a common name and logo. This will facilitate access to any of the DIC across the countries for MARPs who are on the move.

The steps for setting up DICs and other service centers are detailed below.
1. **Understanding the needs of the Project Beneficiaries (IDUs – Male and Female):** As part of the Needs Assessment, the project will understand from the primary stakeholders (IDUs) their needs in terms of requirement for a DIC. It will explore as to what they expect out of DIC and which is the preferred location and what key services and facility are required to address their sexual health needs as well as injecting behaviour.

2. **Location of DIC:** The NGO partner along with IDU community members will select a location that is best suited for them. On short-listing, the NGO team will initiate efforts to locate a premise. On locating couple of suitable premises, further short-listing will be done and one final building to house DIC will be selected. In all the processes, the community members will be involved. While finalizing the premises, it is important to discuss details with the owner on the purpose for which the DIC is being set up. The premises should have at least two rooms and a hall that can accommodate around 15 persons at the same time and also at least two toilet facilities.

3. **Creating safe place around DIC:** On finalization of location of DIC, the NGO partner along with community will make visit to neighborhood and meet key leaders in the vicinity to apprise about project activities. These meetings will aim at providing clear and detailed information about the kind of activities planned at DIC and to allay any fear they might have.

4. **DIC Management Committee (DMC):** DMC will be created with the participation of key secondary stakeholders and community members (Local community leaders, police representatives, local NGOs, Prominent personalities in the locality, Project Manager, DIC staff, MARP representatives etc). This committee will meet to review the services within the DIC and discuss issues related to stigma in the locality and ways to ensure participation of the local community. It is suggested for the DIC to meet at least once a month at the start of the project. Once the project has taken off, frequency could be once in three months.

5. **Configuring services of DIC:** Based on primary data and minimum standards set by EDP/NCASC for DIC services, NGO partner along with community members will develop menu of services that DIC will offer. It will also discuss about how to deliver such services and should there be any user free for the same. A minimum package of services that should be made available for HIV prevention is suggested in the box given.

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**Minimum Package of Services in DIC:**

1. BCC (access to risk reduction information through one to one, one to group, IEC materials)
2. Risk Reduction Counselling
3. STI Treatment
4. Primary Health Care (Minor illness, minor abscess, wounds etc)
6. Entertainment – TV, board games, literature, movies
7. Referral Services for PLHIV care and support
8. Referral to Rahab/Detox/After Care services
6. **Interior and layout planning:** The community members should be involved in the process of planning the interiors and location of services within the DIC.

7. **Demand Generation:** The project will implement a systematic IEC Campaign technique to launch and popularize the DIC and its services among the IDUs. An incentives scheme will also be planned for those who are regular to the DIC.

8. **Staffing and Office hours:** The timing of the DIC will be decided in consultation with IDU representatives and based on findings from the Needs Assessment study. The proposed staff structure of the DIC is given below. This will need to be finalized based on DIC requirements of IDUs in the locality. Based on the minimum package of services suggested above, following is the proposed staff structure. This structure is suggested for DICs with catchment population of 500 and above. For smaller number of population, separate counselor may not be required as the number of IDUs catering to is low. In this context, the DIC coordinator should be trained in counseling and should double up as a part time Counselor.

**STEP 4: PROJECT SYSTEM DEVELOPMENT:**

This step focuses on evolving appropriate systems that will standardize understanding of processes and procedures and ensure quality delivery and management of the interventions. Any prevention project that needs to deliver effective processes and high quality outcomes, needs systems. These systems range from simple stock keeping to systems related to financial management, human resource management, systems of monitoring, evaluations and learning, procurement and supply etc. These systems are vital while implementing a project by an Organization there by reducing the scope for confusion and personal interpretation of procedures and policies.

The systems so evolved needs to be comprehensive, simple, operational and easy to communicate. The organization needs to have written, ratified and widely disseminated systems in the following areas:

- Office Administration
• Procurement & Supply Management
• Financial Management
• Human Resource Management
• Monitoring, Evaluation and Learning Systems.

• **Office Administration:** The systems will address areas such as asset management, logistic support, office supplies, break-down service, rental and maintenance contract management, etc

• **Procurement and Supply Management:** This system will address the procurement process and procedures, authorization, demand assessment, storing, supply management, stock maintenance, etc

• **Financial Management:** This system will outline accounting systems, authorization, controls, financial delegation, approvals, etc

• **Human Resource Management:** HR systems will detail out process of hiring, interview procedures, approval, performance management, compensation, contracting, benefits, terms of references, exit, etc

• **Monitoring, Evaluation & Learning Systems:** This system will detail out the monitoring and evaluation framework, reporting formats, data follow, learning systems mechanisms etc.

The above systems will be discussed in greater detail in the section on Project Management in volume 6 of the TI Operational Guideline.

**STEP 5: RECRUITMENT AND CAPACITY STRENGTHENING:**

Though recruitment is part of project system (HR system), it is discussed here in greater detail, since recruitment and induction are critical elements as part of the set up of a project.

The success of the project depends on the right kind of people selected for the job and also how quickly these positions are filled. The NGO partner will put in place a system for rapid recruitment of project staff. The following steps will be adopted for quick and effective recruitment.

1. **Finalize project structure** and obtain required approval for all positions from the NCASC TI division.
2. **Form project set-up team** comprising of decision makers of the Organization and other specialists. This team will be charged with the responsibilities of recruitment along with setting up the project.
3. **Preparations of TOR:** Based on the guidelines provided for TORs of staff in this document (Staff TOR in the annexure 1) TORs are finalized with specific qualification and experience descriptions. Once the TOR is ready, advertisement will be prepared for dissemination with specification on the requirement.
4. **Publicize the vacancies both internally and externally.** Recruitment of internal team members has its advantage since the person is familiar with Organizational processes and procedures. If this is not the case, the NGO partner will look for
talent from outside the Organization through advertisements using locally appropriate media options.

5. **Recruitment and Appointment:** CVs will be shortlisted and staff will be recruited through a formal process (according to recruitment policies of the NGO). If any staff recruited is blood relatives of the Board or existing employees, this needs to be specifically communicated to NCASC.

6. **Induction:** The newly recruited team will undergo a detailed induction training which will include – Organization background, project design, processes, policies, systems and expected roles. The induction will focus on domain knowledge (HIV, STI, condoms and allied health issues). The induction process will help the newly recruited team to quickly grasp the Organizational goals, project outcomes, their roles, etc thereby enabling them to start their work more confidently.

7. **Handholding and Mentoring:** The newly inducted team over a period of time requires handholding and mentoring on various issues related to field, strategies, secondary stakeholder management, etc. The senior team or the project set-up team will have to play a vital and responsive role to allay their difficulties and to install a sense of security and confidence. This will go a long way in contributing to improved performance of the project staff and better project outcomes.

Please refer to Project Management Section in this volume – for more details on Capacity Building and Human Resource Management.

**STEP 6: PROJECT LAUNCH:**

This step focuses on introducing project and key activities to primary and secondary stakeholders. During this step the project will concentrate on creating enabling environment by orienting and engaging key primary and secondary stakeholders and at the same time launching the project. Key activities will involve Entry Point Programs, Advocacy, Linkages and Networking.

This is section is more applicable for those NGO partners who are being contracted newly and starting new project. However the existing projects has ample scope to implement these during the beginning of following project year

The focus of this section is to guide NGOs on how to launch the project involving primary and secondary stakeholders.
1. Preparing Ground:

- Setting context and Planning with primary stake holders. Involve the IDUs in the planning process.
- Orientation and sensitization of secondary stake holders: NGO Partner will identify key stakeholders who have potential to influence the outcomes and who need to be informed about the proposed project.

2. Launch:

- Below are some of the practices that can be adopted based on the local realities:
  - Launch the project around a theme. Some examples of themes are:
    - Stigma Reduction,
    - I am for Change,
    - I know my responsibilities what about you, etc
  - The themes should run for at least a week’s time so that it can reach out to substantial number of IDUs.

3. Prepare for exigencies:

- NGO partner needs to scan the environment to identify possible challenges they could face from primary and secondary stakeholders. On identification of the problems, will have to put in place a mitigation strategy. It is also important to keep the senior management in standby mode to address any such untoward incidents.
  - NGO partner will have to take special care of media. It is important to provide information to media when they ask for it. If not given, they may try to get information from other sources which may be wrong and counterproductive to the project. On carrying the wrong report, the project may face more challenges and damages. Hence NGO needs to be ready with Press Note during any event that gets implemented during the course of project period.

The diagram below summarizes the key steps, key focus and components of program set-up phase.
**Key Steps**

- **Formative Research**
  - To understand the situations, risks, vulnerabilities, key players, risks, existing policies, programmes and more importantly the needs and aspirations of MARP.

- **Planning**
  - To evolve goals, objectives and key outcomes the project aims to achieve by end of project.
  - To understand the resource requirement including skills and capacities.

- **Infrastructure for Management & Service Delivery**
  - To set-up and operationalize key service infrastructure such as project office, drop-in centres, condom depots, etc.

- **Systems**
  - To evolve appropriate systems and procedures for standardization and clarity in operations.

- **Recruitment & Capacity Strengthening**
  - To attract best talents and skills; recruit team members; build/strengthen capacities on core issues, core deliverables including induction.

- **Launch**
  - To introduce the project appropriately to key stakeholders and to create an environment for its effective operations.

**Key Focus**

- **Formative Research**
  - To understand the situations, risks, vulnerabilities, key players, risks, existing policies, programmes and more importantly the needs and aspirations of MARP.

- **Planning**
  - To evolve goals, objectives and key outcomes the project aims to achieve by end of project.
  - To understand the resource requirement including skills and capacities.

- **Infrastructure for Management & Service Delivery**
  - To set-up and operationalize key service infrastructure such as project office, drop-in centres, condom depots, etc.

- **Systems**
  - To evolve appropriate systems and procedures for standardization and clarity in operations.

- **Recruitment & Capacity Strengthening**
  - To attract best talents and skills; recruit team members; build/strengthen capacities on core issues, core deliverables including induction.

**Components**

1. **Mapping**
2. **Needs Assessment**

1. **Micro Planning**
   a) Outreach Plan
   b) Stakeholder Engagement Plan
   c) Service Delivery Plan
   d) Risk Mitigation strategies

1. **Office Set-up**
2. **Drop-in centre set-up**
3. **Condom Depots**

1. **Office Administration**
2. **Procurement & Supply Management**
3. **Financial Management**
4. **Human Resource Management**
5. **Monitoring, Evaluation & Learning Systems**

1. **Capacity building Needs Assessment**
2. **Capacity Strengthening**

1. **Entry Point Programmes**
2. **Advocacy**
3. **Linkages & Networking**
6. PROGRAM COMPONENTS

6.1 INTRODUCTION

Broadly the intervention components are categorized as Prevention and Treatment and Care. Within the Prevention Component there is a further categorization to emphasize greater focus for prevention services on the IDU taking into consideration the complex nature of prevention and care need and context of the IDUs. This categorization includes: 1. Outreach Model and 2. Residential or Treatment and Care Model.

Within the outreach model there is minimum package of services which should be implemented as part of targeted interventions and optional services which according to context and need can become part of the service package. The Core TI components are within the minimum package focusing on risk reduction and vulnerability reduction.

Within the Residential or Treatment model - Rehabilitation packages and aftercare packages are included for the IDUs which are essential for sustaining behaviour change and contribute to nourishing prevention efforts with lasting impact on HIV prevention.

PLHIV – care and support components are also added focusing on IDUs who are infected and requiring care and treatment. This component will not have any direct service provision, but focus would be to support them by referral to existing services for care and support. So no additional budget will be required. This is mentioned to emphasise the need for addressing the requirements of PLHIV among the MARPs who normally experience double stigma and denied access to care and support services.

The diagram on the following page captures in brief the core components of services for the Injecting Drug Users
These packages are delivered through the Harm Reduction approach that is globally used for HIV prevention among the IDUs

**What is Harm Reduction?**

The concept of ‘harm reduction’ first emerged in HIV/AIDS prevention programs with the promotion of condoms for interventions linked to sex workers. Since sex work had inherent risk to HIV, it was important to promote the idea of ‘safe sex’ and condoms were an acceptable way of controlling sexually transmitted infections and HIV. The idea is that even if one cannot provide the perfect solution, at least the damage can be controlled and reduced.

The same principle of damage control is applied to the practice of injecting drug use and the risk of HIV. Since drug users often shared needles and syringes to inject drug, their risk of HIV infection is very high. Therefore, giving them clean needles and syringes in exchange for the used ones or putting them on opioid substitution treatment is critical in reducing the harm and risk of HIV.

