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India's voice against AIDS
Department of AIDS Control
Ministry of Health & Family Welfare, Government of India
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6

STAYING SAFE

A Manual to Train Staff in IDU Interventions on Advocacy, Community Mobilization and Referral Networking

TRAINING MANUAL

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

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"Currently 'Injecting Drug Users' (IDUs) are referred to as 'People Who Inject Drugs' (PWID). However, the term 'Injecting Drug Users' (IDUs), has been used in this document to maintain consistency with the term used presently in National AIDS Control Programme".

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

Preface

The success of any strategy to reduce the harms associated with drug use such as HIV/ AIDS depends on how best they are implemented at the grass roots level, which in turn requires significant training and capacity building of service providers and programme implementers who implement the strategies.

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

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

1) Conduct Operational Research & Diagnostic Studies

2) Develop Quality Assurance SOPs

3) Develop Capacity Building/ Training Manuals

4) Training of Master Trainers

This manual is part of a series of six training manuals developed by UNODC. This has been developed for the training of project managers and counselors of the IDU Targeted interventions in India. This manual aims to build both knowledge and skills of staff in IDU interventions on advocacy, community mobilization and referral & linkages using participatory and adult learning principles. In addition, conscious efforts have been made to keep the manual interactive through frequent use of group discussions, group work, role play and brainstorming exercises included in this manual to facilitate better learning.

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

Acknowledgement

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

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

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

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

Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ART	Anti Retroviral Therapy
ATS	Amphetamine Type Stimulants
BBV	Blood Borne Virus
BCC	Behaviour Change Communication
CBO	Community Based Organization
CD4	Cluster of Differentiation 4
COPD	Chronic Obstructive Pulmonary Disease
DIC	Drop-In Centre
DOTS	Directly Observed Treatment, Short-course
FDU	Female Drug Users
FSP	Female Sex Partners
Hep B and C	Hepatitis B and Hepatitis C
HIV	Human Immuno-deficiency Virus
HIV+	HIV Positive Person
HRG	High Risk Group
ICD	International Classification of Diseases
ICTC	Integrated Counselling and Testing Center
IDU	Injecting Drug User
IEC	Information, Education and Communication
IPC	Inter-personal Communication
LSD	Lysergic Acid and Diethylamide
N/S	Needle/Syringe
NACO	National AIDS Control Organisation
NACP III	National AIDS Control Programme Phase III
NDPS	Narcotic Drugs and Psychotropic Substances Act 1985

NGO	Non Government Organization
NSEP	Needle and Syringe Exchange Programme
OD	Overdose Management
OI	Opportunistic Infections
ORW	Outreach Worker
OST	Opioid Substitution Treatment
PD	Project Director
PE	Peer Educator
PEP	Post Exposure Prophylaxis
PLHIV	Person Living with HIV
PM	Project Manager
PWID	People Who Inject Drugs
RMC	Regular Medical Check-up
SACS	State AIDS Control Society
SPYM	Society for the Promotion of Youth and Masses
STI	Sexually Transmitted Infection/s
TB	Tuberculosis
TI	Targeted Intervention

Contents

Preface iii

Acknowledgements v

Abbreviations vii

The Training Manual 1

Day One 7

Session One: Introduction to the training programme 9

Session Two: Understanding IDUs and issues affecting their vulnerabilities and mobilisation 12

Session Three: Basics of referral and networking 18

Session Four: Resource mapping for referral 22

Day Two 25

Session One: Establishing and maintaining referral networks 27

Session Two: Referral Analysis 31

Session Three: Understanding the basics of community mobilization 34

Session four: Facilitating community mobilisation 37

Session Five: Understanding advocacy 42

Day Three 47

Introduction to Day-3 49

Session One: Developing advocacy strategies 50

Session Two: Advocating with law enforcement agencies 55

Session Three: Advocacy to facilitate referral 60

Session four: Advocacy with the wider community 64

Session Five: Monitoring of referral & networking, community mobilisation and advocacy 67

Session Six: Conclusion and Evaluation 73

Annexures 75

Annexure 1: Tools for facilitator 77

Annexure 2: Pre and post training questionnaire 79

Annexure 3: Training agenda 85

Annexure 4: Day – wise feedback forms 87

The Training Manual: Preparing for the Workshop

Introduction to the Manual

This three day training manual has been developed in response to the need felt to provide a comprehensive curriculum for training of Project Managers and Counselors working in Injecting Drug Users' (IDUs') interventions in India. This is part of a series of training modules designed in order to build the capacity of Project managers and counselors working with IDUs in the TIs.

Most of the sessions have been designed to cover a period of 60 to 90 minutes, which includes theory, discussion and/or activities. It is important that the training fosters an environment of learning, and is not just delivered by a person standing in front of a class lecturing about a particular subject. Trainers are encouraged to consider how they will use the training manual to develop the knowledge and capacity of the trainees. Trainees should be encouraged to take responsibility for their own learning experiences so that this process will be sustained long after the training workshop. The trainer should not feel obliged to implement all the activities within the training manual.

Purpose of the Training Manual

The purpose of the training manual is to increase knowledge, skills, confidence and build the capacity of Project Managers and Counselors on advocacy, community mobilization and referral networking. Through a combination of theory and complementary activities, trainees will have an enhanced comprehension of the key topics. The training manual provides an overview of key topics related to HIV prevention and drug use.

Who is the Target Audience?

This manual is aimed at Project Managers and Counselors working with IDUs. The training manual provides evidence based approaches to the provision of services to IDUs.

Design of the Training Package

This package has been designed to develop and clarify the perspective of the participants on advocacy, community mobilizationand referral networking issues. Most of the sessions have been planned with interactive methods such as brainstorming, problem solving, discussions, etc. to facilitate the process of experiential adult learning for greater participation and better recall of the core issues.

The package contains the following elements:

1. Manual

The manual has been designed for three day training workshop. This training manual can be used in one of two ways. First, it may be implemented as a complete training package

and presented in its entirety over three days. Alternatively, the trainers may focus on a selection of topics for a particular audience and expand upon the information that has been provided. It is recommended that the trainer read all the topics covered in the training manual from the beginning to the end, in order to gain a better understanding of the subjects and scope of each topic within the workshop.

2. CD

The CD provides PowerPoint presentations and all the necessary material in a print ready format which can be replicated and used during other trainings.

3. Annexures

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

a) **Annexure 1:** Contains direction for role plays and work sheets for group activities referred to in the individual chapters.

b) **Annexure 2:** Pre and Post training questionnaire containing a battery of multiple choice questions. The same questionnaire needs to be administered in the beginning of the training programme as pre-training questionnaire and at the end of the training program as post- training questionnaire. After administering the pre-training questionnaire, the analysis should be done immediately so that weightage can be provided for certain sessions as per the current knowledge level of the participants. Therefore, if the analysis reveals that the participants do not have an understanding of or have less understanding of – a particular aspect, then the facilitator should emphasize on it during the relevant session/s.

c) **Annexure 3:** Day-wise feedback forms are also provided. Copies are to be given to the participants at the end of each day for their feedback on the day's proceedings. It would be helpful to review the feedback forms on a daily basis so as to be able to respond to significant issues, if any, on the topics and issues such as lack of comprehension of important content or perceived lack of applicability.

Before the Workshop

A three day workshop needs extensive preparation and the facilitator should ensure that the following is done well in advance:

a) Tips for Trainers

- Before each day's training, it is recommended that the trainers familiarize themselves with the topics to be covered for that day, by carefully reading the relevant materials. This will enhance understanding of the concepts and points raised on each slide and its correlation to the accompanying text. Depending on the skills of the trainer, and their background, they may wish to include examples or case studies to bring further depth and clarity to the topic being presented.

- Most workshops require more than one trainer. In such cases, it should be ensured that the co-trainers have read all the workshop materials in this package and that they feel comfortable facilitating the workshop on the selected topics from the training manual. A meeting of the trainers before the workshop should ideally be conducted to agree on the agenda and to decide who is going to teach which topic. Some trainers feel more comfortable presenting certain topics than other trainers and for the benefit of the trainer and the trainees; this should be taken into consideration.

b) Workshop Logistics

- It is always wise to check that the equipment needed is available and working properly, like projector and laptop to screen the PowerPoint presentations.
- When organizing the workshop, various arrangements need to be made such as transport for the participants, to and from the venue, site visits, accommodation, restroom facilities, catering, social activities, safety and security of personal belongings, equipment and materials, emergency medical assistance and so on.

c) Read the NACO Operational Guidelines and training manual completely before the workshop.

d) Prepare all materials required for the sessions such as pre and post training questionnaire,feedback forms etc.

e) If possible, arrange for other films or newsletters/magazines that document best practices on working with IDUs from across the country. These films can be screened during the lunch break or after the day's sessions have ended. Newsletters and magazines could be placed on the side at the training venue and participants could be encouraged to go through them.

Workshop Completion Certificate

It is a good idea to award certificates to all participants on successful completion of the workshop. A small gesture of endorsement or recognition by the organizers helps a great deal to boost the level of participation and motivation both during the workshop and afterwards.

Materials Required during Training

- LCD projector (for slides) or overhead projector
- Computer with slides or printed overhead slides
- Flipcharts, a stand, at least 10 marker pens (various colours)
- Whiteboard or blackboard (plus chalk for blackboard or special whiteboard marker pens if using whiteboard)
- Resource manual for each participant

- A notebook for recording information or aspects not documented in the training materials
- Training agenda
- Pre and post training questionnaire
- Daily feedback forms
- Certificates
- CD-ROM of the training manual including each of the power point presentations

How to Facilitate

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

How to Use the Manual

The chapters on each session provide the following information:

1. **Objective:** What the facilitator hopes to achieve by the end of the session.
2. **Expected Outcome:** The outcomes anticipated as a consequence of the session.
3. **Methodology:** The suggested methods and techniques to be used.
4. **Materials Required:** Materials may include flip charts, marker pens, handouts, etc. in addition to any preparation that is required.
5. **Duration:** Approximate time each session will take.
6. **Summary of session flow:** A bird's eye view of the topics, activities and overall flow of the session.
7. **Process:** The step by step details of how to conduct the session.

Key Things to Remember as a Facilitator:

Do's

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

Don'ts

- Let any one person dominate the discussion.
- Speak more than the participants – let the participants brainstorm and discuss.
- Allow distractions like mobile phones or chatting between participants.
- Make the training a boring experience – intersperse the sessions with energizers/ games.
- Read out from the PowerPoint presentations – prepare yourself well and use the presentation slides as cue cards to elaborate on relevant points.

Day 1

Session One:

Introduction to the Training Programme

Session Two:

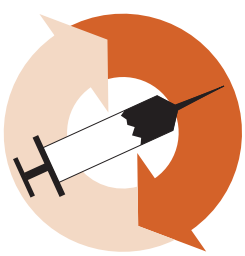
Understanding IDUs and Issues Affecting Their Vulnerabilities and Mobilisation

Session Three:

Basics of Referral and Networking

Session Four:

Resource Mapping for Referral



Introduction to the Training Programme

OBJECTIVE

To introduce the participants to each other, record the participants' expectation from the training and set ground rules for the smooth running of the session.

EXPECTED OUTCOME

At the end of the sessions the participants will be able to:

- Agree on the ground rules of the workshop
- Explore the expectations for the workshop
- Know each other
- Know the agenda for the three day training workshop

DURATION

30 minutes

SUGGESTED TRAINING METHOD

- Group activity
- Discussion

MATERIALS / PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentations
- Flip chart/white board
- Chart papers
- Post-its
- Marker pens
- Pre-training evaluation: copies for the participants

PROCESS

STEP 1: Establish ground rules

- Ask participants to decide on the ground rules. Allow the group to brainstorm for a short time.
- Write the ideas on the flip chart, putting similar ideas together or close to each other on the chart sheet.
- Assist the group in making rules by asking questions or giving examples.
- After brainstorming, the group should have consensual ground rules. After the session, the facilitator(s) will rewrite the rules in an orderly fashion on a different flip chart. These rules will be posted during the entire training.
- To reinforce, facilitator will present the following slide on ground rules.

Ground Rules

Examples

- **Respect :** Everyone has a right to his or her opinion. We need to listen to whoever is talking and to respect them even if some of us disagree.
- **Emphasize on Time :** Be here on time so you won't miss out.
- **Active participation :** You are not required to stop using drugs to be in this program; but plan to be alert so you can get as much out of this training as possible.
- **Confidentiality :** We need to trust each other; we will not talk about the private lives of other group members to our friends and families.
- **Honesty and Openness :** It is important to be honest and open, without talking about extremely personal things about other and ourselves.

STEP 2: Expectations from the workshop

- Ask the group to share the expectations they have from this training.
- Write their responses on a flip chart. After getting their responses, review the list and mention which issues will be covered in the workshop and which will not.
- Explain that the issues covered in this workshop were developed through a consultative process involving people who use drugs, service providers, non-governmental organizations, National AIDS Control Organisation officials, donor agencies and UN agencies from all the regions of the project.

Step 3: Introducing the three -day workshop agenda

- Provide the training agenda to the participants and review it with them.
- Introduce the workshop; duration of each day of the workshop; logistics arrangements including breaks during the day, food and location of toilets.
- Invite volunteers from among the participants and assign them the task of noting 'reflections' from the participants at the end of each day of the workshop. Also ensure that volunteers are assigned the role of recapping the previous day's sessions at the beginning of each day. Inform them that this is applicable to all the days of the workshop.

The agenda for the three-day workshop is included in Annexure III.

Step 4: Pre-training evaluation

- Explain to the participants that the objective of the pre-training evaluation is not a formal assessment of the participants; rather, it is meant to understand the current level of knowledge of the participants, and reassess the same at the end of the training. This will provide feedback on the possible change as a result of the training program.
- Distribute the pre-training questionnaire and ask participants to complete and return it. The questionnaire is anonymous and does not require the respondent's name or any other identifying information.
- Collect the completed questionnaires and thank the participants.

The pre-training evaluation questionnaire is included in Annexure II.

Understanding IDUs and Issues Affecting Their Vulnerabilities and Mobilization

OBJECTIVE

To help participants understand the IDUs, the factors affecting their vulnerability and mobilization.

EXPECTED OUTCOME

By the end of the session participants would have:

- Clarity on factors that make IDUs vulnerable
- Understand the issues associated with community mobilization

DURATION

Two hours

SUGGESTED TRAINING METHOD

- Brainstorming session
- Discussion
- Group work

MATERIALS / PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/whiteboard
- Chart papers
- Marker pens

PROCESS

Step1: Group work

- The facilitator divides the participants into four groups and requests them to list out the issues/ factors that affect the vulnerability of the IDUs based on the following aspects:

Group 1: Drug use /dependence

Group 2 : Drug use, law and its implications on the IDUs

Group 3 : Stigma-perceived and actual and subsequent discrimination/stereotyping/ prejudice

Group 4 : Lack of knowledge and skills related to healthy practices

- Facilitator requests the participants to graphically represent their findings focusing on the factors that make IDUs more vulnerable to HIV and other Blood Borne Viruses (BBV). The facilitator requests the groups to work for 15 minutes and then present their findings.

Drug use / dependence:

Continued drug use may lead to dependence. Drug Dependence is a health condition where the drug user has experienced any three of the following within the period of last one year:

- **Craving :** A strong desire or sense of compulsion to take the substance
- **Impaired control :** Difficulties in controlling substance-taking behaviour in terms of its onset
- **Withdrawal :** A physiological withdrawal state when substance use has ceased or been reduced, as evidenced by the characteristic withdrawal syndrome for the substance
- **Tolerance :** Increased doses of the psychoactive substances are required in order to achieve effects originally produced by lower doses
- **Pre-occupation :** As manifested by important alternative pleasures or interests being given up or reduced because of substance use; or a great deal of time being spent in activities necessary to obtain, take or recover from the effects of the substance
- **Persistence use despite harm :** Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning.

International Classification of Diseases (ICD-10),WHO

Thus a drug user is more prone to using drugs and cannot be expected to stop overnight or refrain from it as and when required. The withdrawal of opioid is particularly severe (but is not fatal like that of alcohol) due to the pain it causes.

Due to preoccupation, most of his/her time, efforts and resources are spent in drug procuring, using and recovering from its effects, in spite of being aware of the consequences/harms (being) caused by drugs.

Therefore, in spite of knowing about the risks of injecting - an IDU is unable to stop or refrain from drug use and unable to take the necessary steps to seek and continue treatment. Thus, he/she needs greater effort from the service provider.

Drug use, law and its implications on the IDUs:

The IDUs are either injecting illegal drugs (i.e. heroin or its impure derivatives) or using pharmaceutical drugs procured illegally (i.e. buprenorphine, dextro-propoxyphene) without a proper medical prescription.

Since law is against them, the IDUs want to hide their drug use and are not comfortable in disclosing it unless they feel confident about the information being not used against them.

Moreover, the illegality of injecting these drugs also pushes them into unsafe injecting in unhygienic conditions- public toilets, abandoned houses, behind garbage dumps etc. The IDUs are often rushing to finish the injecting and get rid of the evidences (needle or syringes) that may be used against them. So the practice of injecting on 'unclean' body parts and the risk of injecting in the arteries and wrong veins is also very high.

If known as a drug user, chances of harassment by the police on 'every pretext' is also very high with little respect for their human rights.

Stigma –perceived and actual and subsequent discrimination:

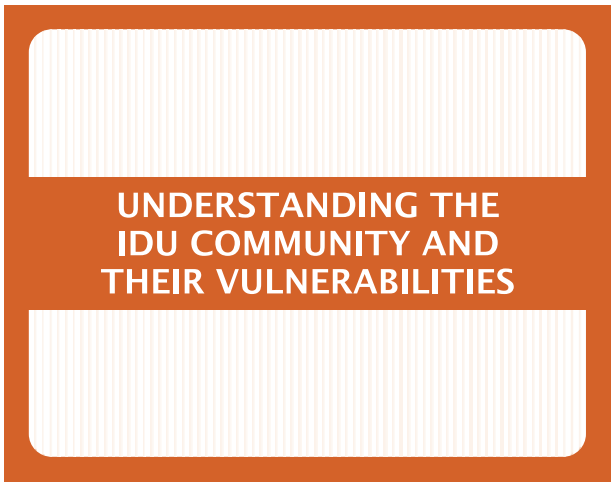
Service delivery is often affected by stigma existing among the service providers. At times, hearing of negative experiences from others and/or due to low self-esteem of their own, the IDUs and their partners are affected by perceived stigma and do not want to access the services available.

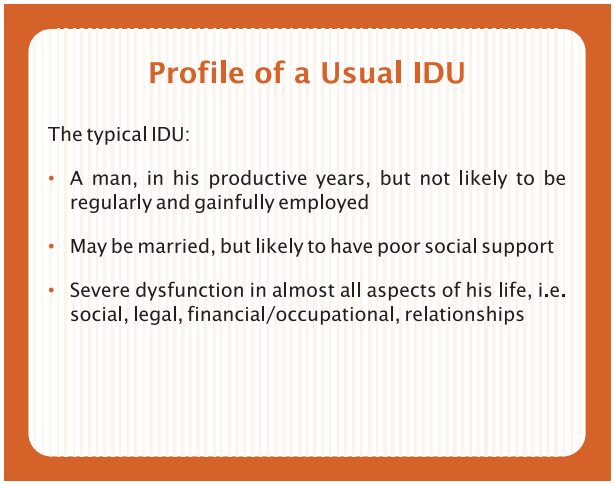
Lack of knowledge and skills related to healthy practices:

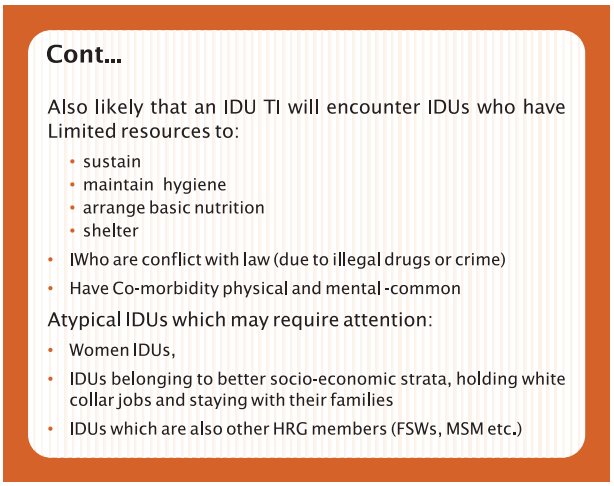
Most of the drug users learn to inject while injecting and from other injectors. Thus their knowledge in this regard may be incorrect and subsequent injecting practice may be unsafe. They may not have the skills to negotiate safer injecting and sex practices in their groups or with their partners thus making them vulnerable.

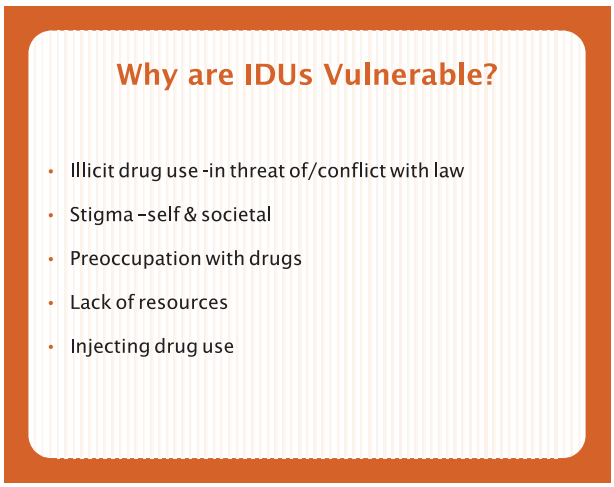
Step2: **Presentation on "understanding IDUs"**

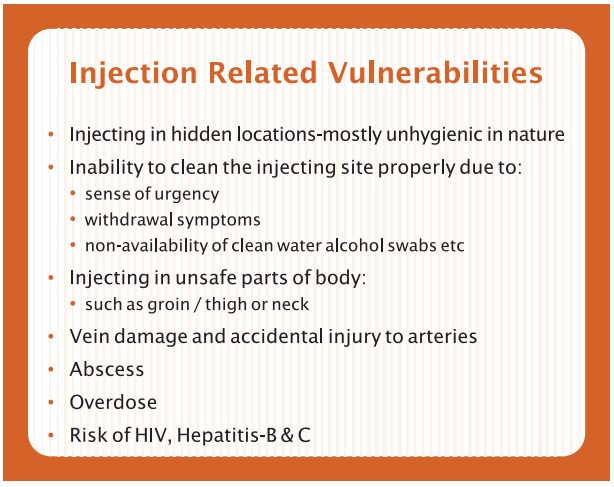
- The facilitator sums up the session with the presentation on 'Understanding IDUs.











Sharing

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

Why do IDUs share?

- Economic reasons: lack of money to buy needle syringes. Injecting equipment may be available only at a pharmacy, who may be reluctant to sell needles-syringes or may choose to sell them at a premium.
- Psychological reasons: they feel their bonding with each other will be strengthened by this act.
- Poor awareness: of consequences of sharing or of safe injecting practices

Vulnerability due to drug use

- IDUs at greater risk to transmission of infections through the sexual route than general population.
- Due to drugs judgement is compromised resulting in greater risk taking in many of their actions, including sexual acts.
- Drugs affect their power of working with hands and fingers – making it difficult to wear and take off a condom correctly.
- Drug use often leads to disruption of relationships and broken families, leading IDUs to engage in sex with casual and or commercial partners.
- IDUs may be compromised to sell sex to procure drugs. More true for female drug users adding to their vulnerability of contracting HIV, Hepatitis- B infection.

Impact on women and children

- Burden of supporting family may fall on women and children
- Women may be pushed into sex work
- Financial & family issues may cause children to drop out
- Health issues may be compromised
- Vulnerable to domestic violence

Female IDUs and their special needs

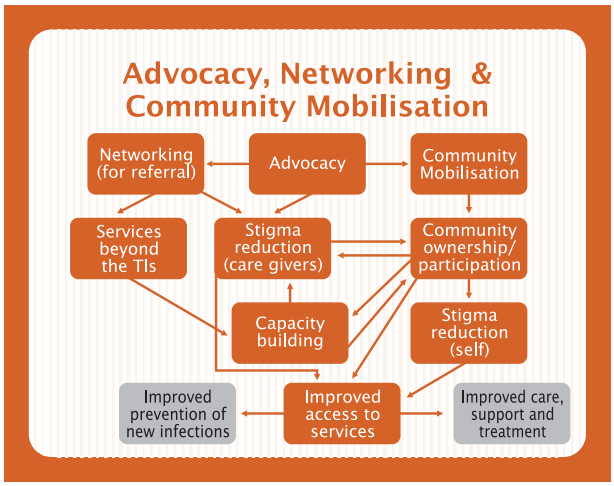
- Females as IDUs have greater challenges than the male
- Drug use among female more stigmatised than the male so more hidden
- Women due to social inequality in providing education, health care and employment have little or no power status in society, or social expectations.
- Biological factors like being physically less strong than men makes women vulnerable to physical violence.
- Biological make up of women make them more at risk of HIV and STIs.

IDUs NEED SERVCES

- IDU would require help regarding:
  - High-risk behaviours
  - Drug related issues
  - Co-morbidities
  - Many other areas of life

Step 3: **Conclusion**

- The facilitator concludes the session by highlighting the need for Advocacy, Referral Networking and Community Mobilisation to help reduce these vulnerabilities



Basics of Referral and Networking

OBJECTIVE

To provide participants with an understanding of the objectives of establishing referral and networking and the key principles.

EXPECTED OUTCOME

By the end of the session participants will have a:

- Clear understanding of the various terminologies associated with referral and networking.
- Also understand different activities required for referral and networking.

DURATION

75 minutes

SUGGESTED TRAINING METHOD

- Brainstorming
- Group activities
- PowerPoint presentation

MATERIALS / PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/whiteboard
- Chart papers
- Marker pens

PROCESS

STEP 1: **Brainstorm**

- Facilitator begins the session by asking the participants 'What do you understand by the terms referral and networking?' The responses are then listed on the white board/ flip chart.

- The facilitator should then consider using 'role-play' to show referral of a PWID to a hospital for abscess treatment.

The objective of the role-play is to give a quick background to the participants on how community feels about access to health services.

Role play one:

An IDU and a nurse talking one on one, where the nurse is trying to convince him to attend hospital for his abscess, which is becoming severe and needs hospitalisation. The IDU is reluctant to attend due to fear of stigma, discrimination and also expenditure, as he is not having family support.

Role play two:

Group of PWID gathering at hotspots: PE is educating/informing/talking about the referral network being developed for IDUs to access service with respect.

Note: Five minutes of preparation time is given to the participants.

Step 2: Group work

- The facilitator divides the participants into four groups and requests each group to take up one question from the following:

  1. Why is referral and networking important in the context of an IDU TI?
  2. Who all are benefitted through referral and networking?
  3. Who all are involved in ensuring that referral and linkages happen?
  4. Which are the service points to be involved in this referral and networking?

Note:The facilitator gives the groups five minutes for preparation and then requests each group to make their presentations.

Step3: Summarize

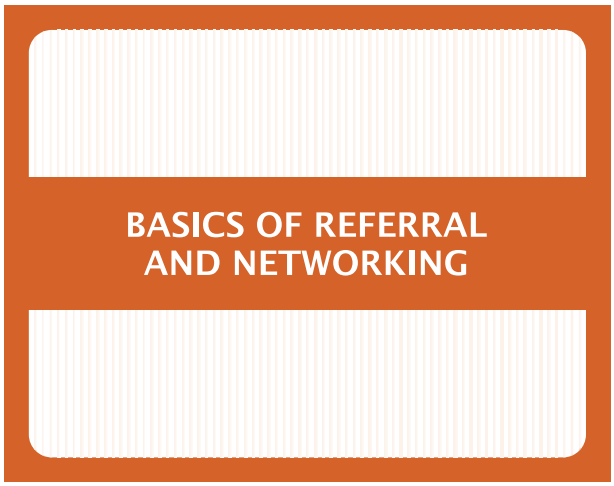
- The facilitator follows this up by summarizing the key issues discussed in their presentations.