Harm reduction refers to policies, programs and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than primarily on the prevention of drug use itself, and the focus on people who continue to use drugs.\(^6\)

Within the broader conceptual approach of harm reduction for prevention of HIV, a comprehensive package of interventions as suggested by UNODC, WHO and UNAIDS will form the basis for the package of services for IDUs in Nepal. The nine package of intervention suggested are:\(^7\):

1. Needle and syringe programs (NSPs)
2. Opioid substitution therapy (OST) and other drug dependence treatment
3. HIV testing and counselling
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections
6. Condom distribution programs for people who inject drugs and their sexual partners
7. Targeted information, education and communication for people who inject drugs and their sexual partners
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis

In the prevention package for IDUs within this guideline, the above services are directly or indirectly included. All the HIV related prevention services will be directly provided through the Targeted Intervention model being proposed here. The remaining services

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\(^6\) [http://www.ihra.net/Assets/2316/1/IHRA_HRStatement.pdf](http://www.ihra.net/Assets/2316/1/IHRA_HRStatement.pdf) (last accessed on 8th June 2010)

such as ART; vaccination, diagnosis and treatment of viral hepatitis; Prevention, diagnosis and treatment of tuberculosis will be made available through linkages with existing services in the government or private health care system.

6.2 SERVICE DELIVERY APPROACH AND MECHANISMS

Service delivery to the IDUs will be implemented mainly through the following three mechanisms.

- Outreach
- Drop In Centre (Exchange Centre)
- Referral

6.2.1 OUTREACH MECHANISM:

Reaching the IDUs through field outreach will be one of the key mechanisms and strategy to achieve scale and reach. Key objective of the outreach would be to reach the IDUs and their sexual partners to provide information on behaviour modification, products and services for prevention of HIV and reduce other health hazards due to their injecting behaviour and sharing of needles.

1. Who will conduct outreach and Where?

Outreach will primarily be done by the project through the Out Reach Worker with the support of Peer Educators. The Out Reach Worker should preferably be an ex-injecting user who knows the network and can easily move around among the IDUs. But even a non user with the right attitude and skill to work with the IDUs can be hired. The Peer Educator should be a current user who can break into newer networks.

Outreach will be done in the identified hotspots where the IDUs inject drugs or are generally found in groups. Outreach should happen at a time when IDUs can be found in the areas they inject drugs. General pattern of drug injecting behaviour is in the morning hours between 9.00 am to 11.00 am, afternoon hours between 1.00 pm to 3.00 pm and evening hours between 5.00 pm to 7.00 pm. Outreach should be ideally planned during these times. **However outreach plan should not be limited to the stipulated time above. In case of urgency distribution must be done from early morning to late evening.** Situational Needs Assessment will provide geographic specific information for outreach plan which should be used to make appropriate plan for field outreach. It is also important to ensure safety of the outreach worker particularly when they have to do late evening outreach. *(Suggestions for safety of ORW in the annexure 2)*
2. **ORW and PE Ratio**

- One PE to reach out to 40 IDUs and in the case of VDCs and rural program it should be 1:20
- One ORW for every 5 PEs should be appointed.
- For Female IDUs – One PE should reach out to 15 IDUs and One ORW for 5 PEs

3. **Peer Education**

Peer Education is one of the key components for outreach and imparting BCC within Targeted Intervention Projects. Peer Education is effectively used to identify difficult to reach groups with prevention messages and facilitate change in behaviour. The basic principle of peer education is that they have very strong influence and people listen to their peers more than an external person. It is easier to identify new networks and build rapport through peer educators.

**Who is a Peer Educator?**

In the Targeted Intervention for IDUs implemented through NCASC support, the Peer Educator will be a person who is a **current injecting drug user**. An ex – injecting user may be preferred and appointed as an Out Reach Worker – but PE will be from the current user community.

**Selection Criteria for Peer Educator**

1. He or she should be a current injecting user
2. No major functional disability which may hamper communication
3. Should not be diagnosed for any Psychiatric disorders
4. Expressed willingness to be a Peer Educator and gives an informed written consent to follow norms laid out for a PE Conduct.

**Key Roles of Peer Educator**

1. Identify new networks of IDUs and new IDUs and refer them to the DIC and to various project services
2. Distribute IEC materials on HIV and other key messages
3. Follow up clients in the field – especially those who are on STI treatment to ensure completion of treatment and motivate partner treatment
4. Accompany the IDUs to various service points (DIC, Clinics)
5. Provide information to the IDUs on various service available within the project and educate them on the advantages of accessing these services
6. Whenever possible (especially when sober) provide correct information on HIV and prevention methods, including NSEP, condoms, STI treatment etc (Detailed list under section on BCC)
7. Organize and mobilize IDUs for group meetings and community get together
8. Assist ORW for distribution of injecting equipments and collection of used injectables.
9. Inform the project of any emergency and assist the IDUs to manage crisis situations—drug overdose, arrest, family crisis etc

Supportive Supervision of PE

- Mentoring support to PE by the ORW: ORWs will monitor PE’s work, provide on the job training to build their skills in carrying out various roles as a peer educator (Condom demo, N&S demo, taking BCC sessions, referral, mobilizing groups, identify new networks of IDUs etc).
- The ORW will make the monitoring visit to the PE on a daily basis
- ORW will help in documenting the activities done by the PE in the Peer Educator Log Sheet (Copy of Log sheet in the annexure 3) on a daily basis.
- Peer Educator meetings once in two weeks: During this meeting the PEs will share and update progress in the field work, target achievement, learning and challenges faced. The ORWs will facilitate the meeting and will ensure a learning environment. Reflection tool will be used to facilitate the meeting (Reflection tool in the annexure 4) Process should guide the PEs to perform better. The meeting discussion will be documented by one of the ORWs.

Capacity Building

- Every Peer Educator who is selected will be taken through an induction training process which will include both theoretical and practical session. The training method will be activity based without any lecture and will have field based practical exposures. It is important that every peer educator go through an induction before he or she is send out to the field.
- Mentoring Support by ORW: ORW will continuously provide field level mentoring support by regular constructive feedback and demonstration of right skills.
4. Out Reach Process

(Outreach planning format, including location map in the annexure 5)

5. Outreach Kit

The ORWs should be provided with an Identity Card by the NGO partner which should be carried every time they go to the field. Every outreach worker and peer educator should be provided with an outreach kit which should contain the following essential materials.

- IEC/BCC Materials
- Needle and Syringe for distribution
- Disposable gloves
- Puncture proof container to receive used and returned syringes and needles
- Condoms and Penis model
- Alcohol swab and Water
- Sterilised Gauze
- Handiplast (Bandage)
- Referral centers contact details
- Referral slips
- Field diary
6.2.2   DROP IN FACILITY:

Drop in Centre will be another key delivery mechanism through which key service packages for IDUs will be implemented. The DIC should be established in a location easily accessible to the IDUs. It is important to select a location that is outside the residential area and at the same time is easily reached by the IDUs. Project team should also ensure to sensitize the community in and around the DIC.

Following are the key steps in establishing the DIC.

i. Identification of Risk Spots
ii. Identification of location to establish DIC
iii. Setting up the facility and infrastructure including appointment of DIC staff
iv. Providing information on the DIC to the IDUs for demand generation through the Out Reach Mechanism
v. Provision of services to the IDUs through DIC

Key Services in DIC

- Provide needle/syringe exchange service and encourage needle/syringe return for disposal
- Distribute bleach and sterile water
- Distribute condoms and deliver safe sex education among IDUs through IEC, edutainment, peer education etc.
- Carry out educational sessions for IDUs regarding the safe use of needles and the dangers of drug use
- Provision of primary health care services to IDU’s
- Entertainment and other co-curricular activities
- VCT service as per need
- Counseling service
- Referrals
- Refreshment

Detailed description on setting up DIC under the section set up

6.2.3   REFERRAL LINKAGES:

There are several needs of the IDUs that cannot be addressed through the harm reduction program, making it imperative to link up with existing providers of such services. The project will focus on building systematic referral linkages through formal referral mechanism. Following are the key activities to establish referral mechanism
• **Mapping**

  - **Identifying Services for linkages:**
    Based on the various needs identified as part of the situational needs assessment, prioritize those needs which are essential but are partially supported or not supported within the TI program. Some examples would be: STI Treatment, VCTC, support for livelihood options, treatment of Hepatitis B and C, Care and Support services for PLHIV etc.

  - **Identifying Providers for linkages:**
    Identify key service providers in the locality for various services that require to be linked up. Possible list could be made during the SNA itself and later can be shortlisted for particular priority needs that emerge.

• **Establishing Linkages**

  Once the priority needs and the appropriate providers are identified project team will systematically link up with various service providers. While initiating the linkages following key steps are to be kept in mind.

    o Prepare a briefing note to be shared with the service providers. The briefing note should clearly provide a background to the project, key objectives of the project and expected outcomes. Also need to provide the problem being addressed through linkage and what would be positive outcomes of the linkages being established
    o Referral Mechanisms and options. While discussing with the providers following process could be suggested especially for treatment and care referrals.
      - Referral slip will be provided to the client who will visit the service provider. The service provider could keep one part of the referral slip at the site for future reference and follow up by the project team. The project team would provide the service provider with field follow up support and ensuring the client come back for the service – treatment follow up, counseling or any other service.

• **Regular follow up with service providers and incentives.**

  Once the referral system is established it is important to regularly follow up and maintains good rapport. The service provider will require support and skill to deal with the client population. Opportunity should be given for exposure and training to the service provider as an incentive to the service they are extending. Regular stakeholder meetings will also facilitate interest and continued support.
6.3 INTERVENTION PACKAGE OF SERVICE FOR INJECTING DRUG USERS

The risk reduction package focuses on behaviors and internal factors that influence the capacities and abilities of IDUs (Male and Female) to protect them from HIV infection. It therefore works towards enhancing knowledge about HIV and STI transmission, information and access to prevention services, knowledge and skills to use condoms, positive prevention, improvement of environment etc. The harm reduction package largely focuses on reducing risk of HIV for the IDUs.

The vulnerability reduction program focuses on those factors that are outside the control of IDUs. These factors influence the practice of safe injecting and sex behavior among both male and female IDUs. There are issues like lack of legal support, lack of financial aid or job security, or inaccessible social entitlement schemes, stigma and discrimination experienced at home and in the community etc. Vulnerabilities are particularly high for the female IDUs, who are often sexually exploited and face lot of vulnerability related to child care and sexual and reproductive health. Vulnerability reduction packages focus on providing services related to protection from violence, providing legal aid to address violation of rights and provide linkages to financial services besides programs such as working with children of female IDUs etc.

This document also suggests optional package of services that can constitute anything that furthers the positive health and improves quality of lives of both male and female IDUs. The concerned Projects can use their discretions whether to include it or not.

The section below discusses the Risk Reduction and Vulnerability Reduction strategies.

6.3.1 PREVENTION PACKAGES FOR IDUS – OUTREACH MODEL

A. Minimum Package - Risk Reduction

6.3.1.1 NEEDLE AND SYRINGE EXCHANGE PROGRAM (NSEP)

Needle and Syringe Exchange Program is the key risk reduction strategy for HIV prevention as most of the infection is spread through sharing of unsterilized and used needles in a group by IDUs. NSEP focuses on providing clean injecting equipments to injecting drug users in order to prevent them from sharing an used needle, increasing their risk of HIV infection and to protect them from other infections due to reuse of unsterile needles and syringes. Through NSEP, clean injecting equipments are provided and also, most importantly, efforts are made to collect back used-needles and syringes to ensure its safe disposal.
1. **Provision of risk reduction information**

Ensure information on HIV, risk related to injecting behaviour, safe injection methods are given to every individual IDU registered with the program. (Details of the information package in the annexure 6)

2. **Distribution of injecting Equipments**

   - Distribute 2 to 3 clean sterile Needles and Syringes to every IDUs registered with program every day or as required
   - Distribute alcohol swabs, sterile water and bleach as required

3. **Disposal of Used Injecting Equipment**

Remove every used needles and syringes and other paraphernalia from circulation lest it result in harm to the community.

   - Returned by the user to the ORW, PE or at the DIC
   - Collected from the field by ORW/PE or volunteers from the community or from among ex-users
   - Use safe disposable container to collect
   - The container should never be over filled
   - Store the used equipment in the DIC in a safe location to be transferred and destroyed in an approved medical waste

**Delivery of Needle and Syringe**

Needles and syringes will be distributed through the following mechanisms:

i. **Drop In Centre** – Needle and syringe will be distributed through the DIC to IDUs visiting the centre. In the DIC one of the staff (preferably DIC – In charge) should be designated and made responsible to distribute the needle and syringe. One person should be fully responsible for distribution of needles and syringe to prevent any possible misuse. In his/her absence there should be a system of ensuring replacing the person so that at no time there is a break in the service. While distributing the needles, the used needles should be collected and carefully stored in disposable bin which can be later destroyed through an approved medical waste service.

ii. **Out Reach** – Needle and syringe can be also distributed through the key outreach points – the Out Reach Workers. While distributing the needles and syringes, it is recommended to give only required number of N and S for a day. In case of a holiday or strike, give stock up to maximum of two days (4 to 6 N and S). (At the same time, this norm should not any way restrict the access of IDUs when they actually require the N and S which should be given maximum importance)

iii. **Satellite Distribution Centres**: Develop satellite centres with private clinics or nursing homes in the neighborhood of IDUs after providing them with proper orientation and training on NSEP. N and S can be regularly stocked in these centres and be closely monitored.