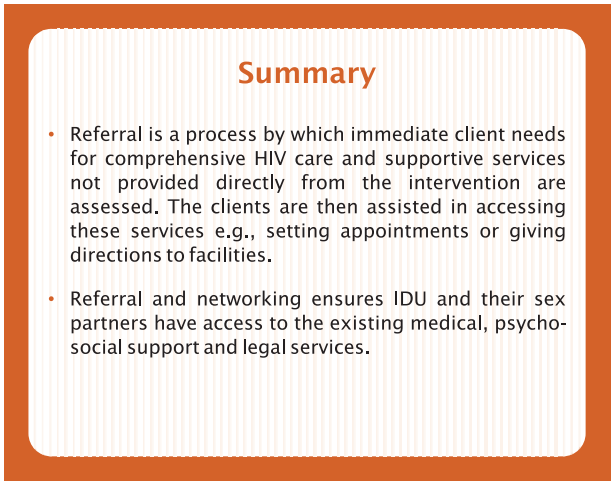
Step 4: Brainstorming

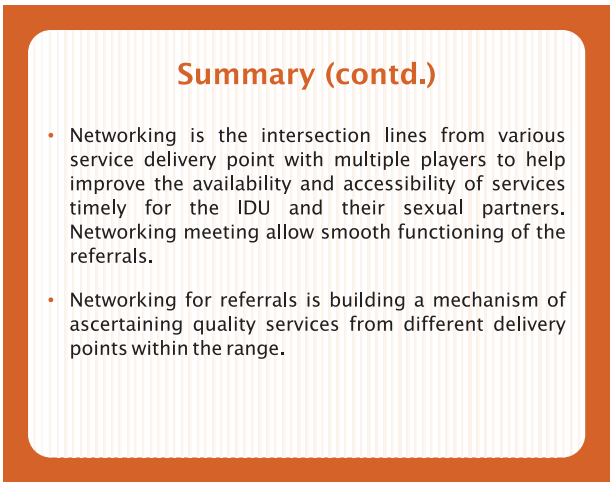
- The facilitator brainstorms with the participants and lists out the steps of starting referral and networking.
- The facilitator then follows up with a presentation on the steps of referral and networking.

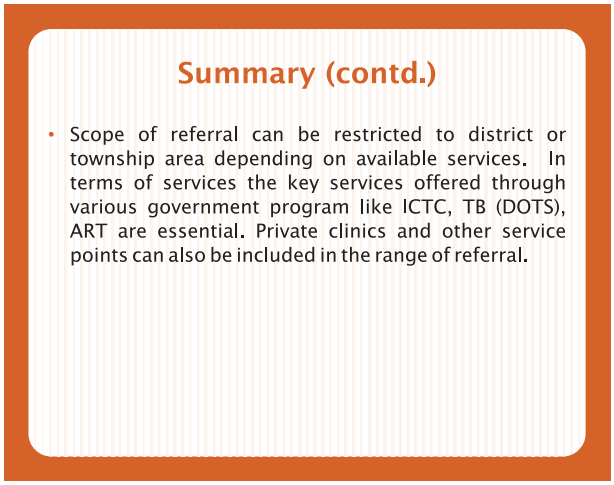
Step 5: Power point presentation:

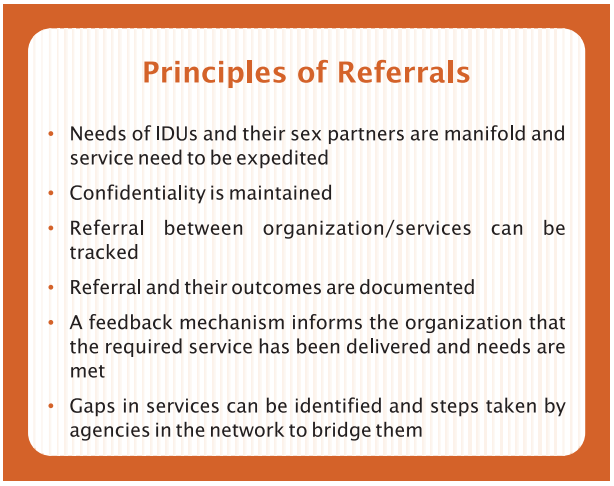
- After the discussion the facilitator uses the PowerPoint presentation to summarize the following points:







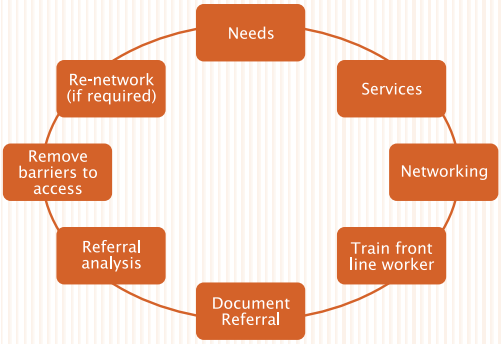




Potential Referral Points

- ICTC, ART, TB-DOTS
- Legal aid cell
- Hospitals for mental and other health issues
- Drug treatment centres, hospice
- Youth organizations
- ANC and maternity clinics
- Social services, churches, volunteers
- Charity organization, clothes and food donors
- Shelter Home for women & children
- Care facilities

Steps of Referral



Note for facilitator with power points:

1. The facilitator should focus on the following points: Referrals are important part of the TI as the needs of PWID are multifarious. Single TI or service providers have limited services to offer.
2. The facilitator may support his ideas through a PowerPoint presentation

Step 6: **Discussion**

- The facilitator asks the participants on the difference between referral and networking
- Present the following slide on the differences

Difference Referral and Networking

Referral	Networking for referral
Assistance, recommendation, transfer, appointment	Interacting, collaboration, supportive, helpful
The act of referring	Act of arranging referral system (plan)
May be done with referral paper to PWID to access certain places/services	Number of networking meetings (0ne-on one or as group) are indicators

Resource Mapping for Referral

OBJECTIVE

To help participants understand basic element of developing a resource map.

EXPECTED OUTCOME

- By the end of the session participants will have a clear understanding and knowledge of developing a resource map.

DURATION

90 minutes

SUGGESTED TRAINING METHOD

- Group work
- Power point presentation

MATERIALS / PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/whiteboard
- Chart papers
- Marker pens
- Feed back forms – Day 1

PROCESS:

STEP 1: **Group work**

- The facilitator divides the participants into four groups. The facilitator requests every group to discuss within their members 'Why is resource mapping necessary?'

Each group is requested to take turns to share their points supported with reasons

Step2:

- The facilitator summarizes all the key discussion points and frames it as one key objective.

Step3: Group work

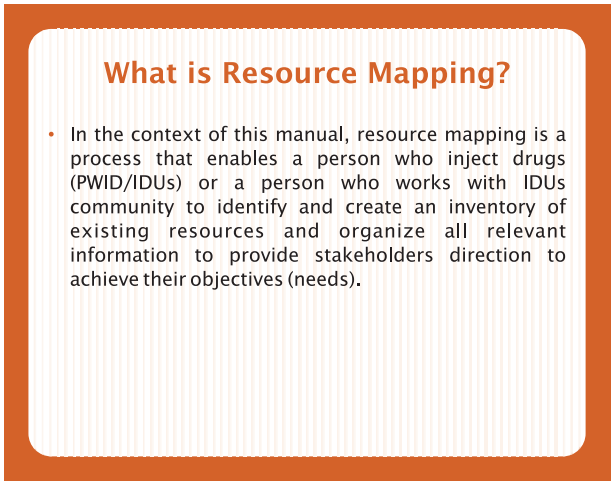
- The facilitator requests the groups to stay within the same four groups and discuss their experiences for the next 10 minutes.

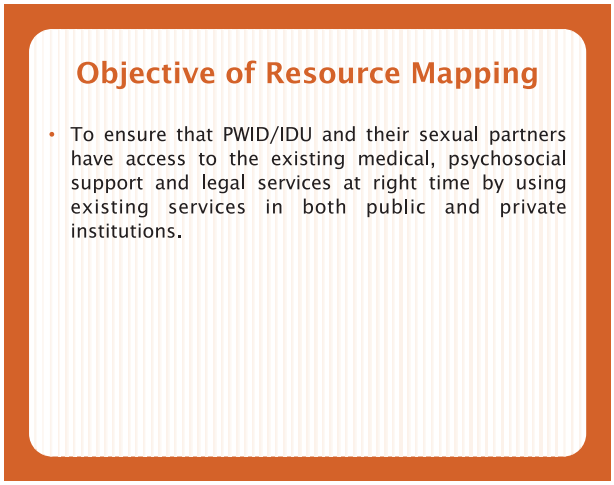
Group Work one (for groups 1&2): Draw a resource map and identify key elements in the mapping.

Group Work two (for groups 3&4): Prepare a resource directory. List the benefits, limitation and potential entities of using resource directory(for 10 minutes)

Step4: Presentation

- The facilitator then requests the groups to present their group work to the larger group. During the presentation the facilitator takes note of the major purpose and elements on a flip chart/white board.
- The facilitator then summarizes the purpose and elements with the help of a small presentation.





Elements of Resource Mapping

- Services needed
- Services available
- Places of services
- Is it accessible to the PUDs
- Contact person and details : phone numbers/emails
- Timing and days of the services
- Knowing the formalities like : procedure, papers, fees, etc.

Potential Entities of Networking

- Health care providers – ICTC, ART, DOTS, community care centers, hospitals, emergency, detoxification, diagnostics etc
- Legal AID cell
- Non medical services – nutrition, clothing, shelter in both public and private
- Vocational training institute
- Actors affecting enabling environment – police, NCB

Potential Entities of Networking (cont...)

- Religious groups
- Influential people
- Pressure group of community – student, women, anti drug etc
- Forums

Steps of Resource Mapping

- Participatory mapping exercise – PUD, PE, ORW, counselor, PM.
- Invite PUD to share their needs (list it).
- Identify key service points and barriers.
- Map traditional authority / structures that can be used to strengthen and expand networking.
- A directory of services.

Note to the facilitator :

- During the course of the PowerPoint presentation, the facilitator can reaffirm and stress on the points the participants already pointed out in the discussions to solicit participation and encourage them

As this is the last session of day 1, distribute the feedback forms (feedback form - day 1) and ask the participants to provide feedback for the sessions conducted through the day.

Day 2

Session One:

Establishing and Maintaining Referral Network

Session Two:

Referral Analysis

Session Three:

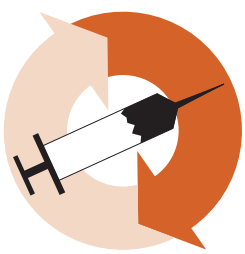
Understanding the Basics of Community Mobilisation

Session Four:

Facilitating Community Mobilisation

Session Five:

Understanding Advocacy



Establishing and Maintaining Referral Network

OBJECTIVE

To help participants understand the key steps, processes involved in maintaining of a referral network.

EXPECTED OUTCOME

- By the end of the session, the participants will understand the processes involved in establishing and maintaining referral network.

DURATION

75 minutes

SUGGESTED TRAINING METHOD

- Discussion
- Group work
- Power point

MATERIALS / PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/whiteboard
- Chart papers
- Marker pens

PROCESS:

STEP 1: **Group work**

- The facilitator divides the participants into four groups and requests them to take up the following role plays:

1. Many agencies attending the first meeting initiated by TI project to start up referral and network (key agencies include doctors, counsellor, diagnostics, PD, TI SACS).
2. A review meeting of referral network is being held.
3. An internal meeting of the TI to discuss the positive and negative points arising out of a first round referral meeting that was held recently.
4. An internal meeting of the TI to discuss the steps needed for keeping/sustaining the momentum of referral networking going.

The groups are given five minutes for preparation and three minutes per group for the role play.

Step2: Presentation

- The facilitator while discussing in detail shares the presentation on the essential elements of the referral network.

Regardless of different models used in different settings, there are certain essential elements that need to be in place to optimize the referral system's operational effectiveness and outcomes

- A group of organizations, which can complete provision of comprehensive harm reduction services to meet the needs of drug users and their sex partner/family. This is best done by health sector or by community groups.
- A unit or organization that coordinates and oversees the whole referral network. This may include the coordinating organization or unit, convening regular meetings, working service providers to address gaps, updating resource directory, providing standard tools and forms, ensuring/enforcing quality for referral system. Engaging one individual to fulfill the task can be more effective.
- Periodic meetings of networks providers.
- Designated referral person (s) at each organization/entities.
- A directory of services and organization within a defined area – state/district/township.
- Standard referral form.

Essential Elements of a Referral Network

- A group of organization
- Coordinating TI or NGO (role can be changed)
- Periodic meeting – equal chance to host
- Designated referral persons at each service points
- Resource directory
- Feedback to track services
- Documentation

- A feedback loop to track referrals.
- Documentation of referrals.

♦ **Presentation on "how to start referral and networking"**

The following steps need to be taken for establishing referral and networking in an area:

- Meeting of all relevant stakeholders in the area.
- Identifying service delivery points in the area.
- Resource mapping of locality, town and district.

How to start?

- Meeting of all relevant stakeholders
- Service/resource mapping
- Preparing directory – details
- Develop a system
- Mobilize community

- Preparing a directory – name of agency, details of service available, key person/ contact details etc
- Developing systems (viz. key contacts, agreed upon referral forms and procedures, referral registers, coordination meetings, client feedback etc.) and mechanisms to start with the referral and networking activities.
- Mobilize the community of people who inject/use drugs and their families to use, make others aware and support the referral network.

♦ **Presentation on maintaining the referral linkages**

Maintaining

- The initial meeting may not fully succeed in bringing the desired result. It is possible that multiple efforts may have to be made to establish a working relationship.
- Since the networking is seen as a two way process, extend all possible help to to look into the relevant interests of the referral agencies.
- Regular feed back by community using referral services.
- Detailed documentation in significant cases (both positive and negative) should be made.

Maintaining (contd...)

- Regular documentation and analysis of referral is important
- Regular meetings with stakeholders at operational levels to discuss barriers and challenges and means of overcoming them
- Regular monitoring and evaluation by PD/PM/OFP
- Thrashing out issues as soon as they are identified
- Involvement of higher levels of staff (PD/PM/OFP) as and when necessary
- Reporting to SACS and higher officials on issues beyond the control of the IDU interventions e.g. stigmatization by designated health care providers

- **Presentation on the roles and responsibilities of the personal involved in establishing referral networking**

Roles of Responsibility

Personnel	Roles & Responsibility
PD/PM/OST focal point	Initial and all high level meetings, planning and coordination, monitoring, evaluation, analysis
Counselors/ nurse	Team level and operational level meetings (at least once a month) with stakeholder counterparts (e.g. ART & ICTC counsellor)
PUD/IDU	Weekly, monthly meetings, representative to discuss issues and concerns of drug users related to referral

Step 3: Conclusion

- The facilitator concludes the session by highlighting following key messages:
  - Providing informed options to the client based on the resource map.
  - Meetings to share outcomes and challenges.
  - Analysis of referrals – gaps, challenges and effectiveness.
  - Changes to accommodate more referral or effectiveness.
  - Regular meeting should be conducted by the team with the referral agencies to ensure continuity of services.
  - Community mobilization – education on rights, universal access, safer behaviour means, legal processes etc.
  - Client feedback.

Referral Analysis

OBJECTIVE

To help participants understand the importance of and processes involved in referral analysis.

EXPECTED OUTCOME

- By the end of the session, the participants would know the 'why' and 'how' of conducting referral analysis.

DURATION

90 minutes

SUGGESTED TRAINING METHOD

- Brainstorming
- Power point

MATERIALS / PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/whiteboard
- Chart papers
- Marker pens

PROCESS:

STEP 1: **Brainstorming**

- The facilitator requests the participants to brainstorm on the following:
  - What is referral analysis?
  - Why conduct referral analysis?
  - How can it be done?
  - Who all are involved in referral analysis?

- The facilitator requests volunteers (preferably one for each question) to write down the responses to the individual questions on flip charts/chart papers.

Step 2 : **Role Play**

- The facilitator divides the participants into three groups; each group to do one of the following role plays showing "referral analysis" in action:

  1. A Focus Group Discussion (FGD) with referral service recipients
  2. A team from a TI visiting ICTC/ART to verify referrals done in last one month
  3. A team of ORW, PE, nurse, counsellor analysing last month's referral.

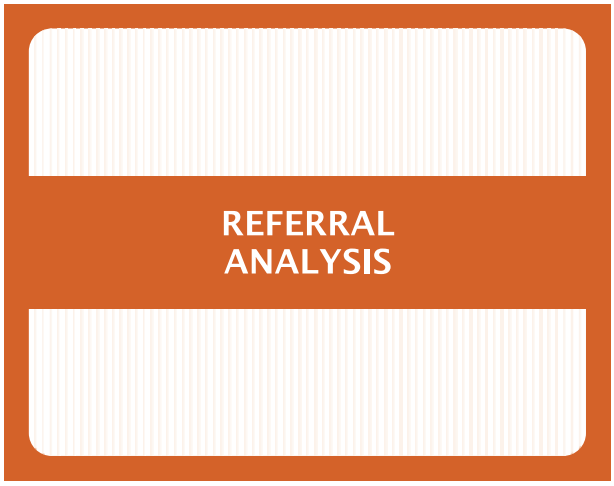
- The facilitator allots five minutes for preparation and three minutes for role play by each group.
- The facilitator follows up by discussing the key points taking examples from the role-play using flip chart or white board and bringing out the salient features of different types of analysis at different levels. He/she also links the point to the final objective of measuring/assessment to ensure that referrals are complete and effectively done with equal treatment.

Note: The role play should bring out the following points:

- The key issues to be discussed.
- The key action points to be decided upon based on the problems identified.

Step 3: **Presentation**

- The facilitator uses the PowerPoint presentation on referral analysis to sum up.



Referral Analysis

- Referral analysis is conducted to study/ examine and evaluate existing referral system for effectiveness.
- Effectiveness can be measured in terms of:
  - Meeting the needs.
  - Completing contact for service without stigma and discrimination.
- The referral analysis also looks into difficulties encountered in referring and also while accessing referred services.
- Referral analysis also helps identify problems in referral and initiates the process of seeking solutions.

Key Players

- PD/PM/OFP/Counsellor should facilitate the process of referral analysis.
- ORWs, PEs and the IDUs,
- Other agencies involved in referral should also be consulted.

Frequency:

- Analysis is done at least once a month preferably towards the end facilitated by project manager/counsellor and shared with the TI team.

Process / how

- Scan the referral register to check on the number of referrals made.
- Tally with the number of successful referrals to see what percentage of the referrals were completed with services received.
- Consult any other report/record/ case history generated.
- Conduct meetings with the ORWs and PEs about their feedbacks on referrals especially on the unsuccessful referrals.

Process / how (contd...)

- Conduct a small group meetings with the IDUs referred- assess quality of services received and the reasons for non completion of referral.
- Conduct meetings within the TI team with all the findings and discuss:
  - Success rates of referral
  - Reasons for non- completion
  - Barriers, if any
- Conduct meetings with the referral agencies to find out more.

Understanding the Basics of Community Mobilisation

OBJECTIVE

To understand the basic principle of community mobilization.

EXPECTED OUTCOME

- Participants shall be able to understand the basic principles related to and purpose of community mobilization.

DURATION

75 minutes

SUGGESTED TRAINING METHOD

- Brainstorming
- Group work
- Group discussion
- Power point presentation by the facilitator

MATERIALS / PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/whiteboard
- Chart papers
- Marker pens

PROCESS:

STEP 1: **Brainstorming**

- Facilitator begins the session by sharing the GIPA principle and the concept of "nothing about us without us" and introduces the role of community in HIV intervention.

Note to the facilitator :

GIPA: GIPA means the Greater Involvement of People with HIV/AIDS, and derives from a principle embedded in the Paris AIDS Summit Declaration of 1994. At this summit, leaders of 42 nations met together to determine how they could effectively respond to the AIDS crisis.

The Declaration, signed by all nations attending the meeting, acknowledged the central role of people living with HIV (positive people) in AIDS education and care, and in the design and implementation of national and international policies and programs, in order to successfully tackle HIV/AIDS. It also acknowledged that, for positive people to take on a greater role in the response, they need increased support.

Article 1 of the Declaration resolved to facilitate this greater involvement of positive people. It states that:

The success of our national, regional and global programmes to confront HIV/AIDS effectively requires the greater involvement of people living withHIV/AIDS... through an initiative to strengthen the capacity and coordination of networks of people living with HIV/AIDS... By ensuring their full involvement in our common response to HIV/AIDS at all - national, regional and global - levels, this initiative will, in particular, stimulate the creation of supportive political, legal and social environments.

The Declaration committed governments to develop and support structures, policies and programs to facilitate the greater involvement of positive people. This has since been adopted by UNAIDS as the GIPA Principle.

(APN+ Position Paper 2 –GIPA)

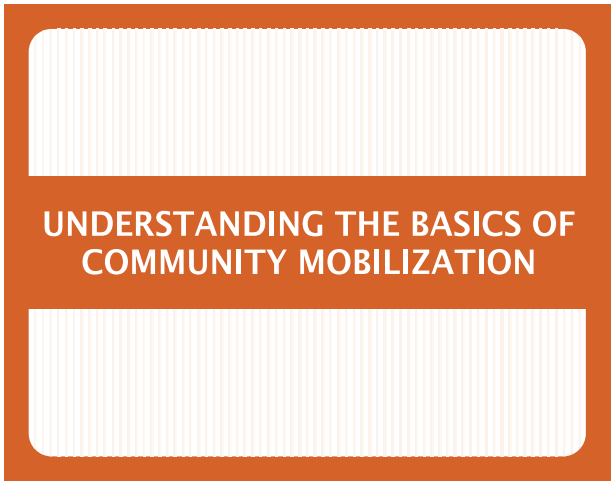
Step2: Group work

- The facilitator divides the participants into four groups and requests them to discuss the following and present:

  1. How does community mobilization help in Targeted Intervention program?
  2. What could be the challenges of community mobilization?

Step3: Presentation

- The facilitator summarizes using the power point presentation on Community Mobilization.



Community Mobilization

- A strategy for increasing demands for and use of health services, helps communities to identify their own needs and to respond to and address these needs.
- "Community", is defined as a group of people having something in common and will act together in common interest.
- Mobilization promotes needs of specific groups and localities, it also leads to greater sustainability, as communities are empowered and capable of addressing their own needs.

Community Mobilization (contd...)

- A capacity building process through which community individuals, groups or organization plan, carry out and evaluate activities on a participatory and sustained basis to improve their health and other needs, wither on their own initiative or stimulate by others.
- Community mobilisation should provide every community member with an opportunity to become a leader or representative in organisations/forums.
- Processes of community mobilisation and ownership building with IDUs should lead to collectivisation and establishment of community based organisations (CBOs).

Criteria to define Community Mobilization

- Community is actively involved in planning, implementing and monitoring and evaluation of the programme and is part of all levels of decision making.
- Community is adequately represented and involved at all levels.
- It is more than providing support service.
- More than a single event – meeting, workshop, but a continuous process.
- Driven by community and their needs.

Role of Community Mobilization?

- Improves the quality of TI program by strengthening the collective bargaining power of community.
- Ensures the sustainability of intervention by creating community ownership of intervention.
- Provides the community members with an opportunity to participate in collective decision making of various issues that affect the community through. This may involve establishment of successful democratic processes.
- Allow each community member an opportunity to lead/ become a leader.

Challenges

- Unique issues of PWID/PUD.
- Keeping ownership alive at community level.
- Achieving long term sustainability.
- Systematically mobilizing community in large area.
- Respond to peer driven needs.
- Monitoring and evaluation, collection of donor driven information.

Challenges (cont...)

- Judgmental by service providers.
- Bringing all in one platform.
- Unpredictable behavior of community.
- Low self esteem.
- Social and legal status of community.
- Lack of capacity in our community.

Facilitating Community Mobilization

OBJECTIVE

Learning how to involve PWUD in referral and advocacy and thereby creating space for their needs.

EXPECTED OUTCOME

- At the end of the session the participants would be aware of the processes involved in mobilizing the community.

DURATION

60 minutes

SUGGESTED TRAINING METHOD

- Brainstorm
- PowerPoint presentation by the facilitator
- Group work
- Discussion

MATERIALS / PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/whiteboard
- Chart papers
- Marker pens

PROCESS:

STEP 1: **Brainstorming**

- The facilitator opens the session by asking the participants ' How do you facilitate community mobilization?' and notes down the responses on the chart paper/flip chart/white board.

Note : Use the definition given in session FOUR of day two. Use the power point slide below to recall the definition of CM.

- Printed copies of a case study on community mobilization should be made available to the participants. The facilitator distributes the copies and requests participants to take five minutes to read.

Note to the facilitator :

MNP+ is a state level PLHA network in Manipur. In addition to the PLHA activities they also do intervention in prison to link PUD prisoners to ICTC and ART through linkages. The current OST program targets 200 PWID. The main objective of this OST is to link the OST client to ICTC/ART.

Strategies adopted by MNP

i. Formed a group called "Recovery Alliance" RA from OST service users in MNP

ii. Key decision making body is elected by the RA members

iii. They contribute money (nominal) into the group fund to be used for emergency, help other member when needed

iv. Regular basics session on OD, HIV & HCV by a physician. The visiting physician fee is given from the RA contribution

v. Physical and Psychosocial support to sick members either in hospital or at homes

vi. Support referrals like ICTC, ART work by the RA members

vii. RA members involve themselves in management of DIC, referral, activism activity, maintaining rules of the DIC, will make effort to solve issues related with RA members

viii. Other activities to support community mobilization:

   a. Home visits by ORW

   b. ORW visits ART and ICTC for follow up of referral and networking (weekly)

   c. Physical support when KPs are hospitalized

   d. Home detoxification, counseling

Some of the measurable indicators from their reports are:

- Total no of KP registered = 607 (cumulative); 317 drop out; 116 completed OST
- No of KP living with HIV = 234 (from 607, those who volunteered to test)
- Out of 234 = 143 are accessing ART, 91 are now pre-registered in pre-ART
- No of KP living with HIV & HCV = 152
- Total no of KP on OST = 171 (June 2012)
- KP regular on OST = 87 %
- KP who didn't turn up for OST last week = 13%

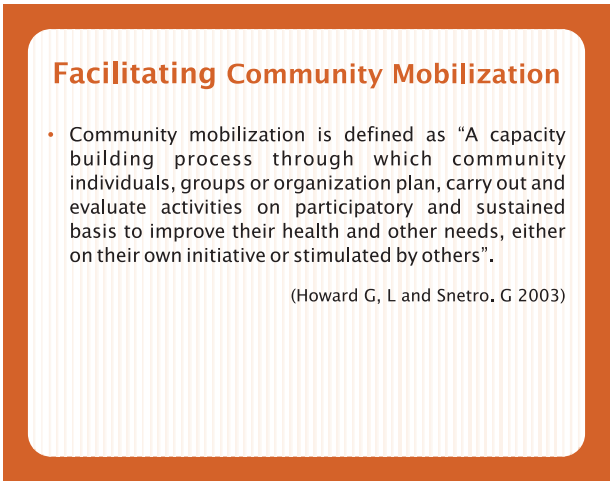
Referral Services: During outreach, IDU who need ICTC, medical help, STI treatment etc will be given referral slips. In addition, a list of referral doctors, ICTC, DOTS, detoxification, rehabilitation, PPTCT, primary health care centre, district hospital, STI providers will be developed for effective referrals. Support for the lab monitoring will be given to the clients who are living under poverty line. The outreach team will do follow up on referrals.

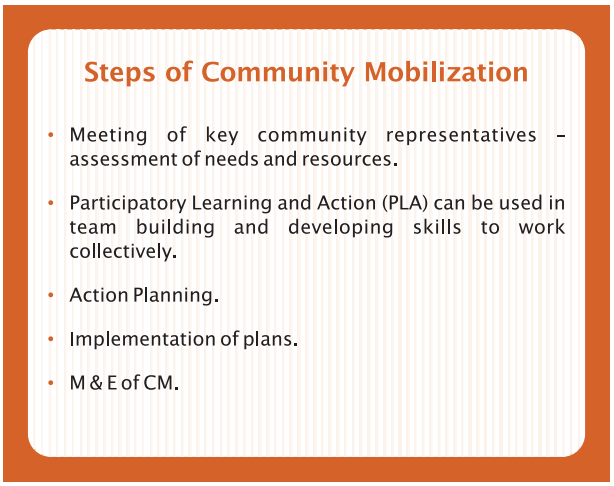
Service Delivery: Services provided through the Clinic have been broadly categorized as: (a) Health and medical care services which would include health monitoring for IDUs living with HIV, IDUs substitution treatment; (b) Psycho-social support including counselling, drop-in-facility, and building support groups; and (c) Outreach activities including Harm reduction, mapping, promotion of preventive behaviour, building referral/ linkages and advocacy and networking.