### 6.3.1.2 BEHAVIOUR CHANGE COMMUNICATION (BCC)

Spread of HIV infection is invariably linked to human behavior and change in behavior has long been identified as a critical factor in prevention of spread of HIV.
BCC is one of the key strategies within HIV prevention that focus on behavior modification for risk reduction. BCC is a process that involves developing appropriate communication messages and designing right channels to deliver these messages with a focus on facilitating positive behavior modification.

BCC for the IDUs and their sexual partners deals primarily with reducing risky behaviours such as sharing of needles, reuse of unsterile needles, unprotected multi-partner sex behavior, poor health seeking behaviour etc. Through focused prevention messages on improving risk perception, IDUs are motivated to modify risky behaviours.

**Key Mechanisms for Delivery of BCC**

1. Evidence Based BCC Plan
   While designing appropriate BCC messages and tools, it is important to gather adequate evidence from the field to understand the information needs and nuances of risky behavior of IDUs which could vary with geography and cultures. Therefore first step in implementing BCC within the project is to collect adequate information on risk pattern, information requirement in the particular cultural context of the IDUs. Once the adequate background information gathered – develop appropriate BCC plan that will address information requirement as well cultural sensitivity and context in which the project is being implemented. The plan will include – message, method of sharing the message, mechanism to deliver the message, focus target group, Risk etc.

   Following matrix can be used to make the BCC plan

2. One to One Education:
   This is one of the most traditional methods of BCC for HIV prevention. One to one education will be delivered through the outreach workers who will interact with one IDU at a time for a period of 10 to 15 minutes to improve risk perception of the IDUs through provision of key messages. In order to engage the attention of the IDU, which will be a major challenge, ORWs should use flip charts and other materials
that will capture his/her attention. Timing of giving one to one to education is also crucial. It may not be useful to provide the information when the client is “high” on drugs. Therefore appropriate time and mental and physical status of the client needs to be considered. In the IDU program One to One education will be primarily given by the ORWs. If the PEs are found to be not intoxicated during the day and injecting episodes are limited to only once in a day, they could be made to involve in giving the one to one session after providing adequate training and skill.

**Key Steps in One to One to Education**

(Details on content of the message and Risk Assessment checklist in the annexure-7)

3. **One to Group**
   This is an educational session where in the ORW spends time with a group of IDUs providing information on HIV and risk of transmission through the injecting behavior. This will also be an opportunity to clarify doubts and myths on HIV and issues related to risk. In a one to group session, the number of participants should be 2 and more. This is an effective method among IDUs who have existing affinity groups that they congregate to share drugs. In a group session primarily there will be 2 steps: Introduction and rapport building and Provision of information. This should be ideally be done by the ORWs

(List of IEC and information to be discussed during One to group – in the annexure-8)

4. **Counseling**
   Counseling is one of the most effective tools of behavior change as it uses skilled personnel who follow certain systematic process which is combination of information as well as psychosocial and therapeutic techniques to facilitate behavior change.
Every client should be made to go through counseling session at least once in a quarter and for a population of 500 IDUs one counselor should be appointed. One counselor working on 8 hr duration should be able to complete at least 5 counseling in a day including documenting the counseling process. Counselor should be adequately trained in conducting risk assessment, providing risk reduction counseling (injecting and sexual health), using therapeutic tools and have the right counseling skills. She/he should be able to document the counseling process in detail and plan for follow up session. Counselor can be positioned in DIC, but should be able to go to the field and provide counseling when there is a request and need. Counselor also should be able to provide family counseling, couple counseling, marital counseling etc.

While planning the counselor’s chamber, ensure adequate privacy and ease to the clients. This will increase the comfort and the client will be more likely to open and be ready for the therapeutic support. Counselor should have all the relevant IEC materials and flip charts to be used during the session. Should also stock NS, free condoms etc for demonstration and education purpose and also for distribution. (For distribution of NS refer to the DIC section). Counselor should also have referral slips and contacts and address of referral centres for detoxification, rehabilitation, aftercare, ART, VCT, PPTCT, TB etc.

A typical counseling session last for about forty five minutes to one hour. Repeat or follow up counseling is important to reinforce information and support and maintain behavior change. Counselor can play a pivotal role in facilitating behavior change of
the client through his/her session and also constantly interact with ORWs and PEs to provide and collect information on the clients (within the limit of shared confidentiality for professional reasons). Through a joined effort there is a greater chance for the client to change behavior and sustain the change. The counselor also should spend time with ORWs and PEs giving them training in lay counseling. This will enhance the interpersonal communication ability of the ORWs and PEs and facilitate better outreach BCC.

5. IEC Materials
In order to compliment the BCC efforts, adequate IEC materials should be developed and stocked in the centre for distribution and display. The IEC materials on HIV, drug behavior, injecting behavior, Condom, STI and other health hazards should be readily available. Most of these IEC materials will be centrally developed by the IEC Officer of NCASC and made available to the NGOs for adaptation and reprinting.

Types of IEC Materials and Methods

1. Brochures
2. Posters
3. Wall paintings
4. Banners
5. Mid Media – Street Plays, Puppet shows, Videos etc

Process of Developing IEC Materials for TI

Developing the IEC materials will be a centrally managed process where, NCASC will take a lead role in gathering evidence and developing prototype. Once the prototype is developed NGOs can adapt and reproduce the IEC materials according to their local needs.
Key objective of the condom program for IDUs is ensuring correct and consistent use of condom. For this free condoms will be primarily made available through the project. Provision of social marketed condoms also will be available, which will be introduced only after ascertaining maturity and higher level motivation to safe sex practice. While planning for condom program it is important to gather critical information from the client about the sexual behavior, frequency of sexual contact, number of condom required in a month, ideal place for free condom outlets, understand key barriers to condom use etc. Once the information is collected, can be used to make appropriate condom distribution strategy

Principles and Approach in Condom Programming:

- **Free Distribution**: The condoms will distributed free of cost to the IDUs.
- **Adequate**: Condom distribution will take into account the needs of the community and ensures that the demand is met; at no point in time there will be stock out of condoms at central, regional or district warehouses or at NGO Partners end. A steady flow of condoms through a robust supply chain will be adopted and executed.
- **Appropriate**: The condoms so procured by National Authorities and subsequently distributed will be of appropriate quality, length and width. The condoms will be adequately lubricated and adhere to all quality parameter that is currently in practice.
- **Menu of option**: Though the emphasis will be on free distribution of condoms, appropriate systems will be evolved to include social marketing of condoms. The system of social marketing of condoms is not in lieu of free supply but only an option provided for IDUs.

Condom Promotion Matrix:

The sole objective of condom promotion is to ensure steady and adequate supply of condoms; build demand for condoms by addressing lack of information and skill to use condoms; provide enabling environment in which IDUs (Male and Female) can negotiate for condom use. Thus condom promotion will encompass components related to Procurement and Distribution (supply side), Demand Generation
& Condom usage and quality assurance. This system is applicable to both type of condoms – **Free supply and Social Marketed Condoms**.

**Procurement & Distribution:**
- **Procurement:** The Logistic Management Division (LMD) of NCASC will procure condoms from appropriate competent manufactures with specification that is most suited to country’s context. The stock so procured will be further transported to DPHOs in the districts from whom the NGOs will get its supply.
- **Stocking:** The LMD, DPHO and NGO partner at any given time will have stock to meet the demand for next 3 months. For e.g. if the national demand for condoms is around 2 million pieces per month, the concerned authority will have at least 6 million pieces of condoms in stock. The same is applicable to all the agencies involved in condom distribution.
- Following are to be followed by the NGOs for effective management of condom stock
  - Update Condom stock register on a weekly basis. There should be consistent documentation on distribution of every condom.
  - Re-ordering of condom supply should be done when only 3 months stock is available at the centre.
  - There should be adequate storage space for stocking condom and ensure that stocked condoms are not exposed to heat or dampness

Following are some of the key strategies that are suggested to increase the use of condoms by IDUs.

**Free Distribution of Condom**

Free condom will be made available through procurement system as suggested earlier. Following are the key activities that will be undertaken in order accelerate the distribution of condoms among the IDUs.

- **Education and Distribution through Outreach:** Condom education will be provided including condom demonstration during one to one and one to group sessions by the ORW. Free condoms also will be distributed after every session to needed clients. Peer Educators will take a lead role in distributing the free condoms to peers and encourage them to use it. The ORWs and the PEs will take good care to demonstrate the right use of condom. PEs also will follow up with their peers to know about their condom using behavior from time to time and provide necessary input
- **Distribution through DICs:** Free Condoms also will be made available to the clients through the condom outlets established for the purpose in the DIC. It will be placed at a convenient place where the IDUs can easily pick up the condom.
• **STI Clinic**: Every client who comes to treat STIs will be educated by the doctor and free condoms will be provided.

• **Condom Outlets**: free Condom outlet boxes will be established in strategic location where IDUs and their sexual partners meet. Ideal location for establishing such condom outlets will be finalized after the SNA during which an assessment will be done to locate spots where condom boxes can be put up.

**Condom Social Marketing**

Depending on the demand and the local realities, NGO will initiate social marketing of condoms. For the purpose of facilitating an understanding among the NGOs, the below section details out four key steps in setting up SMC.

**The 4Ps approach to Social Marketing of Condoms:**

**Needs Assessments or Diagnostic Study**: Use primary and/or secondary data to understand the needs and requirement of the IDUs. Also look for current condom buying ability and behaviour, key players in the market, brand preference, etc. This will help in configuring SMC as per the needs of IDUs.

**P-1: Define and identify “Product”**: NGOs based on the data generated will zero in on a product or slew of products that will address their current needs and gaps. The product so identified must meet the quality standards and should be culturally acceptable to the IDUs.

**P-2: Define “Place” or “People”**: The initiative will identify typology of IDUs (in both male and female) who prefer variety of condoms and lubes. It is not likely that every typology among IDUs would prefer to buy condoms. It is also important to identify sex work sites where condoms can be located and is easy to access as and when needed.

**P-3: Define “Affordable Price”**: The condoms and lubes so offered needs to be affordable and enable the poorest of IDUs, to buy it, if preferred. The pricing should not put anybody at disadvantage. The price should be commensurate to the value offered.

**P-4: Determine ways to inform about or "Promote" the products**: Inter personal communication (one to one, one to group and one to mass) are a great way to promote the condoms. The condoms can also be promoted during community events or any other opportunities where IDUs congregate.

**Output and Outcome Monitoring**: Project team through a robust monitoring framework will monitor the demand and supply of condoms. It will assess the changing needs and preference of condoms and lubes among MARPs from time to time. This framework

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8 This section is borrowed from USAID’s Nepal Social Marketing and Franchising Project and modified to suite the context.
should also assess the condom usage, condom breakage and barriers which will feed into re-strategizing SMC.

Addressing Challenges in Condom Programming

- **Capacity of Staff.** It is important to build the capacity of the staff to deal with sexual health issues. Since greater focus of IDU program is on NSEP, condom which is one of the key components of harm reduction is often overlooked. Besides, the field staff (ORW and PE) is not adequately trained by giving them the right skills, attitude and information to deal with sexual health issues. Regular training and field level mentoring support to be provided to address capacity gaps of the outreach staff in addressing sexual health issues.

(Steps in condom demonstration in the annexure -9)

6.3.1.4 STI TREATMENT AND CARE SERVICES

**Scope of STI treatment:** The Intervention will identify and treat all forms of STIs including syphilis through established norms of Syndromic Case Management. *(Refer to National guidelines on case management of sexually transmitted infections, Ministry of Health and Family Welfare, NCASC).*

**Setting up services and role of community members:** The community members will play an important role in setting up the STI services. The concerned NGO Partner will have Focused Group Discussions (FGDs) among IDUs, both male and female separately, to understand their STI treatment needs in terms of accessibility, timings, preferred service providers, issues related to confidentiality etc. Based on the findings the NGO partner in consultation with the community will decide on where to locate the STI services. Since most of the STIs services are co-located in DIC, it is important to follow same procedure in identifying location for DIC.

STI treatment and care services will be provided through the project by adopting following key steps for Management of STI:
Identification: One of the key challenges that programs do face is in identifying the STIs and getting them treated. Most often this is due to lack of adequate focus and capacity of the field level staff to conduct interpersonal communication session and identify persons having STI symptoms and refer them for treatment. It is therefore important to train the ORWs and PEs and improve their comfort level to discuss sexual health issues and identify STIs. Providing them with appropriate flip chart with STI pictures and symptoms will help them to identify and provide BCC effectively.

Counseling: Every STI case suspected and referred from the field should be given STI counseling at the DIC by the counselor. This is to ensure that the client get right information based on the need and facilitate treatment access and treatment completion and appropriate behavior change that will help in ensuring non-recurrence of STIs.

Treatment - Project Based: Refers to clinics that are run and managed by the NGO with the help of grant or any other source of fund. The entire medical and
Para-medical team is hired by the project who can be on full time or part time basis depending on the intensity of drop-in to the clinic.

- **Project Static Clinic**, will be co-located within the DIC that is near to the majority of IDUs site and ensures confidentiality and stigma free treatment environment.