Step2: Presentation

- The facilitator uses the PowerPoint presentation to continue the discussion:

Community mobilization is a process of consulting with community, giving role in decision-making, management and building capacity.



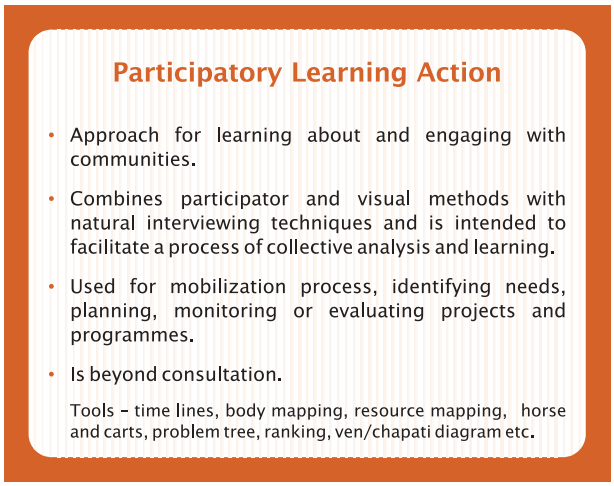


Step3: **Group work**

- Divide the participants into five groups and ask them to prepare notes on what they can do under each step. Each group will work on one step. Attention should be given more on the activities.

Step 4: **Presentation**

- The facilitator gives the presentation on the Participatory learning action:



Participatory action used can be used in the :

- Mobilization process
- To develop approaches and implement action plans
- For follow up on mobilization and action

- In community mobilization the role of implementing agencies shifts from more traditional one of teachers/advisor/leader to that of facilitator. Facilitator used the five steps (above) to mobilize the community,
- Presentation on the success of the community mobilization.

What Makes Community Mobilization Success

- Using PE to build community.
- Adequate time for the process.
- Define people, role, how.
- Recruit effective leaders, community rep and volunteers.
- Skillful facilitation.
- Understand sociocultural context.
- Develop activities in the context of larger social reforms.

Cont...

- Accommodate surprises.
- Demonstrate respect and non-hierarchy relationship.
- Work with established network.
- Optimize by involving local service providers and community reps in gathering information, advocacy.
- Training to build knowledge about legal issues.
- Support service to PUDs and their families.
- Specific measures to create supporting environment.

Understanding Advocacy

OBJECTIVE

To help participants understand the importance of advocacy in facilitating service delivery to the IDUs and their sexual partners.

EXPECTED OUTCOME

- By the end of the session participants will be able to identify types of advocacy and the importance of developing advocacy plans.

DURATION

75 minutes

SUGGESTED TRAINING METHOD

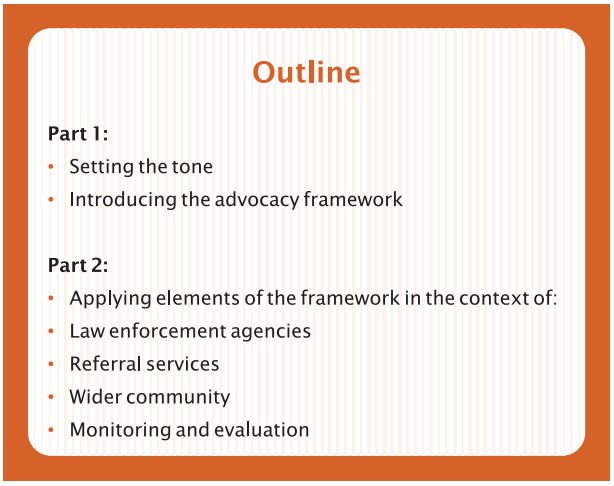
- Brainstorming
- Discussion
- Group work
- Role play
- PowerPoint Presentation

MATERIALS / PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/whiteboard
- Chart papers
- Marker pens
- Feedback forms – Day 2

Note to the facilitator :

The section on Advocacy opens with the slide below. It outlines the session plan over the second half of this training. Through the course of the six sessions that comprise this section, participants will be provided tools, check-lists and templates that may be adapted to address a range of advocacy needs and areas.



PROCESS:

STEP 1: Why is advocacy important in service delivery?

- The facilitator initiates the session with a brainstorming activity that should help participants understand the connection between advocacy and service delivery. He/she begins by asking the participants- Why is advocacy important to service delivery?'
- The facilitator then notes down the responses from the participants on a chart paper/flip chart/white board.
- He /she then follows up with the following discussion questions: "Why do we advocate? "How can advocacyhelp us deliver services better?"

Step 2: What is Advocacy?

- The facilitator asks the group, 'What are the different types of advocacy?' or, "What comes to mind when you hear the word 'advocacy'?
- Note down responses on the whiteboard/chart paper and then fit the responses into the categories in the box below:

- Activism (includes protests, sit-ins, marches, web/internet campaigns, petitions, etc.)
- Policy advocacy (includes high level meetings with government officials/monitoring bodies, UN level meetings/appeals to UN monitoring bodies, bilateral diplomacy, local government bodies, local institutions etc.)
- Legal recourse (law suits, appeals to international, national, or local courts)
- Community education (grass roots mobilisation, community awareness campaigns like concerts, sports events, etc., creating institutional partnerships)
- Others (which do not fall into any of the above categories).

- The facilitator then presents the slide on' What is advocacy?' and clarifies:

What is Advocacy?

Advocacy is a process to bring about change in the policies, laws and practices of influential individuals, groups and institutions. (International HIV/AIDS Alliance)

Advocacy is the combined effort of a group of committed individuals or organizations to:

1) Persuade all influential individuals and groups/ organizations through various persuasive activities as quickly as possible to adopt an effective approach to HIV/AIDS among injecting drug users, and
2) Start, maintain or increase specific activities to a scale where they will effectively prevent HIV infection among IDUs and assist in the treatment, care and support of IDUs living with HIV/AIDS (Burrows 2003).

He/she guides the discussion using the following questions:

- Do these definitions capture what advocacy means to you?
- What would you add or detract from this definition to fit your experience of advocacy?

STEP 3: **Understanding the importance of planning for advocacy**

- The facilitator informs the participants that now they will do group activity

Note to the facilitator :

- If the group is experienced in advocacy, then Activity 1: i.e., Experience sharing is a good way to draw on real examples.
- If the group is not experienced in advocacy, then Activity two i.e.: Role play is an effective way for making participants understand by putting them in the position of someone else including someone they would be advocating to.

Activity one: Experience sharing.

- The facilitator divides the participants into four groups and presents the following:

Group 1 and 2 discuss among the group members on the experiences of successful advocacy and share with the larger group. The facilitator uses the following question to facilitate group discussion

'What was successful and why?'

Group three and four discuss experiences of unsuccessful advocacy to share with the larger group. The facilitator uses following question to facilitate the group discussion

'What did not work and why?'
OR

Activity two: Role play- Planning for advocacy.

- Choose a large group of participants (4-10) to act out the following role plays.
- Role cards (annexure- 1.1) should be written or printed out before hand and given to the volunteers.

The background to the role play:

An IDU in your district reported to a district hospital after experiencing stomach pain and was turned away after a nurse noticed track marks on his arms. The following week, he reported the incident to the district PLHIV network manager at an open forum, who decided that the incident added to a number of other similar incidents and demanded a response.

Role play one: Unplanned advocacy

One participant plays the role of the medical superintendent, another participant plays the PLHIV network manager and the rest of the participants play network members. The Network Manager and members aggressively confront the medical superintendent. Participants should be encouraged to choose from "aggressive" type advocacy activities defined in Step two, such as protest, march, etc. Other participants can join in other roles as needed (ie. police men, sympathetic community members, etc).

Role play two: Planned advocacy

One participant is the IDU, presenting the case to another participant. The network manager and other network members, suggesting aggressive activities like those done in the first role play. This time, the network manager is encouraged to suggest to plan a strategic advocacy strategy. Participants should then discuss and explore what is needed for a planned advocacy strategy including evidence (what kind of evidence is needed to present this case thoroughly to the medical superintendent?), who are other stakeholders (reporters, other community members, etc). After collecting evidence and organizing their story, the group presents the case to the medical superintendent in a formal meeting. Other participants can join is as needed (i.e, more reporters, other victims of discrimination, the accused nurse, etc.)

STEP 4: Summarizing the Main learning

Summarize the session by giving following key message to the participants:

- Careful planning is the key to successful advocacy.

As this is the last session of day 2, distribute the feedback forms (feedback form -day 2) and ask the participants to provide feedback for the sessions conducted through the day.

Day 3

Session One:

Developing Advocacy Strategies

Session Two:

Advocating with Law Enforcement Agencies

Session Three:

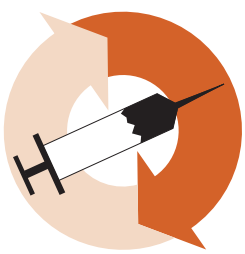
Advocacy to Facilitate Referral

Session Four:

Advocacy with Community

Session Five:

Monitoring and evaluation of Referral & Networking, Community Mobilisation & Advocacy



Introduction to Day 3:

Note to the facilitator :

- Introduce the day ahead to the participants in the following manner:
- "Today we will focus on advocating with three specific groups- the wider community, law enforcement and referral agencies. Interacting with these groups is imperative to ensuring comprehensive and high quality services for IDUs.
- In each session, we will use different tips and approaches to help develop and guide planning for advocacy. All these tips and approaches can be used in all kinds of advocacy. Consider them tools in your advocacy toolbox. We shall be using one case study for the rest of today's sessions'.
- The facilitate then distributes the case study to the participants.

Case-study:

An NGO takes up a new intervention project to provide harm reduction services to injecting drug users (IDUs) for the first time in XYZ town. Recent estimates show that there are more than 1000 IDUs in XYZ town. The Drop-in center (DIC) is located in a quiet, residential area. Within a week, a large number of drug users start coming to the DIC to access clean needles and syringes and other services provided there, often spending long hours in and around the premises. The following week, residents of the locality get together to demand the closure of the DIC as the drug users frequenting the locality pose a potential threat to the safety of the residents. A few days later, two Peer Educators (PEs) are picked up for questioning by the police as they were found to be distributing needles and syringes and were therefore suspected of peddling drugs. Some of the project staff members rush to the police station and manage to obtain the release of the PEs, but their request to meet the higher authorities is turned down. The next day, three drug users who have been regularly visiting the DIC are threatened and beaten by some members of a local youth organization. This is meant to serve as a lesson and a warning to stop using drugs. When the injured drug users go to a nearby health centre to get their wounds attended to, they are made to wait till all the other patients have left. Soon afterwards, DIC attendance falls drastically as most of the drug users believe that they will be identified and targeted as drug users if they are seen going to the DIC. The NGO now faces the challenge of being forced to suspend operations.

Developing Advocacy Strategies

OBJECTIVE

To help the participants understand the steps of developing effective advocacy strategies.

EXPECTED OUTCOME

- By the end of the session, participants will be able to recall, describe and apply the steps that go into planning and developing advocacy strategies/initiatives.

DURATION

75 minutes

SUGGESTED TRAINING METHOD

- Group work
- PowerPoint presentation
- Discussions

MATERIALS / PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/whiteboard
- Chart papers
- Marker pens

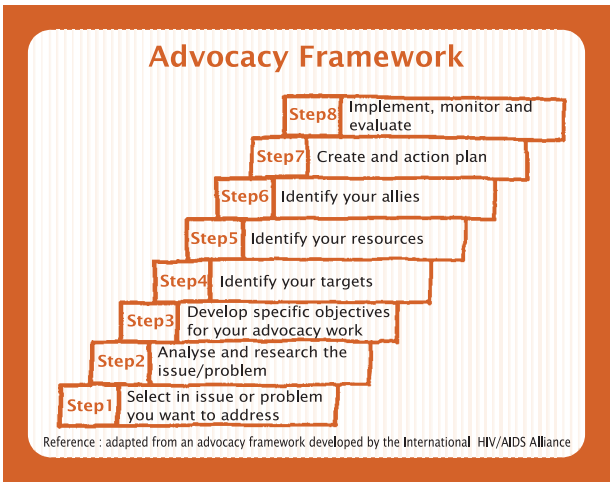
PROCESS:

Step1:

- The facilitator informs participants that in this session they will be looking at the steps involved in developing advocacy strategies. The framework used here will be used as reference through all the following sessions.
- For this session, the focus will be on the first three steps that will lead to pin-pointing key advocacy objectives and developing effective messages. At the end of the session, a check-list will be handed-out to the participants.

STEP 2: **PowerPoint presentation and discussions**

- Using the slide below, the facilitator introduces the advocacy framework and briefly explains the context for each of the steps, if possible, incorporating relevant examples from the previous day's examples (Experience sharing or Role play):



- The facilitator describe the steps using the notes below, focussing on steps one to three and inform participants that the remaining steps will be addressed in the following sessions:

1. **Select an issue or problem you want to address**
   - Prioritize the most urgent issue requiring advocacy efforts, for which you have the appropriate resources and knowledge. Being able to prioritize advocacy issues makes it easier to gain support and resources during the planning and implementation process.
   - Discuss why you want to take up the issue and what you hope to achieve.
2. **Analyze and research the issue/problem**
   - Gather as much information about the issue as possible.
   - What are the key areas that you want to focus on? Are there any existing advocacy efforts to address the issue? How much documented evidence is available?
   - What kind of evidence can be used for advocacy?
     - Physical evidence (includes photographs)
     - Testimonies (from those directly affected or bystanders)
     - Official records (medical records, police records)
     - Correspondence (emails, letters sent, letters received)
     - Any others?

- How can these be used?
  - Establish a record of consistent neglected or discriminated clients
  - Provide evidence of abuse
  - Support legal recourse
  - Any others?

3. **Develop specific objectives**

- The advocacy objective should be clear and focused. While developing objectives one must consider resources, timing, and the level of experience of the people doing the advocacy.
- It should be a specific statement that clearly describes particular results that will be pursued within a specific period of time. Good objectives are 'SMART'—Specific, Measurable, Achievable, Realistic and Time-bound.

4. **Identify your targets**

- Primary target audience includes decision makers who have the authority to bring the desired change.
- Secondary target audience includes persons who have access to and are able to influence the primary target audience, such as other policymakers, community leaders, friends, relatives, the media, religious leaders, etc.
- Identify individuals in the target audience, their positions, a relative power base and then determine whether the various individuals support, oppose or are neutral to the advocacy issue.