- **Mobile / Outreach Clinic** will cater to the distant and difficult to access IDU sites. Here the NGO Partner with a team of essential medical and Para medical team will go to a pre-identified location on a pre determined day and time. The visiting team will ensure they have basic amenities with high priority to issues of confidentiality. The concerned field team on the said day and time will mobilize IDUs and their sexual partners to seek medical intervention to their problems. The frequency of such clinic will be determined by the field team depending on the demand and the need.

- **Referral Based**: Referral to Private and Public Service Providers: NGO Partner will identify Private and Government medical care centre that have ability and willingness to provide required STI services. NGO Partner should also make careful assessment about right attitude of clinical team, clinic timings (should be open in mornings, or late evenings), about right kind of facilities, accessibility/distance and willing to comply with confidentiality clause. This identification should be done in consultation with the community taking into account their choice and preference. These centers should be in the IDU sites or close to it.

On identification of such service providers, the NGO team will orient the concerned doctors about SCM and record keeping and also will ensure he or she is able to go through a formal training on SCM organized by the NCASC TI Unit.

The field team will be aware of functional referral centre and will have with them full details about the Clinic/Hospital, timings, and address with landmark and referral slips. As and when the field team identifies STI symptoms with IDUs, they are referred to the referral centers.

**Package of services provided:**

- Health promotion and STI prevention activities, such as promoting correct and consistent use of male condoms (and female condoms where available)
- Provision of free male condoms (and female condoms if available)
- Provision of socially marketed condoms
- Immediate diagnosis and clinical management of STIs
- Health education and counseling for treatment compliance,
Periodic check-ups, syphilis screening
- Partner management programs (i.e. contact referral)
- Follow-up services
- Referral links to VCTC, HIV care and support, Hep-B management and other relevant services

6.3.1.5 VOLUNTARY HIV / AIDS COUNSELING AND TESTING CENTRE - VCTC

HIV testing and counseling will be part of prevention package offered to IDUs both male and female. This service will improve the effectiveness of HIV prevention. Some of the strategic advantages are:

- Early detection leading to initiation of Positive Health, Dignity and Prevention programs which includes ART support, Care services and other supports.
- Early detection will help project to facilitate intense behaviour change program among those IDUs who are tested positive.

Key Outputs:

- NGO Partner will make effort and motivate IDUs to test for HIV status once in every six months. (Test option will still remain voluntary)
- NGO partner also will motivate ex users who have been rehabilitated to test themselves (if not already tested) to check their HIV status.
- All such test will be done by professional and certified HIV testing centers.
- All IDUs who are being tested for HIV will undergo pre and post test counseling and all other norms that is stated in National HIV Testing Guidelines

Delivery Mechanism:

- Project Linked Voluntary HIV / AIDS Counseling Centre (VCTC).
- Referrals to Government VCTC

To increase Accessibility and Acceptability VCTC services should have....
- Welcoming and friendly environment,
- Privacy and confidentiality are respected
- Hours of operation are conducive for target population
- Waiting time and delays are minimized
- Test results are provided immediately
- Blood collection is made less painful and invasive (e.g., finger-stick blood).
- Counselling provided for specific groups,
- Services are offered in non traditional settings (i.e. community or outreach settings)
- Services tailored for vulnerable groups.

Source: National Guidelines for VCT, 2007

• **Project Linked VCTC**: A project working with over 1000 IDUs can apply for VCTC centers which can be located within the DIC and in such a manner that it caters to the testing needs of general population along with IDUs. This will ensure that there is adequate client flow to the centers and there is return on investment. The DIC counselor should be trained also to provide VCTC counseling, so no additional investment needs to be made on counselor. Project linked VCTC will be given, in addition, rapid test kits for HIV.

• **Referrals to Government VCTC**: NGO Partner will identify VCTC in and around the project area and such centre will be made part of the referral network. A sensitization program will be conducted with the VCTC team about issues surrounding IDUs, the need for confidentiality of highest standard and stigma free service.

• NGO Partner will also print referral slips to track the flow of IDUs and to generate data for monitoring and planning.

**Flow Chart for Testing:**\(^\text{11}\)

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Counselling in VCTC:  

HIV/AIDS counselling / education is a confidential dialogue between Client (herein IDUs and or their partner) and a counsellor aimed at providing information on HIV / AIDS, to jointly assess the risk behaviour, identify problem together and to assist client in taking appropriate decision regarding HIV testing.

The purpose of counselling in VCTC is to:  

1. Ensure an understanding of HIV transmission and the risks  
2. Ensure an understanding of the benefits and risks of HIV testing  
3. Facilitate a decision whether to undergo an HIV test  
4. Ensure that HIV positive persons have access to prevention, care, support and treatment  
5. Ensure that HIV negative persons have access to the means of prevention and to remain HIV negative

Steps in HIV Counselling

- Pre Test Counselling  
  - Basic Information on HIV / AIDS  
  - Risk assessment  
  - Prepare the client for outcome of HIV test results

- Post Test Counselling  
  - Help cope client with the test results  
  - If Positive: Implication of the test, behaviour modification, life after being HIV positive, information about services available, linkages & networking  
  - If Negative: Reiterates information about HIV transmission, behaviour modification and motivates to come back again for testing (can be negative due to window period...)

- Follow-up Counselling  
  - Reemphasis on adoption of safe sexual behaviour  
  - Help cope with any mental stress  
  - Establish linkages with referral networks, ART centers, access to nutrition supplements, referrals to positive networks, etc

Strategies for Improving demand for HIV Counselling and Testing:

The NGO Partner will put in place a robust demand generation mechanism that ensure adequate number of IDUs are motivated to seek HIV testing and counselling services. The following steps needs to be followed to improving demand for VCTC:

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**Understand the barriers for low/no service uptake:** NGO Partner will hold community consultation (IDU – both male and female) to understand the barriers in accessing VCT services. It will explore the dimension of distance of testing centre, timings of the centers, waiting time, confidentiality issues, time taken to deliver the report, attitude of service providers, etc. This assessment also should include mystery client approach and exit interviews (More details on this approach (mystery client and exit interview) in the annexure-10). This process will be repeated once every year. Based on the findings further planning and strategies will be adopted for demand generation.

**Build community motivators and catalysts:** NGO Partner will train Peer Educators and ORWs (for both male and female IDUs) who can influence the behaviour of the IDUs and motivate them to access VCTC services. They will be trained on messaging and about the importance of HIV testing. Besides the PEs, other volunteer IDUs also will be trained who can further influence and motivate more IDUs to access VCTC. These PEs and volunteers themselves will be encouraged to get themselves tested for HIV and become a role model. The identified motivators will be encouraged to speak about their experiences with fellow IDUs (herein the results will be not shared) and in turn motivate others to get themselves tested.

**Configure Service to communities time and convenience:** The HIV testing centre will make efforts to suite the requirement of IDUs in terms of hour of operations (total hours of operations), time of operations (early morning, late evening…), waiting time, time taken to deliver reports, etc. While all requirement may not be taken care but efforts needs to be made towards configuring services as per the needs of the community.

**Community feedback:** Once in a quarter community feedback will be solicited to understand the responsiveness, comprehensiveness, adequacy and other aspects. This process can be done through focused group discussion or through informal feedback mechanisms.

**IEC on VCTC:** In order to disseminate information on the VCTC services, IEC materials in local language will be printed and widely distributed by the NGO partner both among the IDUs and in the general community.

**Life after being Positive – Positive life:** The project will provide comprehensive information about life after being HIV positive. It is vital for FSWs and other to understand that life does not end after being HIV positive. In most cases this understanding is key barrier for HIV testing since they feel what the point in getting tested… NGO Partner will have to make efforts to identify HIV positive speakers to speak about life after being HIV positive. This may motivate few to come forward to for HIV testing and will provide confidence to those who are already positive.
B. Minimum Package – Vulnerability Reduction

6.3.1.6 PRIMARY HEALTH CARE

There is high incidence of abscesses, wounds, drug overdose, pain management, vein collapse etc that require medical attention among the IDUs. Most of these health hazards results in great pain and physical discomfort affecting even the movement. Therefore availability of these services within the program will attract more IDUs to access the clinical services which will provide an opportunity to initiate risk reduction services especially with IDUs who gets registered anew to get these services. Following are the key services that will be made available through Drop in Centre and Outreach.

- Abscess and Wound Management: Project will make available treatment of abscess primarily for cleaning (removing pus) and dressing of wounds and pharmacological intervention. IDUs will be trained and educated in prevention of abscess and also to recognize abscess early and provide self care
- Drug Overdose: Information will be provided for prevention of drug overdose and injecting drug users will be trained on how to provide first aid and in early recognition of drug overdose and access immediate medical assistance.
- Vein Collapse: Training will be provided to IDUs on prevention of vein collapse by ensuring right methods of injection. Information also will be given on what needs to be done in case of vein collapse and how to avoid permanent vein collapse.
- Hepatitis B and C through referral
- Psychiatric Treatment support will be provided to those IDUs who require the treatment through referral

Treatment of Hepatitis B and C

Co infection with HIV and Hepatitis B and C is a significant problem especially among the Injecting drug users. This often complicates the treatment regime for both the diseases for an infected patient, particularly with drug problem. The risk of contracting Hepatitis B and C among the IDUs is so high that it is important to initiate prevention and care focus within the interventions for the IDUs. Hepatitis C, like HIV, is transmitted through blood and therefore, IDUs who share the injecting equipments would easily contract both the diseases. Studies have shown that HIV infection in a person who is also infected with HCV results in higher levels of HCV in the blood and more rapid
progression to HCV-related liver disease, and increased risk for cirrhosis and liver cancer.\(^\text{14}\)

**a. Prevention:**

Effort at prevention of Hepatitis among the IDUs is possible through the HIV intervention itself. By ensuring prevention of sharing of needles and other paraphernalia of injection Hepatitis also can be prevented. Besides, project should supply adequate IEC materials on Hepatitis B and C. The BCC as well as the counseling sessions also should include topics on Hepatitis B and C and educate them on the prevention and care methods. Particular focus of education on treatment and care is important for those already infected with hepatitis B and C so that they treat and avoid infecting others.

**b. Diagnosis and Treatment:**

Project will provide financial support for Hepatitis B and C diagnosis testing, consultation and treatment for IDUs who are already infected with HIV. This is to ensure better management of HCV and to avoid complication of those who are co-infected with HIV. The diagnosis and treatment support will be given to the PLHIV IDUs through the referral system with both government and private hospitals that have the facility to test and treat Hepatitis B and c.

**6.3.1.7 ENABLING ENVIRONMENT**

Enabling environment is a crucial component within targeted interventions projects, because by providing education, condoms and treatment services alone, will not lead to sustained behaviour change. The intervention should also identify and address barriers to change. This could be structural barriers or linked to environment of the IDUs.

**Addressing Structural Barriers**

**a. Policy Advocacy – National Level:** At the national level TI Unit within NCASC will initiate policy level advocacy to influence changes in legal structures and policy framework. In order to facilitate this TI unit will take up the following activities:

i. TI unit will initiate policy research among the IDUs focusing on creating evidence to influence argument around legal barriers that prevent access to care and treatment for individual IDUs and open avenues for treatment and rehabilitation.

ii. TI Unit also will take up ministerial level advocacy with health and home ministries particularly, to create a better environment for the IDUs to access various prevention and care services.

iii. The Unit also will move the parliamentarian forum for HIV to influence positively changes in policy and law that will improve access of IDUs reduce stigma and discrimination against the drug users.

b. Enabling Environment through Advocacy– Project Level

Project should map out key agencies or individuals that need to be linked up for delivery of services. This will need to be included while doing situational assessment study. Following are some of the key activities that will be undertaken for local advocacy and linkages

- Mapping out key Stakeholders using stakeholder analysis tool (Refer the Annexure on the description of the tool-11)
- Stakeholder Management Plan – specifying advocacy and linkage plan
- Implementation of the advocacy and linkage plan

Following are some of the advocacy activity that should be taken up locally, for right environment for implementation of the project.

i. Police Advocacy: It is important to work closely with local law enforcement agencies to sensitize them about the project components and objectives, particularly about harm reduction. This will reduce the chances of harassment of the IDUs and the project staff. Following are some of the activities that can be undertaken to improve their support.

- Involving the senior police officials at the planning stage of the project
- Inviting them as chief guest to project related functions
- Collecting from senior police official in the locality a Letter of Support to project components accepting in principle the objectives of the project and its scope.
- Using sensitized police who are convinced about the program and its effectiveness to advocate and sensitize other police officials. Particularly when a sensitized police is getting transferred, request the person to directly brief the new person and introduce the project.
- Regular sensitization in the local police station. This has to be a continuous process and should be part of the project monthly work plan
- Organizing the HIV and drug awareness programs in the community in the presence of police officials.

ii. Community Sensitization

Link and sensitize the local political leaders, Village Development Committees, Religious leaders and religious organizations, youth clubs,
community leaders and other key stakeholders and win their support for the project. In order to select these stakeholders and plan advocacy interventions among them, use the stakeholder analysis tool that was mentioned earlier in this section.

iii. Public Awareness and Support

With the help of these leaders mentioned above, organize community sensitization programs. It is important to raise their awareness about the project and create community volunteers to support the project objectives. Use evidence available locally and from other parts of Nepal and region on the effectiveness of harm reduction in order to build confidence among the community about effectiveness of this strategy. Use the testimony of the ex IDUs and drug users on the benefit they have received from the program, this will help in winning confidence of the community.

Addressing Environmental Barriers

In order ensure the benefit of the program sustains, it is important to influence and modify the environment in which IDU lives. The project will work with the family and immediate community in which IDUs live, sensitizing them about the injecting behaviour, and role they should play in supporting the IDUs in rehabilitation. Key activities the project will undertake for this purpose is family counseling, group education to peer groups, community sensitization and awareness programs – such as mid media campaigns (street plays, cultural shows etc)

C. Optional Package

6.3.1.8 POSITIVE HEALTH, DIGNITY AND PREVENTION

Positive Health, Dignity and Prevention (PHDP) is a more comprehensive term used to address the needs of People Living with HIV (PLHIV). PHDP does not myopically look only at prevention or physical needs of PLHIV but rather looks at “overall health and well being, dignity and respect of individuals including prevention”.

PHDP is more a need than an exception, since world over there is recognition of the role PLHIV can play in furthering their own health and well being along with contributing to HIV prevention efforts. The network of positive groups have played a pivotal role in carving policies and program that contribute to overall wellbeing and towards reducing impact of HIV infections. Globally, HIV prevention efforts have always concentrated on reducing HIV acquisition risk, focusing primarily on uninfected individuals or ignoring the sero-status of target populations. But the fact is that, person infected with HIV, much smaller population, can potentially infect another person. Focusing on persons who are infected for behavioral modification, therefore can reduce the risk of transmission. Following steps are suggested within the TI project of the IDU for positive prevention:
1. Identification of PLHIV among the IDUs – In order to ensure maximum identification of PLHIVs from among the IDUs and initiate BCC focused on positive prevention, provider initiated testing strategy will be adopted. If the risk is established, then the doctor as well as counselors should motivate the person to get himself or herself tested in a VCT. While this is being implemented, in no way, persons’ individual freedom to decide to test or not to test will be breached. Final decision will lie with the client himself.

2. Focused prevention: once the PLHIVs are identified, focused attention for behavior modification will be ensured without stigmatizing the person. PLHIVs who are identified will be supported to access care and support services. Will be motivated to practice safe behavior to protect themselves from myriads of other infection or being infected by other strains of HIV and complicate their condition. The outreach mechanism as well the DICs will make all efforts to help the person to engage in safe practices by ensuring his or her access to all the prevention services and products such as access to needles and syringe, condoms, STI treatment, counseling.

3. Reducing Stigma and Discrimination: While focusing on the persons who are infected, all efforts should be made to ensure reduction in stigma and discrimination within the project as well as in the community. Regular sensitization sessions will be conducted for the staff in the project as well for the client populations. IEC materials with the messages of stigma reduction will be printed and displayed in different parts of the project site. Frequent sensitization programs also will be organized among the community members.

4. Improved Referral system for care and support services: Project will also initiate referral linkages with care support services such as OI management, ART, PPTCT, Community Care Centres etc.

What are the basic services offered under PHDP?

The services can be categorized under following headings:

i. **Access to critical health promotion and care** following services need to be provided:
• Anti-Retro Viral Therapy through referral to the existing services through
government hospital. Will provide support in treatment adherence through
counseling and field follow up and travel support to needed clients. (Follow
ART guideline in selection of persons who need to be referred to ART
services)
• Health Education for maintaining overall health and well being through ORWs
and counselors.
• Counseling services to promote positive mental health and other issues
• Preventing disease progression and further infections/prophylaxis for
tuberculosis (TB) and opportunistic infections (OIs) through referral to the TB
clinic as well as community care centre for PLHIV
• Referral for Palliative care to community care centre for those who have
reached the AIDS stage.
• Nutrition support through provision of supplementary nutrition diet. This will be
facilitated through linkages with existing nutrition programs for PLHIV in the
country.
• Health Insurance through Private Public Partnership.15

ii. Sexual and Reproductive Health and Rights services include:
• Providing basic sexual and reproductive health information, access to
reproductive services such as medical termination of pregnancy to the
spouses of IDUs and female IDUs etc.
• Maternal and Child care related information for positive women (spouses of
IDUs and female IDUs) who are pregnant or have delivered; motivation for
institutional delivery, education about breast feeding, etc
• Family planning services to positive couples (spouses of IDUs and female
IDUs and their spouse) to remain sero-discordant
• Prevention and treatment of sexually transmitted infections(STIs), including
hepatitis B and C
• Sexual health education including providing information about low risk
behaviour, use of condoms and regular health check-ups

iii. Prevention Services include:
• Education about transmission dynamics includes how HIV does not transmit
• Prevention of Parent to Child Transmission
• Focused BCC/NSEP/Condom/STI services for IDU who are PLHIV. This will
be done through Counselor who through follow up counseling sessions.
Where the identity can be shared with the ORW only with the consent of the
client, could also do the field follow up and provide the prevention services in
a focused manner.

iv. Livelihood Promotion Services: On being diagnosed for HIV, in most cases, it
impacts their earning opportunities and impacts on the size of earnings. Given
this scenario, NGO Partner should provide linkages to CBOs/NGOs/other

15 Explore the model of PSI in India
Institutions for alternate and diversified livelihood programs. TI Unit of NCASC to dialogue and work together at national level on livelihood programs/schemes for MARPs by tying up with EDPs that promote such programs.

v. **Vulnerability Reduction services consists of:**
- Providing services related to reduction in stigma and discrimination. Stigma reduction includes both self and external stigma. At the same time services will have to aim at enhancing self-esteem and self-worth.
- Crisis Response / Violence Redressal: PHDP program should include systems for addressing and reducing violence among PLHIV. Please read annexure-12 for more details on how to set-up systems for addressing violence.
- Legal Aid Services: PLHIV faces issues related to property disputes/rights, denial of right to work, etc. The program will put in place an appropriate system through network of private lawyers to extend legal aid services.
- Access to Social Entitlements: The NGO Partner will provide information about existing social security and entitlement schemes and facilitate access to same based on the eligibility criteria’s.
- Working with infected and affected Children of IDU (male and female) PLHIVs: The NGO Partner will develop appropriate linkages and networking with NGOs/CBOs and other Institution to extend health, nutrition, education and recreational services to the children.

vi. **Mobilization and Collectivization of communities for results:**
- Support in initiating network of PLHIV among the IDUs, if the demand arise.
- Provide appropriate Organizational Development services to PLHIV networks to strengthen systems, process and procedures including governance mechanisms.
- Leadership development with accountability among key IDU PLHIV
- Build advocacy and campaign skills among group of IDU PLHIV for highlighting their issues and the needs
- Strengthen capacity of IDU PLHIV on issues surrounding project management that includes basics of identification of problem, basics of planning, designing small programs, etc.

**Delivery Mechanism:**

Where there is a strong PLHIV network with adequate experiences of managing projects, the NGO Partner should link with the network and allow it to take the lead in delivery of services. In the absence of such a network, the implementing lead NGOs should take the lead in providing above mentioned services.

The NGO Partner will over a period of time build and strengthen PLHIV Networks for program transition after careful assessment of its capacities to manage and deliver results.
In both the delivery mechanism referral and linkages with other Organization is critical since all above stated services cannot be provided by NGO Partner or the PLHIV Networks alone.

6.3.1.9 ADDRESSING STIGMA AMONG IDUS/FIDUS AND PLHIV

The Context:
The deep rooted negative understanding among people, regarding drug use and injecting behaviour, sex and sexuality, sex work, gender, caste, race, etc influence the way those involved in injecting drug or sex work is viewed. This differentiation has contributed in denying them basic right to live with dignity. More so the HIV epidemic has changed the way things are viewed and has changed social cohesion and support structure. This change has led to HIV infected and affected being left with little or no support or social net to fall back.

The key reason for stigmatizing is often:

- Lack of awareness, ignorance about the risk groups, HIV epidemic including transmission dynamics.
- Moralistic view about behaviours linked to HIV infection – “Injecting Drug Users are Criminals”, “PLHIV are sinners” “FSW are promiscuous”, etc.

The Effects:

Stigma and discrimination faced by IDUs lead to very negative public health hazards. They go hiding and following issues emerge:

- IDUs become inaccessible to TIs to provide education and referral services.
- Low service uptake among IDUs for STI, OI, VCTC etc
- Hesitation in voluntary disclosure of HIV status
- Prevents people from caring for people living with HIV and AIDS.
- Prevents community from collectivization
- Preventing affected communities form seeking justice

In the above context most IDUs face self-stigma and External or Enacted Stigma or Discrimination.

Key Response:

The following are some of the key steps that NGO Partners will implement to set-up stigma reduction program.

16 References: UNDERSTANDING AND CHALLENGING HIV STIGMA: TOOLKIT FOR ACTION, ICRW
• **Context Assessment:** The NGO will conduct context analysis to assess the extent of stigma and discrimination; who is being stigmatized the most? Who are the perpetuators? What are the other factors contributing to stigma and discrimination of IDUs? Etc.

There are two ways to do this context analysis; one to integrate stigma related queries during the initial site assessment; two, to conduct independent assessment if site assessment is already completed. The study needs to be repeated once in a year and should feed into the annual project planning.

• **Strategic Planning:** NGO partner will develop a plan of action that is result based in which key outcomes are defined and have a system to monitor the same. The plan will also discuss challenges and possible solutions to overcome. The project will involve IDUs (Male and Female and PLHIV) during the planning, execution and monitoring phases.

• **Capacity Strengthening:** NGO will plan and implement a systematic capacity strengthening plan based on needs assessment. Such plan will cover the process of recognizing and reporting stigma in community, organization and at individual level. Plan also will detail how to confront stigma positively, define key campaign techniques, conduct stigma audits, skills and counseling

• **Execution of Plan:** Project partner will prioritize key outputs and key IDU sites that have experienced maximum incidents of stigma and discrimination. It will then spread its works across the project area. While this is one approach, the NGO may use its discretion to have blanket coverage at one go.

• **Sensitization and psychological intervention with IDUs, IDU PLHIV and Secondary Stakeholders:**

  o **IDUs and IDU PLHIV:** It is important to address the issues of self-stigma among the primary group for improving self-esteem and self-worth. This will be done through NGO Partner, campaigns and counselling.

  o **Secondary Stakeholders:** Primary focus will be to identify key stakeholders (including media) who are stigmatizing the MARP and those who have ability to positively influence the situation. Will develop separate curriculum to orient and to sensitize them on the issues surrounding IDUs and IDU PLHIV. The sensitization and orientation can be done through one to one intervention or through formal trainings.

• **Monitoring:** NGO as part of its regular monitoring will look for signs of change of outcome level indicators on stigma - at Individual, Group and Institutional level. It will assess performance against each indicator and will analyze possible reasons for low or high performances. The findings will again be fed into re-planning.
NGO will use participatory tools for monitoring stigma related changes. Cob web analysis tool can be used for measuring key outcome indicators related to change in stigma and discrimination. (Cobweb analysis tool in the annexure-13)

- **Stigma Audit:** A system needs to be established to audit environment for any stigmatizing behaviours/statement/ from among media, influential leaders and religious institutions. At the same time to analyze public policies and programs for stigmatizing approaches. If such instances are found, appropriate campaigns and advocacy programs should be implemented.

NGO will also audit BCC materials, capacity strengthening modules, manuals and field staff communication for stigmatizing statements. It will also audit service infrastructure such as DIC, STI, Care and Support services, etc for stigma free process and systems.

6.3.1.10 CRISIS RESPONSE

IDUs experience several crisis situations in their lives. It could be health related, psychological, family or legal. Due to their condition of drug dependency, coping with crisis is a major challenge that they experience. Project will offer support to respond to crisis situation of the IDUs. The support can be accessed through a telephone help line and depending on the nature of support required; project will provide the services to the Clients. The crisis support system will be classified into following categories and set of actions for support. More concrete action plan will be incorporated by the concerned NGOs based on the actual field requirements.
• **IDU Support Community Volunteers:** Project should create a cadre of community volunteers from the general community or from among the ex-user who would volunteer in responding to crisis situations in the field. These volunteers will be specially trained to handle such crisis situation.

• **Tele-counselling Support:** Telephone number of the DIC will be made available to the clients, to call for accessing any support in the eventuality of any crisis they experience. The telephone for crisis response will be attended to by the counselor. Counselor should be specially trained in crisis handling. Crisis handling checklist and flow chart should be available with the counselor. In case of field support is needed by the client, depending on the locality ORWs and PEs will be intimated to attend to crisis situation in the field. A cadre of community volunteers also will be created in the field who will assist the ORWs in responding to crisis situation.