5. **Identify your resources**

- Resources can include people and funds, although not all advocacy initiatives require funding.
- What are the resources you have within the organization? Can you also access external resources?

6. **Identify your allies**

- Potential allies may include other organizations or community groups.
- Building a wide support-base is essential, as working in collaboration with other partners can help while pulling together resources, approaching decision makers and rallying supporters.

7. **Create an action plan**

Put together an action plan to guide the advocacy initiative. This should include details of activities, time-lines and allocation of responsibilities. (Please refer to template ahead)

Sample Check-list

Issue	Evidence	Objective desired	Who is it aimed at? (Targets)	Resources & Allies	Activities with Timelines	Monitoring activities	Person(s) responsible
✓	×	✓	✓	✓	×	×	×

(Adapted from: Beyond the Barricade: Advocacy Manual, Indian Network for People living with HIV/AIDS)

8. Monitor and evaluate

- Build in monitoring and evaluation as an on going component to the advocacy strategy.
- Periodically review each step in your advocacy plan and determine whether it was implemented effectively, or if there are course-corrections required.

(Source: International HIV/AIDS Alliance; Beyond the Barricade: Advocacy Manual, Indian Network for People living with HIV/AIDS; DAPCU training manual, NACO).

Note to the facilitator :

- Introduce the check-list for advocacy and provide pre-printed copies of the table above also provided as hand-outs (Annex 1.2).
- Explain that this check-list can be used in most situations requiring advocacy; and that it can also be used as an action-plan template.

STEP 2: Putting it all together:

- The facilitator shares printed copies of the above sample check list with the participants.

STEP 3: Discussion on developing effective advocacy messages

- Advocacy messages are developed to frame the issue and persuade the receiver to support your cause. There are three important questions to answer when preparing advocacy messages:
  - What type of people is this message for; what do they already know?
  - What do you want to achieve through the message?
  - What do you want the recipient of the message to do as a result?

STEP 4: Group brainstorming

- Ask participants to suggest different kinds of activities that might be used in an advocacy initiative. Record ideas on a flip chart/chart paper for display

Sample responses: *Meetings, workshops, interpersonal communication (IPC), music or drama performances, marches and rallies, sports events, mass media (cable TV, radio, newspapers).*

- Ask participants to suggest different types of materials that could be developed and distributed during an advocacy initiative. Record ideas on a flip chart/chart paper for display.

Sample responses: *Fact sheets, personal testimonies, newspaper reports, apparel (T-shirts, caps, etc with appropriate messages), brochures, banners, posters.*

STEP 5: Activity: Understanding your audience

- The facilitator prompts the group to think about a particular audience in order to decide which kinds of activities and materials can be used in an advocacy campaign.
- Facilitator puts up the slide as given in the table below. The slide displaying appropriate characteristics agreed upon as a group.

Developing Effective Advocacy Messages

Size: Large Medium Small	**Social and political standing:** Government official Community/religious leader Community member
Literacy: Literate Low-literacy	**Access to media:** Adequate access Little access
Age: Young Middle-age Elder	**Knowledge about issue:** Knowledgeable Little knowledge

- The facilitator divides the group into four smaller groups and hands out copies of the worksheet below (from Annexe 1.3). Ask each group is asked to select a particular audience for advocacy and fill the worksheet in together.

Sample filled-in template (using scenario presented at the start of the session):

Target Audience	Example: Nursing staff of District Hospital
Characteristics	Medium, literate, young and middle aged government officials/employees with adequate access to media and little knowledge of issues around Harm Reduction
Appropriate activities	Meetings, workshops, IPC, cable TV messages
Appropriate materials	Fact sheets, personal testimonies
Key message	Treat patients who are drug users as you would treat regular patients
(Adapted from Family Care International: An Advocacy Training Guide, 2008)	

STEP 4: Summarization

- Summarize the session by giving following key message to the participants
  - Advocacy is a process that needs to be strategically planned in order to be effective.

Advocating with Law Enforcement Agencies

OBJECTIVE

To make participants understand the key approaches in advocacy initiatives with law enforcement agencies.

EXPECTED OUTCOME

- By the end of this session, participants will identify and apply basic approaches in advocating with law enforcement agencies.

DURATION

75 minutes

SUGGESTED TRAINING METHOD

- Group work
- PowerPoint presentation
- Discussions

MATERIALS / PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/whiteboard
- Chart papers
- Marker pens

PROCESS:

Step1: Discussion

- The facilitator opens the session by asking the following questions:
  - Why is it important to work with law enforcement agencies?
  - Do you think they are for or against the work that you do?
- Enumerate the main law enforcement agencies that you encounter in their line of work.

Note to the facilitator :

Give examples of law enforcement agencies (central or state agencies)

- Police
- Excise
- Narcotics control
- Intelligence bureau
- Paramilitary forces

- Based on the discussion, the facilitator uses the following slide as an example of a good practice:

Good Practice : Police and harm reduction in the UK

- Needle and syringe vending machines in police stations.
- Not arresting IDU in possession of sterile needles and syringe in public places.
- Not prosecuting drug workers who provide drug paraphernalia to clients.
- Not seizing condoms from sex workers as evidence of sex work.
- Supporting the establishment of drop-in centers and community based services where drug users can be educated, receive health services etc.
- Referring arrestees from the police station to drug and HIV services.
- In cases where users swallow drug in an attempt to avoid arrest, police are instructed to take the person directly to hospital.
- In Performance indicators- number of persons referred to drug services.

(Source: Geoffrey Monaghan, Regional Drug and HIV/AIDS expert. UNODC Regional Office *for Russia and Belarus)*

STEP 2: **Presentation on the advocacy targets**

- The facilitator asks the participants who should be advocacy targets, referring to the case study that was introduced at the start of the day
- Facilitator sums up the discussion by presenting the following slide while explaining the key points

Understanding Structures

1. **Operational level:** more likely to come into contact with project staff, Peer Educators and IDUs
2. **Middle management:** those responsible for management and supervision of the operational police
3. **Senior level:** those who are involved in policy making and strategic planning at state or regional level

Operational level: Project staff should establish locallevel rapport with operational police. For a new advocacy initiative, it is recommended that initial contact should be made with middlelevel police from the region, who can organize meetings with operational police and will have the authority to make quick decisions to be followed up.

Middle management: Initiate local level agreements as police at this level can make decisions on actions to be implemented at the operational level. They will often be the ones to represent the department at meetings, committees or working groups.

Senior level (state or regional level): Recommend that Harm Reduction activities be included in police planning processes, adopt HIV work-place policy, include Harm Reduction in syllabus of police training institutes. As police at this level may prefer to talk to people of their equivalent in terms of responsibility or rank, it is wise to enlist the support of senior executives or supportive senior police from other districts or states.

STEP 3: **Understanding how to work with the police**

- The facilitator requests the participants to form two groups and select two representatives each to debate for and against the following statements:
  - 'Police must enforce the law'.
  - "Harm reduction sends the wrong message".
  - "Drug users should not receive special assistance".
  - "Ideas from western (or developed) countries are unsuitable in this country".
  - "Harm reduction activities encourage drug use"

Each group discusses and collates points for their representatives on the basis of the above statements. Speakers from both groups are given one minute each to argue and defend their cases. The purpose of this exercise is to help participants understand the value of seeing issues

Note to the facilitator :

Following the exercise, supplement wherever necessary with points from below:

"Police must enforce the law".

Suggested response: International evidence shows that fear of arrest is often stronger than fear of acquiring HIV – so drug users are likely to take greater risks in injecting drugs when they fear arre st. There are many examples of where the law is enforced with some discretion. It may be worthwhile to suggest that redirecting resources away from relatively minor offences such as possession of drugs by users towards more harmful practices such as trafficking may have better outcomes for the police and community because the supply of drugs will be reduced.

"Harm reduction sends the wrong message".

Suggested response: Implementing harm reduction does not imply 'weakness' or being 'soft on drugs'. All countries that have implemented this approach continue to have strong policies on reducing the supply of and the demand fro drugs. A balanced and comprehensive approach is needed to allow a government to maintain control over drug use by its citizens and prevent an HIV epidemic among drug users.

"Drug users should not receive special assistance".

Suggested response: Harm reduction activities ensure that a society prioritizes HIV prevention among drug users to protect the health of all members of society. To ensure that health insurance premiums do not have to rise, to ensure that hospital beds are available for the frail and elderly; instead of all resources having to be used to bear the cost of treatment for people that we couldn't prevent from getting infected.

"Ideas from Western (or developed) countries are unsuitable in this country".

Suggested response: Because it was possible that these approaches would not be effective in this country, pilot programs were introduced. These programs have shown harm reduction to be effective in this country in reducing the spread of the virus and have therefore been taken up by the government in the National AIDS Control Programme.

"Harm reduction activities encourage drug use".

Suggested response: Scientific evaluations and research have established that Harm Reduction programs effectively reduce the transmission of HIV, Hepatitis B, C and other blood-borne viruses; reduce sharing of injecting equipment; do not increase the amount and frequency of drug use; do not lower the age of first injecting; address the issue of safer sex; provide primary health care services, counselling and testing for HIV/STI/blood borne viruses; spread health information; act as an effective bridge for people needing detoxification, treatment and opioid substitution therapy; and are cost effective.

(Adapted from: HIV/AIDS Asia Regional Program, Law Enforcement and Harm Reduction Manual).

- The facilitator briefly discusses the following steps in dealing with police:
  - Visit police station to introduce field-level work and key project staff.
  - Place IEC materials in police station and offer to provide further information.
  - Police agree to refer drug users to services.
  - Focus on safety for police For example: safety measures such as disposal of needles, first aid for needle-stick injuries, contact with blood products.
  - Invite police to visit DIC at appropriate times – for instance at program organized at DIC.

- Provide feedback to police about successful cases.
- Ensure that fieldstaff carry identity cards at all times.

STEP 4: Summarization

- The facilitator summarize the session by giving following key message to the participants:
  - Supply reduction, demand reduction and harm reduction approaches can coexist and compliment each other to reduce drug related harm and control the spread of HIV.

Advocacy to Facilitate Referrals

OBJECTIVE

To help the participants:

- Understand the importance of making referral agencies your allies.
- Identify, analyze and map relationships with people in power (advocacy targets).

EXPECTED OUTCOME

- Participants will be able to use a power map to identify advocacy targets and allies.

DURATION

60 minutes

SUGGESTED TRAINING METHOD

- Brainstorming
- Group discussion
- Group activity

MATERIALS / PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/whiteboard
- Chart papers
- Marker pens

PROCESS:

Step1: Introduction to advocating with referral agencies

- This session will help participants begin to think about target audience and messaging.

Step 2: **Group brainstorming**

- The facilitator guides a discussion on why referral agencies are important using the questions below. He/she should focus on the fact that ultimately we make referrals in order to increase access to services for IDUs and HIV+ individuals and help reduce the spread of disease.
  - Why do we make referrals?
  - Why should we advocate with referrals agencies?

Note to the facilitator :

- Sample answers to question for brainstorming:
  - To ensure stigma free services for clients; to ensure comprehensive health and lifestyle support for clients; to ensure institutional support for clients.

- The facilitator asks the participants how do they define referrals services:

Note to the facilitator :

- This will help participants think more concretely about the target audience and issues faced by clients such as:
  - What kinds of referrals do TIs make?
  - Do clients have particularly good/bad experiences with any of these agencies?

Step 3: **Group activity**

- The facilitator splits the participants into four groups and requests them to share experiences both good and bad while advocating with referral agencies.

Questions to consider:

- What is the problem experienced? (define the issue)
- Was the type of advocacy used appropriate?
- Did this situation exhibit proactive planning? Identify where it was used/could have been used.
- What would have achieved a better outcome?

Note: In the absence of personal cases, use the case study from the previous session:

STEP 4: **Power mapping**

- The facilitator defines 'power mapping' as a way to identify key factors who have influence or power over a situation. Power mapping helps to identify who needs to be influenced and defines your influential relationships with those in power'.

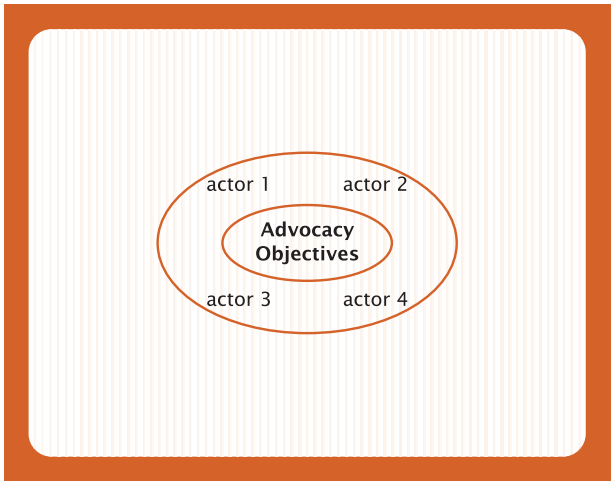
Note to the facilitator :

- Present this as one of the tools to help locate targets for advocacy. We will learn about this tool and use it for referrals

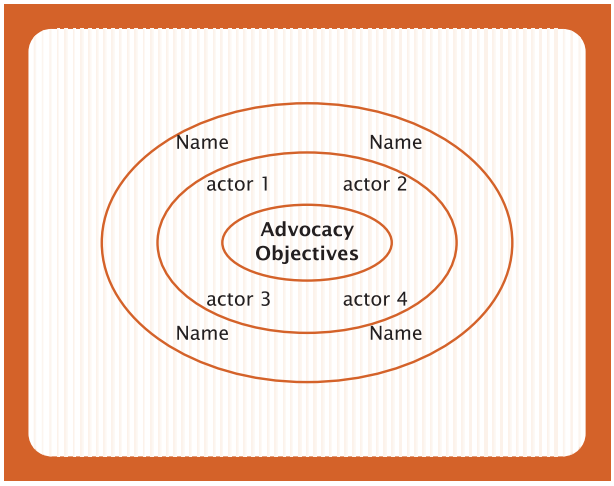
- The facilitator provides a detailed explanation of how power mapping is done through the following slides:

Pick a case study used before (either a hospital stigma case, or an example used by participants) and define the advocacy objective.