• **Legal Aid Service:** Legal aid services will be established with the support of lawyers who are willing to offer free services in addressing legal support needs of the IDUs (both male and female). A group of lawyers who are friendly to IDUs should be created. They should be given training on issues related to the IDUs, their vulnerabilities and kind of involvement of support they could provide to the project.

• **Referral Linkages:** In order to address the crisis needs of the IDUs referral linkages will be established with local private and government hospitals, counseling centres, legal cell, police force, family groups, mothers groups, residential associations, Ambulance Services, youth clubs etc. List of Contact number and contact persons will be made and will be given to IDUs for easy access by the community. All these providers will be adequately sensitized by the NGO partner to get involved in providing support services to the IDUs.

• **Documenting and Monitoring:** Every crisis response will be documented and monitored using reflection tools, first of all to capture the process involved in providing the service, secondly also to capture learning and short comings that can be avoided in the future.

6.3.1.11 **ACCESS TO SOCIAL ENTITLEMENT PROGRAMS.**

**The Need:**

Access to social entitlement/social security (SE/SS) program play a vital role in improving quality of lives of IDUs and indirectly help in winning their confidence on the project. These programs often provide additional support like free medical care for key illness, scholarship to children for pursing primary and higher education, travel allowances etc. Providing access to such schemes will not only reduce the financial burden on IDUs but improve overall quality of life of their family and themselves.

**Process:**
NGO partner will do a Resource Mapping and prepare a catalogue of SE / SS program available in the country through government schemes, bilateral or multilateral support, INGOs, Foundations Service Clubs or NGOs schemes. The process should document details such as the following:

1. Providers of the schemes,
2. Summary of schemes including key services and benefits being provided
3. Sectoral focus,
4. Who is eligible and eligibility criteria,
5. Procedures to apply, including supporting documents required and other details.
6. Whom to approach, number of days for realization of schemes, riders, etc.

This catalogue will be updated once in six months since program tends to change and new program gets added. In summary the scope of SE/SS will dependent on the schemes available at that point in time by different providers including the Government Agencies and other programs and schemes. While categorizing, focus on those schemes which are priority need of the IDUs as highlighted during the SNA process.

Implementing SE / SC: The following are the steps leading to demand generation and realization.

- Once the catalogue is prepared, train and brief the ORWs and PEs on various schemes and other details to identify right beneficiaries and helping them to access the scheme,
- NGO team will sensitize the concerned Government agencies and CSOs programs about IDUs issues and the need to access SE / SS schemes.
- The PEs and ORWs will generate list of IDUs both male and female who need SE / SC services based on pre determined criteria and inter-personal discussions from their locality
- PE and ORWs will make field visit to provide education about SE / SS using catalogue and other aids.
- Prepare IDUs to keep all supporting documents ready; facilitate filling in applications; submitting individually or in groups to appropriate authorities. It is important to ensure IDUs gets an acknowledgement for further follow-up.
- ORWs will help IDUs to make regular follow-up to know the status and to exert pressure for speedy realization.
- NGO can also form group of IDUs who have applied for such schemes; train them to further claim their entitlement through peaceful advocacy.
- NGO will regularly monitor the output and outcomes for further planning and strategizing.
Community Systems Strengthening (CSS) refers to a range of initiatives that contribute to the development and or strengthening of community based organizations.

CBOs are the most effective medium to reach into and mobilize the Most at Risk Populations, particularly Injecting Drug Users. In Nepal, already there is a strong network of drug users, called the Recovering Nepal and in several districts where the prevenetions programs are being implemented; a chapter of this network is active. Therefore focus and efforts will be to link up with the existing network rather than initiate new networks and collectivization.

**Community Systems Strengthening** among the MARPs, particularly the IDUs should lead to the following:

1. **Capacity for Advocacy**: already a national network of the MARPs exists in Nepal. TI Unit of the NCASC will work closely with this network to build their capacity and systems to function as a unit particularly to advocate for policy level changes. Also will focus on addressing human rights violation and fight discrimination and violence against sexual minorities. Particular interest to the IDUs would be discriminating laws that treat the IDUs as criminal. Efforts will be made to amend these laws through a process of collectivization.

2. **Access to Services**: Community involvement will be facilitated in scaling-up the program to reach greater number of target group members with prevention services. Greater involvement of community in the delivery of services will result increased demand and acceptance of the program. This will also help in breaking into newer networks and increase the number of IDUs reached and provided services.

3. **Documenting and Replication**: Several good models of community participation in managing IDU programs exist in the country. These good practices will be documented and scaled up to different parts of the country. Communities have unique knowledge and cultural experience about their communities and this need to be an integral part of the development and implementation of community responses. These experiences need to be documented and used while designing new programs for the IDUs.

4. **Sustainability**: Community system strengthening activities will eventually lead to sustainability of services and behaviour. This will lead to ownership to the interventions, sustainability and ultimately improvement in health outcomes.
Every targeted intervention must have actions and processes that lead to community systems strengthening. Given below is a table that describes the building blocks of community systems strengthening. Key to this is the availability of core funding towards CSS.

### The CSS Framework

**Six Core Components of Community Systems:**

1. **Enabling environments and advocacy** – including community engagement and advocacy for improving the policy, legal and governance environments, and affecting the social determinants of health

2. **Community networks, linkages, partnerships and coordination** enabling effective activities, service delivery and advocacy, maximising resources and impacts, and coordinated, collaborative working;

3. **Resources and capacity building** – including *human resources* with appropriate personal, technical and organisational capacities, *financing* (including operational and core funding) and *material resources* (infrastructure, information and essential commodities, including medical and other products and technologies)

4. **Community activities and service delivery** – accessible to all who need them, evidence-informed and based on community assessments of resources and needs.

5. **Organisational and leadership strengthening** including management, accountability and leadership for organisations and community systems

6. **Monitoring & evaluation and planning** including M&E systems, situation assessment, evidence-building and research, learning, planning and knowledge management;

*Taken from CSS Framework GLOBAL FUND FOR AIDS, TB AND MALARIA*
Introduction:

The purpose of these guidelines is to provide a framework for evidence-based clinical practice to NCASC and other health professionals involved in the management of opioid dependence in Nepal. This is focused on Opioid Substitution Treatment programs that aim to reduce the health, social and economic harms associated with the use of psychoactive substances. The document will highlight the steps essential to the implementation and management of such programs by an agency within the broader Harm Reduction Approach for HIV prevention. Following paragraphs summarizes key steps in setting up and managing the OST program by a technical organization in Nepal. (For detailed guidelines please refer to the OST guideline by NCASC/Home Ministry and also of WHO17)

Locate and Assess Community Needs:

When establishing a successful health care clinic, it is imperative that the services provided meet the needs of the community. In the context of Opioid Substitution Treatment (OST), understanding the epidemiology of injecting drug use should be assessed before establishing any type of treatment system or services. This would include understanding the types of drug use, the prevalence of use and the demographics of the affected population.

The location should be selected based on the initial assessment and provide easy access from points where drug users congregate, as drugs will be administered daily. Likewise, a good location will increase access to care, increasing utilization of the services. Additionally, OST programs commonly contain several different therapeutic components, such as methadone maintenance or administering buprenorphine, counseling, psychosocial assistance. While selecting the location, it should also ensure easy access to such other services.

OST services in Nepal will be established under the guidance of the technical team from NCASC, mostly within a health care facility. An accreditation process will be set up, in order ensure better quality of the services, as well as prevent any misuse

Staffing and Training:

OST programs will aim to establish a staffing mix that enables efficient and effective use of each member of the treatment team. Under limited human resources, the minimum standard of one full-time medical doctor, one nurse, one peer counselor or family worker, ORW and support staff (administrative) will be required to operate an OST. Proper training is vital to provide appropriate care, prescribe medication, and prevention of adverse effects. The technical staff (Doctors and Nurses) will be given specific

17 http://www.unodc.org/docs/treatment/Brochure_E.pdf
training on OST patient management based on NCASC OST guidelines. Additional staff will also receive training and education through certified agencies following the same guidelines before starting work. Ongoing training and education is not required but, highly recommended to increase staff effectiveness.

Development of Program Infrastructure:

Minimal requirements must be met regarding the infrastructure of an OST program to ensure patient privacy and confidentiality while creating a functional work space to enhance consistency and reduce error.

- The OST program should establish a separate space for clinical interview by staff, for drug dispensing and counseling where privacy for the IDU client is assured. This is particularly important as many drug users are uncomfortable while giving a history of drug dependence.

- There should be adequate and established space for the storage of medical records and medicines that ensures safety of the information and goods. Safe drug storage helps to decrease risk of medication being leaked to the black market and grants the OST program control over drug dispensing. A protocol that links supply, storage, dispensing of OST medicines should be clearly established in the clinic. This will increase efficiency and provide a mechanism for monitoring of drug dispersion to decrease legal risks involved with dispersion of OST medications.

- The inclusion of advertisements for risks related to IDU use, such as co-infection, risky sexual behavior and provision of condoms in spaces which are easily accessible to IDU clients, are highly recommended as an outlet to provide education.

Patient Eligibility:

Assessing and implementing quality OST treatment should be carried out according to clinical protocol to ensure consistency from patient to patient. In order to be enrolled in an OST program, the patient must be eligible.

- Eligibility is determined by a positive diagnosis of opioid dependence or harmful substance abuse patterns by the doctor

- Identification establishing that the patient is over 18.

Initiating the Treatment:

After the patient is determined to be eligible, treatment is initiated.

- An initial assessment:
• This can be performed by any trained clinical staff; however, the diagnosis for treatment should be made by the doctor. The initial assessment of a patient should take 45 minutes and include a medical history, physical examination, mental state examination, and additional health screenings (STI, HIV, pregnancy).
• The medical history should detail any past drug/alcohol use, mental health, co-morbid conditions, and psychosocial conditions as these all impact the patient’s success in treatment.
• During the physical examination, the doctor should be checking for injection marks, inflammation, infections, abscess, or any other physical abnormality related to injection drug use. This examination should also rule out serious medical illness that might affect treatment.
• The mental state examination should detail any psychiatric disorders that could interfere with treatment progress or increase the risk of harm.
• Additional screenings should be done to determine any additional unknown health problems associated with injection drug use to rule out serious medical illness.

• Administering the Drug

• After the assessment, OST should be initiated by a trained doctor. The doctor should provide the patient with information about the treatment, establishing clear treatment goals with the patient prior to initiation of treatment.
• An informed consent form signed by the client must be filled before starting OST along with patient registration with the OST program. Patient registration should include: the patient’s name, date of birth, personal contact information, type/dose of pharmacotherapy, prescribing physician, referrals and dispensing agency. All this information will help ensure accuracy of treatment for each patient to reduce error.
• At the time of induction, the doctor should provide or refer counseling for the individual during the course of treatment.
• Patients should present identification cards in order to receive medication. Identification cards can be issued by the treatment program since many of the patients are homeless, or migrants.
• The prescription strength (in mg), type, date, and number of pills, should be recorded in each patient’s medical record to monitor medication usage.
• Additionally, administration of the drug should be directly observed to ensure that the drug is not taken away, crushed, and injected by patients.

OST Patient Management

Given the importance of information gathering and analysis in determining the effectiveness of program, patient management is essential to provide quality care and save time. Each patient enrolled in OST should be registered with the program. This should occur during and after the initial assessment of the patient and before
prescription of OST. The registration information should contain important identification and contact information. This will allow the clinic to manage the number of patients seen per day and types of services provided. Since medical practitioner’s maximum case load is 200 patients in a day, maintaining accurate records of patients will assist in better patient management.

Medical records are another very important aspect of patient management. Each registered patient should have clear, concise medical records kept on file. This file should include all important medical history from initial assessment, the consent to treat form, and information regarding drug dosage. This file should be updated during every visit to ensure accuracy of treatment. The medical file should keep record of any counseling received by the patient, along with referrals made. In the absence of the provider, this record should enable other staff members to meet the patient’s needs at that time. Medical records can provide feedback on patient’s outcomes and treatment through documented history of care. This can be very informative for future direction of care to ensure the highest quality.

Management and control of drug dispensing is essential to reducing risk of overdoses or the spillage of drugs into the black market. Programs should attempt to develop strong professional relationships with those dispensing pharmacotherapy to their patients. Dispensers generally see patients more often than medical practitioners and can provide useful advice about patient progress. The hours of availability should suit the needs of the patients. For example, opening early in the morning facilitates those who have employment commitments.

**OST Operations Monitoring:**

Sustainability and effective delivery of services are essential to the success of an OST program. In order to track the scope, quality, coverage, and impact of the project, the OST program should establish a monitoring and evaluation system to capture the progress and gain feedback. The protocol should be established to collect information on project input, process, output, outcome, and impact levels. Evaluation of different areas, such as coverage and outreach, should be done monthly. Based on the information collected, the data should be analyzed for impact and success. Programs should additionally clarify project barriers and successes, incorporate innovative ideas and inform resource allocation decisions to promote advancements.

**Create additional community partnerships to link to treatment center**

Given patient centered approach to improve the health status and psychological and social wellbeing of the opiate-dependent person, establishing community partnerships that provide supportive care can enhance recovery, increase quality and improve effectiveness of care. There are a wide variety of services that could benefit OST programs. Since injection drug users are at high risk for co-morbid conditions, adding services such as HIV counseling and TB clinics, could increase awareness.
6.3.2 PREVENTION PACKAGES FOR IDUS – REHABILITATION, TREATMENT AND CARE

Injecting drug users face significant problem once they are into drug in terms of loss of education, employment, life threatening health hazards including drug overdose, HIV, Hepatitis B/C. Besides, the injecting drug behaviour displaces them from the society, leading to loss of means of livelihood and acceptance in his/her own community. There are several detoxification and rehabilitation programs in the country being implemented focusing on weaning them out of the drug behaviour.

Anecdotal evidence shows that that, rate of relapse after a person has gone through detoxification and rehabilitation program is high, because the person may achieve a temporary improvement in his physical and psychological dependence on the drug, but no improvement in his/her environment. He/she is often worse of, because there is no means of livelihood, high level of societal stigma and his peer group may still be engaged in injecting drug behaviour. This highlights the importance of aftercare program which helps in the mainstreaming process and prevent relapse (details on the aftercare program detailed later in this section)

Injecting drug user (who has already been through treatment) even after a relapse tends to practice lots of practical skills acquired in the rehabilitation setting to keep oneself away from getting into any type of physical, mental or spiritual jeopardy. Due to this fact, a relapsed client who has gone through treatment facility seems to avoid unsafe injecting behaviours and is more successful to maintain a manageable environment as compared to the life style of an IDU who has never been to treatment facility. Thus the positive outcome of the rehabilitation program has a long lasting impact on the drug user. Therefore the need for rehabilitation package within the IDU intervention for HIV prevention is very crucial. Actually, in the bigger picture of social streamlining, rehabilitation component in the national level could be one of the key components to influence the transmission rate of HIV and sociological hazard in a substantial manner.

Rehabilitation treatment package for drug users is not only limited to focus on promoting a drug free life but it deals with the motivation to bring about a profound personality change (through behavioural reshaping therapy) in a drug user to attain a productive, responsible life. During the treatment period a client undergoes various types of intensive practical therapeutic activities which are complemented by 12 steps training (Details in the annexure-14) program, family meetings, input sessions, group dynamics, yoga, meditation, and counselling to restructure their perception towards life and help them understand their needs.
Here we are proposing a set of strategies and actions for rehabilitation as a package within Targeted Intervention. The social rehabilitation process is about ‘facilitating readiness’ of the drug user to get reintegrated into the socio-cultural environment that he/she lives in. It would mean preparing the individual through building skills and improve social support system around him/her. It is also important to work towards stigma reduction in the community to accept the person back. This would require a two pronged approach: 1. Improving the functionality of the person in terms of decreased or no drug behaviour, achieving economic independence and emotional stability. 2. Enabling Environment.

The diagram given here captures in gist conceptual frame for rehabilitation of the IDUs in this project.

The rehabilitation package will be provided to the registered IDUs who show willingness to come out of their drug behaviour. Rehabilitation package model will include the following key steps as shown in the diagram:

1. Needs Assessment
2. Preparation of Rehabilitation Implementation Plan
3. Implementation of the Rehabilitation Plan
4. Regular Reviews and Evaluation

Following paragraphs capture the different proposed implementation models

**Model 1: Primary Residential Care**

Residential rehabilitation is:

- A highly effective form of treatment for injecting drug users or drug users who wish to achieve a drug-free lifestyle
- Appropriate for a range of drug users at different stages of their treatment journey
- Most effective when aftercare is planned before the end of treatment.

Primary Residential Care program suggested here is residential program of three months duration. The program will have a structured approach to care and treatment. This will be a fully costed model of rehabilitation of IDUs with high level of dependency
on drugs. There are two approaches to Residential Rehabilitation models to be followed for rehabilitation:

1. **Treatment and Rehabilitation Approach (Pharmacological and Psychosocial Intervention)**

   This is will be an intensive treatment model which is fully residential with about 3 month’s duration. The treatment will involve intensive medical and therapeutic interventions. The treatment care facility will be made available to both male and female IDUs separately. The key components of this intervention are briefly described below:

   **Key Service components and Process:**

   i. **Intake and Admission:** Persons with injecting drug behaviour will be supported through this rehabilitation program, with a view of weaning the person out of injecting behaviour and prevent HIV infection. Financial support for rehabilitation program will be given on priority to persons who are marginalized and below poverty line (as defined in Nepal). A checklist will be used for eligibility of the patient for financial support at the time of admission. Separate programs will be initiated for both male and female IDUs. Following key steps will be followed for admission of the persons into the program

   - Assessment of Client: Before the admission every patient will be assessed using a checklist. This is to understand the status of the client (type of drug used, duration of drug use, previous treatment history, family history, educational status, economic status, health status etc). Assessment form will be filled in and if the patient need to be admitted a formal consent form will be filled by the patient or the person accompanying the patient.

   - Medical Check up: Every patient who is admitted will go through a medical check up to ascertain any other illness or psychiatric disorders which should be known while the detoxification treatment is initiated.

   - Briefing: At the time of the admission the client is briefed about the norms and rules of the centres which they should strictly follow.

   ii. **Detox Program:** This program is an assisted withdrawal management program with the support of medication. Unlike the “Conventional model” of detoxification approach which is focused on psychosocial intervention and “cold turkey”, in this model there is an intense medical management of the drug user. Appropriate drugs are administered in right quantity and the persons are helped to medically manage withdrawals and build resistance capacity to drugs. It is essential to have the supervision of a medical doctor in managing the detoxification program. The doctor should visit at least twice a week in a 20 bedded facility and examine every patient. Doctor should be also available on call during any emergency. The detoxification program is normally for a period of 10 to 12 days. The process

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would help the persons to reduce physical and psychological dependence on the drugs.

**Medication for Detoxification**

The latest strategies in detoxification attempts to compact a long detoxification procedure into a very short one so that the patient could be induced into antagonist and maintained on it. This can be achieved by Rapid Opioid Detoxification (ROD) and Ultra-rapid Opioid Detoxification (UROD). In the protocol of ROD the patient is pre-treated with alfa-2 agonists like lofexidine, anti-emetics, benzodiazepines, anti-diarrhoeals, muscle relaxants, NSAIDS and taken into a state of light sedation. Depending upon the amount and frequency of use of opioids the patient is rapidly induced with intravenous naloxone, nalmefene or oral naltrexone at the dose of 12.5 to 50mg. Any aggravation in withdrawal symptoms or haemodynamic disbalance is managed with medications. Only after three supervised doses of naltrexone can one be sure that the patient is detoxified completely.

In the protocol of UROD the antagonist induction is done under general anesthesia, either with oral naltrexone or naloxone infusion. The whole process is completed within 6 hours and the patient can be discharged on the same day. According to Waisman it is a form of accelerated neural regulation (ANR). Though there is some literature highlighting the complication of this procedure, the results seem to be due to deviation from standard protocols and inadequate supervision and knowhow.


**Rehabilitation Package**: After the person has gone through an intense detoxification program successfully, he or she is taken through a rehabilitation package of about three months (Three months include 10 to 12 days of detox). This is a critical phase immediately after a detox program – relapse prevention. The longer the duration of abstinence from the point of detoxification, better the chance of recovery. Following are some package of services for rehabilitation and relapse prevention.

**iii. Intense Counselling**: In this approach – along with medical management intense counselling support is also ensured. Every patient goes through an intense one hour counselling at least once a week. Role of a trained counsellor is crucial and the NGO partner should ensure the counsellors have appropriate training related to drug rehabilitation. Counselling is also given to the spouses and family members, which is crucial as part of environment modification. If certain family problems persist it is important to address the issue, otherwise chances of relapse will be high when person get back home. Every counselling session is individual focused and documented in detail to capture the problems, action plans and progress being made.

**iv. Education Sessions and Class**: Focused on the 12 steps of Alcoholic Anonymous (AA), the clients will be taken through these steps in the educational and reflection sessions. Sessions related to – Self Realization, socialization, personality development, health related, HIV, personal hygiene, nutrition etc.
should become part of the education curriculum. Based on the need of the patient appropriate teaching curriculum should be prepared by the NGO partner.

v. **Recreational Programs and Events:** Recreational programs would include outdoor games such as foot ball, volley ball, gym and for female - throw ball and such other outdoor sports which can be played within the space limitation and would create involvement and interest of the client. Also indoor games like, caroms, ludo, chess, table tennis, should also be made available. Regular tournaments and matches also can be organized. Cultural events where in the clients can participate and show their talents also should be organized. The recreational program provides adequate relaxation from the tight schedule of the rehabilitation program and also contributes to improved health. This also teaches the need for community living, sharing, team work, relationship management etc. Also organize picnics and celebrate festivals and involve them in the preparations. This will be an opportunity for them to bring out their talents and learn to adjust to renewed environment.

vi. **Psychiatric Treatment support:** Psychiatric treatment will be given to patients who are diagnosed with psychiatric disorders at the time of admission. They will be regularly monitored and will be under the treatment of the psychiatrist.

vii. **Meetings and workshops:** meetings and workshops of the family members, ex users will be organized to facilitate interaction between the patients as well as the family. Interaction with ex users will be used as motivational approach to stay “clean” for long. Workshop for family members will focus on educating them to deal with drug behaviour of the client.

viii. **Therapeutic interventions** – Besides the counselling and family therapy mentioned earlier other therapeutic interventions will be planned as part of rehabilitation process. Therapies such as aversion therapy, spiritual Therapy, group therapy, work therapy etc will be regularly used as part of treatment and rehabilitation.

ix. **Tipping Point:** This is an effective strategy to facilitate behaviour change among the drug users by creating role models who have demonstrated change and become a motivation for others to follow. Create such tipping points for various activities – who will be leaders and role model for others. These individuals should also be trained and prepared to provide peer education and support to other drug users.

x. **Outreach:** Outreach for home visit and follow up is crucial in the process of rehabilitation. The clients who are at the centre requires sometime visit to their homes to counsel and work with parents or spouse or even children. Outreach also will be done to identify possible clients who need to undergo the rehabilitation package. One outreach worker will be appointed by the centre to

\[20\] Without drugs
carry out these activities. Outreach also will be used to follow up with clients who have completed the treatment process and are back in their families.

xi. **Primary Prevention Activities:** Besides the regular activities at the centre with the drug users, the outreach team also can take up drug prevention sessions in the schools. Talented clients should be brought together and prepare street plays and other shows to create awareness on drug abuse and the need to prevent drug use by youth. During these events, messages on the role of the family and community in preventing drug abuse should be highlighted. Some of the drug users can give testimony of what they have gone through and how things are different.

xii. **Community Involvement:** community involvement in the rehabilitation process of the drug user is important. Sessions in the village and in community circles from where majority of the drug users come, will be made on drug behaviour and the importance of supporting them rather than stigmatizing. Wherever possible community support groups to help the drug users should be formed, particularly in villages or community where large number of drug users is found. The clients also will be taken to the community and involve them in some social service activities. This will provide them with opportunity to adjust to the social and community environment and build the confidence of the community members.

xiii. **Referral Services:** Clients who required additional health facility or testing facilities (HIV, Hepatitis B and C, TB clinics) will be linked up with centres that provide these services and facility will be arranged for them to be taken to these centres.

In addition to the above service for female IDUs following services also will be given **reproductive and sexual health services.** They should also be given crèche for child care

**Staff Structure**
For a 20 bed Facility following is the staff structure suggested.
2. Rehabilitation and Treatment Approach (Non-Pharmacological Intervention)

The model is largely will have all the key components mentioned above except for the medical intervention. The key approach is the conventional psychosocial support and “cold turkey”

Three Staged Approach:

a. Detox Stage: Focusing on Psycho-social inputs through counselling and preventive presence. Key approaches in this would be – cold turkey, acupuncture and homeopathic methods. Focusing on strengthening individuals coping capabilities rather than through Pharmacological management. In case of emergency medical service will be made available. This will be for a period of 10 to 15 days. The client will be very closely watched and followed up to prevent any harm and manage withdrawals. In case of emergency and need for medical support, it will be made available. Once the person has gone through this stage – will be ready to move into rehabilitation and maintenance stage.

b. Maintenance Stage: Once the person has overcome initial dependence on drugs and have managed to cope with withdrawal symptoms better, the person will be made to go through series of service components as mentioned in the previous model (for details please refer above). During this period the person will be more in touch with the family and family support will be part of the therapeutic intervention.

c. Back home. The individual, during this stage will be helped to be reintegrated with the family and society, continues to be in touch with the program through weekly visit.

Model 2: After Care Model\(^{21}\):

One of the key challenges, post rehabilitation program for the drug user is relapse prevention. The longer the person is able to stay out of drug, higher the chance of maintenance. In order to continue to support the drug addict who has been through detox and rehab program is provided continued support to prevent him or her getting back into injecting behaviour. This is critical, since relapse would mean a heightened risk of HIV again. The period after the end of rehabilitation, and for a few months afterwards, is a very risky time for relapse and continuing abuse. A study of 153 DUs who relapsed following their discharge from DRCs in Kathmandu revealed that around half of RDU's couldn't remain drug free for more than one month and two thirds for more than 5 to 6 months (Sinha 2008). It is therefore imperative that the first 5 months be taken as a critical post discharge period, as relapse for a majority of recovering DUs seem to take place in this time line.