Write the advocacy objective in the centre of the chart paper and draw a circle around it.

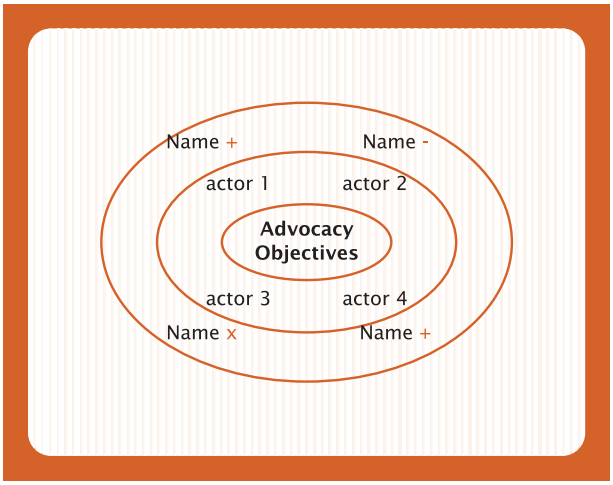


Identify the key decision-making institutions/actors and write these names around the outside of the advocacy objective. Draw a ring around these names.



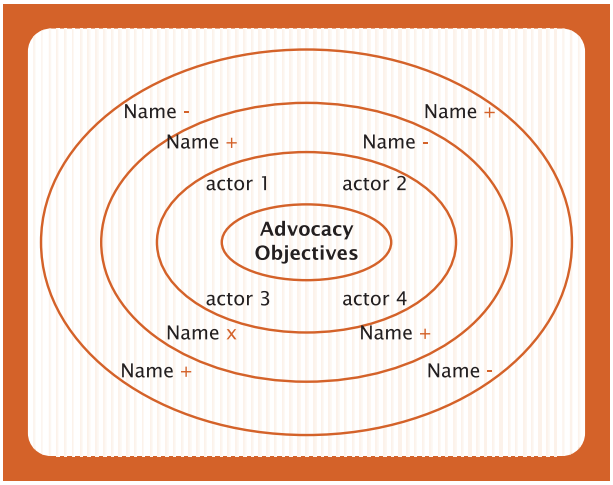
Brainstorm one or two names of people or positions associated with these institutions/actors (for example, District Medical Officer, or the name of the specific DMO). Draw a circle around these institutions/actors.

Discuss relationships with these individuals. If they are supportive, put a (+) next to their name. If they are neutral, put a (–) next to their names. If they are not supportive, put an (x) next to their names. Draw a third circle around these names and relationship markers.



Brainstorm people who have connections or relationships with these individuals. Write their names on the outside of the third circle and decide whether these people are supportive (+),neutral (-) or opposed (x).

Identify if there are any personal connections to these individuals.



Note to the facilitator :

- Ask participants to review the skills they have gained up till this point against the checklist provided during the second day's last session. What has been addressed?

STEP 5: **Summarization**

- The facilitator then summarize the session by giving the following key message:
  - Know your targets and allies.

Advocating with Community

OBJECTIVE

To enable the participants to comprehend the basic elements of:

- Understanding and dealing with opposition.
- Identifying appropriate advocacy activities and materials for advocacy initiatives with the community.

EXPECTED OUTCOME

- By the end of this session, participants will be able to describe and apply the basics of a well-planned community advocacy initiative.

DURATION

75 minutes

SUGGESTED TRAINING METHOD

- Group work
- PowerPoint presentation
- Discussions

MATERIALS / PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/whiteboard
- Chart papers
- Marker pens

PROCESS:

Step1: Discussion

- The facilitator opens the session by initiating a brief round of experience sharing on the following question:

- 'What kind of challenges do we face from different sections of the wider community?'

- Taking a cue from the case-study introduced at the beginning of the session, he/she facilitates discussion around the following questions pertinent to the hostility from the residents of the locality of the DIC:
  - What went wrong?
  - What would have done to prevent some of the negative situations?
  - What kind of advocacy initiatives can be taken up to control the damage?
  - With whom and how?

Note to the facilitator :

- Note the points from the ones given below prior to the discussion; and ensure that the relevant points are covered during the course of the discussion.

STEP 2: **Dealing with opposition**

- Although it is not easy to deal with opposition, a direct and well thought-out strategy can be critical to the success of an advocacy initiative. Key approaches for dealing with the opposition include:
  - **Being prepared:** Identify in advance, which individuals or groups might potentially oppose the advocacy initiative and give reasons .
  - **Listening to their concerns:** Listen to the other side of the issue and understand what causes them to disagree; identify counter-arguments that will be effective in changing their views or addressing their concerns progressively.
  - **Providing clear and accurate information:** People form opinions based on the information that they have – providing them with relevant, evidence-based information may help change their opinions.
  - **Forming networks and partnerships with other organizations:** Build on the contacts and networks that you have – extensive community support and participation demonstrates the popularity of a program and may help generate broader support.
  - **Thinking strategically:** Before seeking to convince people who may disagree, concentrate on an opinion-leader who is likely to be supportive and use his or her support to convince others.
  - **Choosing persuasive messages:** Different types of information convince different groups of people. Focusing on the areas where people agree with the goals will help build common ground.

- **Looking for alternatives**: Sometimes, despite best efforts, advocates may be unable to convince an influential person. In such a case, look for other ways of reaching goals by exploring other channels that may provide the next best option.

STEP 3: Developing an action plan

- The facilitator asks the participants to refer to the casestudy at the beginning of the day and to identify the different audiences from the wider community towards whom advocacy initiatives would be aimed.
- The facilitator divides the participants into four groups and selects one target audience for each. Using the tools discussed in earlier sessions (such as the check-list/action plan template: Annexure: 1.2), requests the groups to develop action plans for advocacy with the target audience.

STEP 4: Summarization

- The facilitator summarizes the session by sharing the following key message with the participants:
  - Invest time and efforts to understand opposition so as to develop effective and appropriate strategies.

Monitoring and Evaluation of Referral & Networking, Community Mobilisation & Advocacy

OBJECTIVE

To help the participants understand importance of monitoring, referral & networking, community mobilisation & advocacy

EXPECTED OUTCOME

- The participants understand the importance of monitoring and learn how to use different tools to monitor referral & networking, community mobilisation & advocacy.

DURATION

60 minutes

SUGGESTED TRAINING METHOD

- Discussion
- Group activity
- PowerPoint presentation

MATERIALS / PREPARATION REQUIRED

- White board/flip chart
- Chart papers
- Marker pens
- Power point presentation
- LCD Projector
- Laptop

PROCESS:

Step1: **Discussion**

- The facilitator introduces the topic and explains 'monitoring' and its 'purpose' in the particular context.
- The facilitator uses a flip chart to list all the key words followed with discussion.

Step 2: **Presentation**

- The facilitator then gives presentation on monitoring and evaluation

MONITORING AND EVALUATION OF REFERRAL NETWORKING, COMMUNITY MOBILISATION & ADVOCACY

What is Monitoring?

Monitoring is a continuous process of systematic collection of data on specified indicators to provide the management and the main stakeholders of an on going development intervention with indications on the extent of progress and achievement of objectives

It allows to continuously improve the program at each stage

What is Evaluation?

Evaluation is judgment:

- made of the relevance, appropriateness, effectiveness, efficiency, impact and sustainability of development efforts,
- based on agreed criteria and benchmarks among key partners and stakeholders.

Evaluation:

- involves a rigorous, systematic and objective process in the design, analysis and interpretation of information to answer specific questions;
- provides assessments of what works and why;
- highlights intended and unintended results and provides strategic lessons to guide decision-makers and inform stakeholders

Why Monitor?

- To understand its progress - in terms of the numbers referred and those accessed the referred services
- To identify the barriers and challenges if any and seek solutions

Step 3: **Group Work**

- The facilitator divides the participants into three groups and requests them to discuss the processes that will be involved in monitoring of referral networking, community mobilisation & advocacy, the staff who shall be involved and the indicators.

Probable answers:

Processes/Activities Referral Networking	Purpose	Personnel responsible
Checking records- Referral slip / referral registers/PE daily diary cum tracking sheet / ORW field visit diary	To know the number of referrals , completed/ incomplete referrals, follow ups etc.	Counselors
Field visits/focus group discussions with the IDUs	To learn about the issues related to the IDUs- the quality of service received and the challenges faced	PM/ORW
Team meetings- fortnightly	To take stock of the referral status and plan follow up	PM/Counselors
Meetings with referral partners	To discuss issues/bottlenecks and seek solutions	PD/PM/Counselors
Community mobilisation		
Check record of various meetings held by the TI (not at the community level)	To check the number of community members involved in planning , implementation and monitoring	PD/PM/Counselors
Check records of group meetings at the hotspots and the DIC with the community members	To check the numbers of meetings held at the hotspot levels with the community members and check the number of participants in these meetings.	PM/Counsellor
Conduct FGD with the community (once a month)	To learn about their perception of community involvement, the barriers/challenges and the suggested solutions	PM
Conduct monthly meetings with the staff	To discuss the activities related to community mobilisation and the achievements of targets, the challenges and the way forward	PM/Counsellor

- Facilitator sums up the discussion by presenting the following slides;

Monitoring Referral Networking

Processes/Activities	Purpose	Personnel responsible
Referral networking		
Checking records- Referral slip /referral registers/PE daily diary cum tracking sheet / ORW field visit diary	To know the number of referrals, completed / incomplete referrals, follow ups etc.	Counsellors
Field visits/focus group discussions with the IDUs	To learn about the issues related to the IDUs- the quality of service received and the challenges faced	PM/ORW
Team meetings- fortnightly	To take stock of the referral status and plan follow up	PM/Counsellors
Meetings with referral partners	To discuss issues/ bottle necks and seek solutions	PD/PM/Counsellors

NACO-Indicators for Referral Networking

- % of HRG referred twice during the year to ICTC
- % of HRG tested twice for HIV at ICTC
- % of registered at ART (of those tested positive)
- % of registered at TB/DOTS centers (of those diagnosed)
- % of HRG referred to detoxification

Monitoring and Evaluation Community Mobilisation

Social change typically takes place over many years, involves many different actors and is difficult to measure. For the same reasons it is difficult to determine "attribute", or the degree to which a change can be credited to a specific intervention.

http://www.endvawnow.org/en/articles/343-community-mobilization.html

Monitoring Community Mobilisation

Processes/Activities	Purpose	Personnel responsible
Check record of various meetings held by the TI (not at the community level).	To check the number of community members involved in planning , implementation and monitoring.	PD/PM/Counsellors
Check records of group meetings at the hotspots and the DIC with the community members.	To check the numbers of meetings held at the hotspot levels with the community members. And check the number of participants in these meetings.	PM/Counsellor
Conduct FGD with the community (once a month)	To learn about their perception of community involvement, the barriers/challenges and the suggested solutions	PM
Conduct monthly meetings with the staff	To discuss the activities related to community mobilisation and the achievements of targets, the challenges and the way forward	PM/Counsellor

Indicator - NACO

- Percentage of hotspots where group meetings were organized with at least 10 HRGs
- Number of meeting events held with more than 50% of the HRG
- Meeting at DIC level

Note to the facilitator :

- The indicators used by NACO

Area	Indicator	Target	Frequency of Reporting	Data Source	Definition
Linkages	% of HRG referred twice during the year to ICTC	60% for TI in the first year of intervention 80% for TIs in the second year of implemen-tation but not completed 3 years 90% for TIs who have completed 3 years of implemen-tation and above	Annually	Referral slip / referral registers/ PE daily diary cum tracking sheet / ORW field visit diary	Total number of HRGs referred twice during the year divided by the denominator.

Area	Indicator	Target	Frequency of Reporting	Data Source	Definition
Linkage	% of HRG tested twice for HIV at ICTC	30% for TI in the 1st year of implementation 60% for TIs in the second year of implementation but not completed 3 years 70% for TIs who have completed 3 years of implementation and above	Annually	Referral registers/ ICTC registers	Number of HRG tested twice at Integrated counseling and testing centers (ICTCs) divided by the denominator.
	% registered at ART (of those tested positive)	100%	Annually		Number of individuals registered with ART center divided by the number of HRG tested HIV positive during the year.
	% registered at TB/DOTS centers (of those diagnosed)	100%	Annually		Number of TB cases registered with TB/DOTS divided by the number of TB cases identified during the year.
Detoxification	% of HRG referred to detoxification	2 % for TI in the 1st year of implementation 5 % for TIs in the second year of implementation but not completed 3 years 10 % for TIs who have completed 3 years of implementation and above	Annually	Referral format (for IDUs)	Number of clients referred for detoxification divided by total number of clients accessing any kind of services (may be separately specified for client receiving NSEP/ OST
Enabling Environment	Crisis management team formed.	20% of violence reported have been addressed- for TI in the 1st year of implementation 50% of violence reported have been addressed- for TIs in the second year of implementation but not completed 3 years 80% of right of violence reported have been addressed- for TIs who have completed 3 years of implementation and above	Monthly	Harassment report / Advocacy activity register.	Violations include any incident that violates Indian law where one or more community members are subject to extortion, abuse, violence or unlawful arrest by police or others. Tracking should be done regularly through peers and consolidated by NGO/CBO in a harassment report register and the NGO should determine, in consultation with community, if the reported incident is a rights violation before reporting it here.

Area	Indicator	Target	Frequency of Reporting	Data Source	Definition
Community Mobilization	% of hotspots where group meetings were organized with at least 10 HRGs.	In 80% of the hotspots, group meetings were conducted	Monthly	PE and outreach worker daily report, meeting registers	In every hotspot, at least one group meeting is to be conducted on the issues relating to the specific hotspot in each month.
	Number of meetings/ events held with more than 50% of the HRG	Twice in a year	yearly	Even register/ group meeting register and Minutes of SHG/ CBO/ community events meetings	Number of meetings/ events held for >50 HRGs
	Meeting at DIC level	Two meetings per month in DIC with 30 – 40 HRGs	Monthly	Meeting register / ORW daily report.	DIC register, meeting register, ORW and PEs daily reports

Conclusion and Evaluation

OBJECTIVE

- To help facilitator and participants assess knowledge and attitude change after workshop.
- To conclude the training programme.

EXPECTED OUTCOME

By the end of the session participants will be able:

- To ask for any clarifications.
- To provide any comments, suggestions or inputs.
- To give feedback about the workshop – methods and content.