Besides, drug behaviour, post rehabilitation care focusing on sexual health information and products are crucial, as anecdotal evidence show that post rehab, and when the

\(^{21}\) Adapted from: “Service Delivery Approach for Post Rehabilitation Care of Drug Users”, Ashish Sinha and Apurva Rai. Save the Children. December 2009, AND Learnings from Naolo Gumti, Pokhara and KYC, Dharan
person is out of intense drug dependency, there is a chance that person becomes more sexually active than compared to when he or she was on drugs. This could further increasing the risk to HIV

This model would be providing after care services as part of the existing TI program with additional resources and space added. The table below shows a menu of options for rehabilitation support – particularly focusing on recovering users – who were registered with harm reduction program, but have moved on and requires Rehabilitation support

**Key Objectives:**

i. Provide day care facility to recovering drug users who have completed rehabilitation care and requiring continued support for relapse prevention

ii. Provide Psychosocial support service to enhance the persons mental and physical stability

iii. Empower the recovering users by increasing self confidence and reintegrate them back to community

iv. Prevent HIV transmission by providing them with sexual health services and products.

v. Create a stigma free enabling environment which would facilitate access to post care requirements and social reintegration.

**Target Group**

- Injecting Drug Users who have successfully completed 3 months residential rehabilitation program and their family members

**Implementation Process**
These six service components will be implemented as part of the aftercare model. The services will focus on family integration through counselling and family visits. Focus also will be given to improving competencies and work conditioning of the client, so that he or she is able to gather job skills and can become employable. This will not only increase their self confidence but also increase their chance of winning a job, which itself will keep them away from drugs.

Project also will focus on providing health care services, particularly focusing on sexual health and HIV vulnerability. The clients will be educated through the counselling process and outreach educators who are placed as part of the PRC program. The centre also will ensure their access to condom and STI treatment is enhanced.

By occupying the clients, through various activities including occupational therapy, education session, counselling, social service activities, their self confidence and social
reintegration will be facilitated. The project team also will work intensely with the community, to build their awareness on drug behaviour and related drugs. They will be better sensitized to the needs of the clients. Through this process will create an enabling environment for the IDUs, which is free of stigma and discrimination. (For more details on these services and component – refer the following document: “Service Delivery Approach for Post Rehabilitation Care of Drug Users”, Ashish Sinha and Apurva Rai. Save the Children. December 2009)

**Delivery Mechanism**

Post Rehabilitation Care program will be independently implemented by a team and separate Drop in centre facility will be opened for the clients. There will be a coordinator, counsellor cum educator and 2 community mobilizer in the team and in addition there will be volunteers from the drug using community itself. The services as mentioned in the above diagram will be implemented through this drop in centre.

### 6.3.3 CARE AND SUPPORT SERVICES

Even after nearly 3 decades of HIV pandemic and the prevention efforts, the number of infected persons is on the increase especially among the MARPs. Therefore programs focused only on prevention activities for MARPs cannot by itself address the goal of reversal of the epidemic.

With more infections among the MARPs and especially with the IDUs, it is important to facilitate care and support services as part of the targeted intervention program, as this is a serious and priority need of the community. Lack of adequate focus on the PLHIV among MARPs can further marginalize people living with HIV among them. Programs that cut across prevention to care continuum would sustain adoption of good health seeking behaviours among the MARPs. A full range of services starting from HIV counseling and testing services to HIV care, support and treatment, ART, PPTCT, drug substitution and treatment, maternal and child health services can be made accessible to the affected population.

Care and Support Services include the following:

- CD4 testing
- ARV therapy
- Prevention of Mother to Child Transmission
- Opportunistic Infection Management including TB and CTX
- Linkages to Peer Support Group
In a resource constrained setting like Nepal, it will not be possible for the government to fund all of this care and support activities along with targeted interventions services. However, in Nepal, it has been proven that providing certain fundamental care and support services at home and in the community are much needed since the public health system is not easily accessible to most of the marginalized population like the IDUs. Targeted interventions should include the simple home based PLHIV care, OI management, wound dressing, psycho-social support, nutritional advice etc. Peer Support Groups are necessary to provide safe emotional haven among those who suffer similarly and have need of coping mechanisms. There are several constraints for the PLHIV to access facility based care due to stigma and discrimination, poverty, substance abuse, emotional unpreparedness, fear of rejection and isolation, lack of awareness and knowledge. Thus, there is a need for much more focused programe to improve access to care and support for the PLHIV among the IDUs. This will involve the outreach worker accompanying the PLHIV to the facility for appropriate treatments and follow up. This referral support will be given by the TI program to services like CD4 testing, ART, PPTCT, complicated OI management, Secondary and Tertiary hospitals care, Community Care Centers/Crisis homes etc.

Who is eligible for Active and accompanied referrals?
- Newly diagnosed as HIV + and/or Struggling to cope with HIV status
- Pregnant woman or those contemplating pregnancy
- Substance dependent PLHIV (alcohol or drug/IDU)
- Isolated/ completely marginalized PLHIV
- Physically and/or mentally incapacitated PLHIV

While it is necessary for all PLHIVs to be able to access health care when needed, in a resource constraint setting, there has to be prioritization of who receives active and accompanied referrals. Therefore targeted interventions will also provide active and accompanied referral support to a select number of individuals who have been identified as the most needy and vulnerable. All this will be done through the Community and Home based care model.

The focus of CHBC will be to provide home based services as well as empower care givers and family members with the training and knowledge to provide the care. This will lead to sustainable services as well as resolve human resource constraints while outreach workers attempt to reach ALL those who are in need.
Community and Home Based Care

This is a range of services leading to PLHIV from the IDU community receiving need-based services at their homes or community centers. These services must be confidential, voluntary; it is by choice and is part of the continuum of care and not a replacement for institutionalized service. This is ensuring optimal appropriate care within available resources and qualified and paid staff.

Targeted intervention will include the CHBC model which involves NGO staff and NGO outpatient clinic. (National refresher training curriculum on community and home based care for adults and children living with HIV/AIDS in Nepal)

Role of the outreach worker in Community and Home based care:
- Creating awareness on HIV and nutrition
- Psycho social support
- Provide treatment, take the medications from the appropriate facility and administering (i.e. DOTS, CTX, ARV). Scope of treatment provision to be decided
- Accompany eligible clients to health care facility and follow up
- Dressings, wound management, training to PLHIV and care giver on the same

Role of the counselor in CHBC
- Community mobilization and facilitating peer support group sessions
- Providing psycho social counseling for those with special needs (outreach workers will refer difficult cases to the counselor for home visits)

Supplies
The outreach workers will need a package of supplies added to the regular kit to be able to provide appropriate care and support to the PLHIV at the household levels. They are dressing material like cotton, gauze, anti-septic bandages and sterile dressing equipment like forceps etc which can be supplied through the NGO linked program clinic.

Peer Support Groups
Dealing with an HIV diagnosis can be very isolating and disturbing experience. Peer Support is one of the most powerful and sustainable tools to bring likeminded people together, to share experiences and knowledge and to make living with HIV less painful and isolating.

There are challenges for facilitators in making peer support groups run well. The participants may be at different stages of coming to terms with their diagnosis and with living with HIV. The support groups must be facilitated by an experienced counselor who can, not only guide and facilitate the sessions but also provide group counseling, spirituality sessions, capacity building sessions like simple dressing, condom negotiation, hygiene, nutritional advice etc.

Apart from Peer support group, the NGO can also facilitate twinning of the PLHIV with those who are more stable, confident, helpful and caring, so that the newer or more vulnerable PLHIVs can be given closer attention. Mentoring, twinning or a ‘shoulder to cry on’ is an effective strategy where the outreach worker facilitates a relationship between the new or vulnerable PLHIV to one that is able to provide a shoulder, a ear or time.

**Referrals**

Most of the critical care, treatment and support services for the PLHIV will be provided through referrals. The referral system entails a process of coordinating service delivery to ensure that\(^{23}\):

- Access to needed services is expedited.
- Confidentiality is maintained.
- Referrals between the organizations in the network can be tracked.
- Referrals and their outcomes are documented.
- A feedback loop informs the organization initiating the referring organization that the requested service has been delivered and has met the needs of the client.
- Gaps in services can be identified and steps taken by organizations in the network to bridge them.

A referral directory must be maintained by the NGO partner so that any client can access information on various HIV related care and treatment services any time they require. This can be maintained in the form of a roster, and a booklet that peer educators can carry with them. This referral directory must be developed following a listing of preferred providers as well as a written memorandum of understanding between the institutions particularly for access services like ART, OI Management, PPTCT, Care home etc. The referred institutions must also be assessed for sensitivity and capacities based on which needed inputs should be given. The Referral Directory must have contact person’s name, institution’s contact details, opening hours, cost of services and any other consideration.

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\(^{23}\) Establishing Referral Networks for Comprehensive HIV Care in Low-Resource Settings, FHI, January 2005
Referral system and the partner institutions must be part of the targeted intervention M and E system for ensuring monitoring of service quality.

6.3.4 SPECIALIZED PACKAGE OF SERVICE FOR FEMALE IDU

Female Injecting Drug Users have the greater risk of HIV as their access to information and other services are poor, they are highly stigmatized and exploited and often there are no program focused on addressing the needs of the FIDU. Besides that, anecdotal evidence in Nepal shows that most of them are also involved in sex work in order to support their drug behavior. Thus, their vulnerabilities are high but not much is being done mitigate the harm. Following are the key intervention strategies approaches suggested to cater to the needs of the FIDU.

First of all it is important to initiate separate interventions for FIDU, in cities where there is a sizeable number of FIDUs numbering to more than hundred. If separate programs are not planned FIDUs will be unwilling to access services in the DICs along with male IDUs due to heightened stigma and exploitation. Therefore it is suggested that wherever possible separate intervention DIC should be planned for FIDU. In case the number of FIDU is small and DIC is clubbed with existing program of male IDU, it is suggested that a separate space, with adequate privacy should be ensured for FIDU. All effort should be made to ensure non-stigmatized and non-discriminatory services access for FIDU.

FIDU will be given all the key harm reduction services as discussed in the case of male IDUs, which includes, NSEP, BCC and IEC, condom program, STI treatment and care, primary health services, Positive prevention services, Crisis response etc. In addition to these, it is important to provide the following services to the FIDUs.

1. Sexual and Reproductive Health Services:

One of the critical service requirements for the FIDU is sexual and reproductive health treatment and care. Sexual and Reproductive health service aim at enabling satisfying and safe sex for the population and ensuring adequate information and freedom to decide when or how often to have children. For the FIDU, critical gaps in the program include any services related to pregnancy, safe termination of pregnancy, drug behavior of lactating mothers affecting the baby’s health etc. Through this program it is proposed to provide basic sexual and reproductive health services. Following services will be made available within the DIC:

   a. Treatment and care support: Provision of a gynecologist, visiting the DIC clinic once a month will be introduced. Those who require medical termination of pregnancy, this will be made available within the purview of the law governing it.

through referral to the government hospitals. Women requiring care during pregnancy period, this will be made available through linkages with ANC care facilities in the government hospital.

b. Information and Counseling: Counseling will be provided on sexual and reproductive health issues, particularly in the context of drug use. Appropriate IEC materials for this will also be printed and distributed to the FIDU. Information on various service available through the public health system will also be given to the FIDU and help them to access these service through the outreach system. Lactating mothers will be counseled and educated to not to feed the baby when on drugs.

2. Child Support Services like crèche
Lack of a safe place for children of FIDU is one of the concerns and need. Within the DICs, the crèche service will be made available for the children of IDUs. The service will include support of a nurse, nutritional support, playing materials for children. A costed plan will be made for the implementation of crèche services with female IDU DIC.

3. Personal Care and Hygiene
Many of these women are homeless and are also into sex work. Often they do not have a place to go for their personal care and hygiene. DIC will offer personal care facilities and minimum support for essential make up and toiletries. This will motivate them to access the DIC service for HIV prevention and care.

4. Advocacy Support
Within the regular enabling environment activities one of the crucial needs for the FIDU in Nepal is to work with Hotel owners and other care takers who employ them for providing sex services in the hotel and other places. Due to heavy load work, they are denied opportunity to access sexual health and HIV prevention services from the DIC. It is important to sensitize them and get their help in ensuring these services reach them and also ensure adequate supply of condoms and other protection mechanisms.
7. STAFF STRUCTURE – TI – HARM REDUCTION MODEL

- Project Coordinator
  - Part Time Doctor
  - DIC Coordinator
    - DIC Support staff
      - Creche Nurse for FIDU DIC
      - Paramedical Assistant cum Educator
    - Counsellor
    - Out reach Coordinator
      - Out Reach Worker
        - Peer Educators
  - Out reach Coordinator
  - DIC Team
  - VOLUNTEERS (Ex Drug Users)