DURATION

60 minutes

SESSION CONTENT

- Clarifications to questions from participants.
- Comments, suggestions and inputs from participants.
- Feedback about the workshop.

MATERIALS / PREPARATION REQUIRED

- Post-training questionnaire (Before the session, ensure that copies of pre- and post-training questionnaires are available as per the number of participants for the training.
- The pre and post training questionnaire is attached as Annexure II. Answers are also provided).
- Feedback forms – DAY 3
- Training feedback forms

PROCESS:

Step1: Post-Training Questionnaire

- Remind the participants that at the beginning of the training workshop, they had filled up a pre-training questionnaire.
- State that the 3-day training has provided the participants some knowledge and has increased their skills.
- Inform them that before concluding the workshop, the participants need to fill in a post-training questionnaire.
- Distribute the questionnaire – one for each participant. Give them 15 minutes to complete the questionnaire. At all times, ensure that the participants are filling the questionnaire individually and not with any assistance from their peers.
- Collect the filled-in questionnaires and thank the participants.

Step 2: Conclude

- Encourage a few participants to say a few words about their experience through the workshop and their learning.
- At the end, thank the participants for their active participation in the workshop.
- As this is the last session of Day 3, distribute the feedback forms (Feedback Form – Day 3) and ask the participants to provide feedback for the sessions conducted through the day.

ANNEXURES

1. Tools for the facilitator
2. Pre-and Post-training questionnaire
3. Training Agenda
4. Day-wise Feedback forms

Annexure 1

Tools for Facilitator

Annexure 1.1 . Role play character descriptions

Role Play -1

PLHIV network manager:

You are a passionate representative for your community. The incident of the IDU being turned away from treatment upsets you deeply and you are determined to get a positive response from the hospital administrator. You know that the hospital administrator is generally supportive of PLHIV and IDU issues, so this incident confuses you. When you present the case to the hospital administrator you are not angry, but seeking clarity and a renewed show of support.

Hospital administrator:

You are a calm and rational person. You understand and comply with the complex structures of the system in which you work. You have been generally supportive of PLHIV issues in your area, but you know that incidents like this happen. When the network manager approaches you, you are unaware of this incident. Calmly, and without ever raising your vouce, you ask the network manager why he did not report the incident before staging the protest? What kind of evidence does the network manager have from the incident (is there a medical report? A police report?A hospital registry entry?) Does he have information on the nurse who turned the patient away?) The hospital administrator asks the network administrator how he is supposed to help with no information and no warning.

Role play-2

IDU:

You are deeply embarrassed and upset by the incident of being turned away from the hospital while sick. You go to the network manager and board, people you respect, because you want to make sure that this never happens to another IDU. You tell the story to the network manager and suggest staging a big protest or initiating a name and shame campaign against the hospital.

PLHIV network manager:

You are a passionate representative for your community. The incident of the IDU being turned away from treatment upsets you deeply and you are determined to get a positive response from the hospital administrator. You know that the hospital administrator is generally supportive of PLHIV and IDU issues. You show alarm and concern when the IDU tells you about his/her incident at the hospital and begin the planning process by

asking many questions that will help you better advocacy on his/her behalf. Questions can include: "Is there a record of your visit to the hospital?", "do you have the name of the nurse involved?", "were any other hospital staff involved in the incident?", "have you heard of anyone else experiencing such treatment?" "is there a monitoring board at the hospital that takes complaints like this?" "do we know other NGOs working with high risk groups (FSWs, MSM) who may have also had experiences like this?", etc.

Annexure: 1.2

Sample Checklist

Issue	Evidence	Objective desired	Who is it aimed at? (Targets)	Resources & Allies	Activities with Timelines	Monitoring activities	Person(s) responsible

(Adapted from: Beyond the Barricade: Advocacy Manual, Indian Network for People living with HIV/AIDS)

Annexure: 1.3

Worksheet: Developing effective advocacy messages:

Target audience	
Characteristics	
Appropriate activities	
Appropriate materials	

"Begin with an end in mind"	Objective		Outcomes	Indicators
Desired result 1		How do you know you've achieved your desired result 1		
Desired result 2		How do you know you've achieved desired result 2		
Desired result 3		How do you know you've achieved desired result 3		

Pre and Post test Questionnaire

Instructions: *Please choose the correct response or responses from the options provided.*
Remember: *There may be more than one correct option!*

A. Understanding IDUs and issues affecting their vulnerabilities and mobilization

1. Which of the following does not increase vulnerability of IDUs?

a. Poor living condition

b. Inability to access prevention services

c. Stigma and discrimination

d. Drug dependence

e. Punitive drug law

f. ICTC

B. Legal Frame work including rights of the IDUs

2. The full form of NDPS act is:

a. National Drugs Prevention and Sales Act

b. National Drugs Policy System Act

c. Narcotics Drugs Psychotropic Substance Act

3. Which of the following statements is true?

a. Drug users do not have right to health

b. Drug users are criminals

c. Every arrest need not have warrant

d. Universal precaution measures are for all settings, there are no excuses!

e. Fundamental rights are not equal for all

C. Basics of Referral and Networking

4. Which of these statements is true?

a. Comprehensive services for IDUs at one service delivery point is possible

b. Networking is the back bone to support referral

c. Sexual partners of male IDUs are one of hidden population often denied health treatment

d. Education and empowering does not help in completing referrals

e. Knowing potential service specific for certain issues based on sex, age, specialization is essential for effective referral

D. Resource mapping for referral

5. Who are best people to be involved in resource mapping?

a. Health care unit (public and private)

b. NGO and Health care unit (pub and pvt)

c. IDUs, NGO and health care unit (pub and pvt)

E. Establishing and maintaining referral networking

6. Choose one correct statement regarding referral :

a. Networking is the back bone to support referral

b. Sexual partners of male IDUs are one of hidden population that is often denied health treatment

c. Education and empowering does not help in completing referrals

d. Knowing potential service specific for certain issues based on sex, age, specialization is essential for effective referral

e. All of the above

7. How can referral networking be maintained?

a. Open with referral

b. Through meetings, phone calls, exchange visits

c. By sending/sharing reports of referral

d. All of the above

Referral Analysis

8. Why is it Important to analyse referrals?

a. To evaluate or examine the effectiveness of the referral system

b. To check service completion, confidentiality, ethics, rules of institution

c. To improve referral services

d. To make and report to donor for future funding

f. All of the above

Monitoring and Evaluation of referral and networking

9. Which of the following is false, in the context of referral?

a. Monitoring (in our context) is a process of regularly collecting information about referral – system, effectiveness, numbers, quality

b. Monitoring allows opportunity to change or improve referral

c. Monitoring of referral is not necessary in the TI projects as number of clients/PWID is already collected when admitted

d. Monitoring of referrals helps in planning and implementation of providing comprehensive services to IDU

e. Monitoring helps in ensuring activities at the right time by right person

Understanding the basics of Community Mobilization

10. Which of the statement is false, in the context of community mobilization?

a. Don't let the community have too much power as they cannot be trusted for their roles and decision making

b. Knowing where we (community) are going is important – to be able to prioritize – goals

c. Know your community – understanding the community will help in finding right education, skills to empower and mobilize

11. Which of the statement is false, in the context of community mobilization?

a. Community mobilization is an approach involving drug users to address their needs

b. Community mobilization allows each member to become a leader or representative

c. Community mobilization is driven /owned by the NGO/TI

d. Community mobilization is driven by the community / owned by community

e. Community mobilization ensures or helps in quality and effective service

12. Key elements for success (identify the false statement)

a. Using peers, capacity building, creating supportive environment, campaign for changes advocacy campaign

b. Clear understanding between leading, owning and facilitating is important for initiating agencies

c. Community mobilization works better when properly facilitated

d. Mother NGO/initiating agencies should keep a control of to be a success

Monitoring and evaluating of Community Mobilization

13. Which of the statement is true, in the context of community mobilization?

a. Community mobilization is a social change influenced by many factors

b. Monitoring of community mobilization is not possible

c. Monitoring and evaluation of community mobilization helps planning

d. NACO has only four indicators in community mobilization

e. NACO has only three indicators in community mobilization

Understanding Advocacy:

14. Which of the following is NOT an advocacy response to a situation of harassment?

a. Protesting outside the harasser's workplace

b. Talking to a counsellor

c. Lodging a law suit against the harasser

d. A concert to raise awareness about harassment in the area

15. Advocacy is a process to bring about change in:

a. Policies and laws

b. Individuals

c. Institutions

d. All of the above

Developing Advocacy Strategies:

16. Which of the following is not a necessarily part of planning an advocacy strategy:

a. Analyse and research the issue

b. Include only people directly involved in the program

c. Implement, monitor and evaluate the advocacy plan

d. Create an action plan

17. Which of the following statements is false:

a. Advocacy messages should consider the characteristics of the intended audience

b. Advocacy messages should be delivered through appropriate activities

c. Advocacy messages should be general and uniform for all audiences

d. Advocacy messages should include preparing appropriate materials

Advocacy with Law Enforcement Agencies:

18. Which of the following levels within law enforcement agencies should we ideally advocate with:

a. Operational level

b. Middle level

c. Senior level

d. All of the above

19. Identify the incorrect statement:

a. Law enforcement agencies need to be educated on safety measures such as disposal of needles, first aid for needle-stick injuries and contact with blood products

b. Law enforcement agencies should work with TI staff to identify current drug users

c. Law enforcement agencies should visit DIC at appropriate times

d. Law enforcement agencies should be encouraged to refer drug users to services

Advocacy to facilitate referrals:

20. Power mapping is a technique used to:

a. Create effective advocacy messages

b. Make effective referrals to services providers

c. Identify advocacy targets

d. Deal with opposition opinions

21. We advocate with referral agencies because (Tick the false answer):

a. Referral agencies are paid to provide services for IDUs

b. Advocacy with referral agencies increases access to services for IDUs and helps to reduce the spread of HIV

c. Advocacy is always necessary

d. Referral agencies are always hostile to drug users

Advocacy with the wider community:

22. In advocacy initiatives with the wider community, which of the following statements is incorrect:

a. We should approach people who disagree with evidence-based information

b. We should directly approach those who disagree and tell them why they are wrong

c. We should listen to their side of the argument and understand what causes them to disagree

d. We should build wider networks to generate more support

23. (Choose the correct answer) The resources available to advocate with the wider community include:

a. Project staff

b. Drug users

c. Funds

d. All the above

e. None of the above

Monitoring and evaluation

24. Monitoring and evaluation is done at the end of the program, once all activities are complete.

a. True

b. False

25. What do you use to help measure your advocacy activity's progress during implementation?

a. Outcomes

b. Evaluation

c. Goals

d. Indicators

For Facilitator: Answers to Pre and Post training Questionnaire

1. f	6. d	11. c	16. b
2. d	7. a	12. d	17. b
3. d	8. c	13. b	18. a
4. c	9. a	14. c	19. b
5. e	10. c	15. d	20. d

Annexure 2

Agenda for Three Day Training on Advocacy, Community Mobilisation, Referral and Networking for Strengthening IDU Interventions

Time	Topic
DAY ONE	
9.00 – 9.30 am	Registration of the participants
9.30 – 10.00 am	Inaugural
10.00 – 10.15 am	***Coffee/tea break***
10.15 – 10.45 am	▪ Ice breaking ▪ Introduction to the Training Programme ▪ Expectations from the Training Programme
10.45–11.00 am	Pre training assessment
11.00 – 1.00 pm	Understanding IDUs and issues affecting their vulnerabilities and mobilisation
1.00 – 2.00 pm	***Lunch Break***
2.00 – 3.15 pm	Basics of Referral and Networking
3.15 – 3.30 pm	***Coffee/ Tea Break***
3.30 – 5.00 pm	Resource Mapping for Referral
DAY TWO	
9.00 – 9.15 am	Recap of Day One sessions
9.15 – 10.30 am	Establishing and maintaining referral networks
10.30 – 10.45 am	***Coffee/ Tea Break***
10.45 – 12.15 am	Referral Analysis
12.15 – 1.30 pm	Understanding the Basics of Community Mobilisation
1.30 – 2.30 pm	***Lunch break***
2.30 – 3.30 pm	Facilitating Community Mobilisation
3.30 – 3.45 pm	***Coffee/ Tea Break***
3.45 – 5.00 pm	Understanding Advocacy
DAY THREE	
9.00 – 9.15 am	Recap of Day two sessions
9.15 – 10.30 am	Developing Advocacy Strategies
10.30 – 10.45 am	***Coffee/tea break***
10.45 – 12.00 am	Advocating with Law Enforcement Agencies
12.00 – 1.00 pm	Advocacy to Facilitate Referral
1.00 – 2.00 pm	***Lunch Break***
2.00 – 3.15 pm	Advocacy with Community
3.15 – 3.30 pm	***Coffee/tea break***
3.30 – 4.30 pm	Monitoring and evaluation of Referral & Networking, Community Mobilisation & Advocacy
4.30 – 5.30 pm	Conclusion and Evaluation

Annexure 3

Day-1 Feedback Forms

Session	Particulars	Feedback			Remarks*
		Good	Ok	Poor	
Overall response to sessions					
1	Introduction to the training programme				
2	Understanding IDUs and issues affecting their vulnerabilities and mobilisation				
3	Basics of referral and networking				
4	Resource mapping for referral				

Most useful topics

.....

Topics not very useful

.....

Any other comments

.....

Please comment on the duration, content and methodology

Day-2 Feedback Forms

Session	Particulars	Feedback			Remarks*
		Good	Ok	Poor	
Overall response to sessions					
1	Establishing and maintaining referral networks				
2	Referral Analysis				
3	Understanding the basics of community mobilisation				
4	Facilitating community mobilisation				
5	Understanding advocacy				

Most useful topics

.....

Topics not very useful

.....

Any other comments

.....

Please comment on the duration, content and methodology

Day-3 Feedback Forms

Session	Particulars	Feedback			Remarks*
		Good	Ok	Poor	
Overall response to sessions					
1	Developing advocacy strategies				
2	Advocating with law enforcement agencies				
3	Advocacy to facilitate referral				
4	Advocacy with the wider community				
5	Monitoring of referral & networking, community mobilisation and advocacy				
6	Conclusion and evaluation				

Most useful topics

.....

Topics not very useful

.....

Any other comments

.....

Please comment on the duration, content and methodology