Interpersonal Communication

for Action on HIV (InterAct IPC)

A guide to dialogue-based communication methods to help key populations put HIV messages into practice in India

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Acronyms

AIDS	acquired immunodeficiency syndrome
CBO	community-based organisation
FSW	Female Sex Worker
HIV	human immunodeficiency virus
IDU	intravenous drug user
IEC	information, education, communication
IPC	interpersonal communication
MSM	males who have sex with males
NGO	nongovernmental organisation
PLHIV	person living with HIV
PSA	participatory site assessment
STI	sexually transmitted infection
VCT	voluntary counselling and testing

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Introduction

Aim of this toolkit

This toolkit aims to provide interpersonal communication (IPC) methods to help key population communities identify and address barriers to putting HIV prevention messages into practice in their own lives and within their own contexts.

Who this toolkit is for

This toolkit was developed by PATH for nongovernmental and community-based organisations (NGOs and CBOs) and for government health care providers working with key populations on targeted interventions. The methods can also be adapted for use by organisations working on HIV care, support, and treatment.

What do we mean by "key populations"?

"Key populations" are groups of people most directly and acutely affected by HIV. Within the Indian context, they can include sex workers, males who have sex with males (MSM), people who inject drugs (IDUs), and people living with HIV.

Key populations are considered key to the dynamics of the epidemic, as they are (1) most likely to be infected and affected by HIV and/or (2) most likely to transmit the virus. Key populations are also key to the response to HIV, since evidence from around the world shows that if key populations are involved in designing and implementing interventions to prevent and contain HIV, the results are more likely to be effective and sustainable.

Toolkit contents

Section A: Interpersonal Communication for Action on HIV (InterAct IPC)

Defines InterAct IPC, gives a conceptual framework, outlines what the methods aim to achieve, and lists some of the limitations of the process.

Section B: Methods used in InterAct IPC

Explains why participatory methods are important in InterAct IPC and provides a guide to facilitation of 15 methods commonly used in InterAct IPC.

Section C: Integrating IPC into existing HIV projects

Shows synergies between InterAct IPC and other components of a communications strategy. Also gives an example of how one NGO has integrated IPC into its HIV prevention work.

Section D: Maintaining the quality of InterAct IPC

Details 13 standards that can be used by organisations to assess the quality of their InterAct IPC work.

Section E: Sample InterAct IPC training schedule

Shows areas that can be covered during InterAct IPC training sessions.

A film about InterAct IPC is included with this toolkit to help bring the process to life and for use in training and orientation.

Section A: Interpersonal Communication for Action on HIV (Interact IPC)

What is InterAct IPC?

As more is learned about effective responses to the HIV epidemic, behaviour change interventions have moved from giving messages that focus on individual sexual behaviour to processes involving dialogue and discussion about local contexts and barriers to risk reduction, care, and treatment.

There are many types of interpersonal communication frameworks being used in HIV work. InterAct IPC is distinguished by moving beyond messages, and through face-to-face interaction, dialogue, and critical reflection, helping key populations to identify barriers to HIV risk reduction, analyse these barriers, and plan ways to address them.

InterAct IPC, through face-to-face interaction, dialogue, and critical reflection, helps key populations identify barriers to HIV risk reduction and analyse and plan ways to address them.

InterAct IPC aims to strengthen the:

1. Motivation of key populations for HIV prevention.
2. Skills and knowledge for key populations to be better able to reduce risk behaviour.
3. Ability of key populations to access (and demand) necessary services and interventions.
4. Ability of key populations to access necessary peer (and social) support to reduce risk behaviour.
5. Analytical skills of key populations to be better able to address other barriers to health and well-being.

How does InterAct IPC work?

Typically, a peer educator who is trained as an IPC facilitator will go to a place where key populations are known to be located (parks, brothels, bars, street corners, clinics, drop-in centres, etc.). He or she will then identify a group of key populations to work with. The peer facilitator discusses and agrees a safe space and a time when key populations are free to carry out the IPC session.

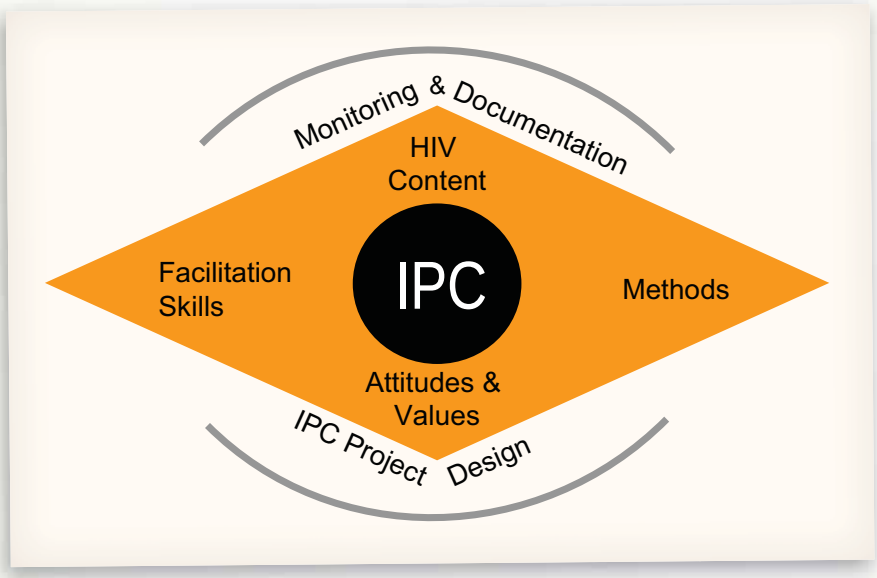
When the session begins, the peer facilitator identifies an appropriate IPC method to use, depending on the time the group can give for the session, the amount of space available, and the level of privacy. IPC methods usually do not require any literacy and are based on visual,

participatory methods that include simulation, diagramming, visual representations of different kinds, mapping, ranking, and storytelling. The IPC session often starts with an ice breaker.

The peer facilitator then introduces the objectives and the various steps of the method. He or she facilitates the group to use the method and to ensure that they go through the process of identifying barriers, analysing these barriers, and finding practical solutions. Each member of the group is encouraged to share how they themselves have tried to reduce their risk of HIV and to explain why they decided to use a particular strategy.

Solutions to problems are then organised into things (1) the group itself can act on and (2) solutions that need support from others (organisation, community, etc). The group makes a plan of action they consider feasible (who does what, when). After the session is complete, the peer facilitator follows up on agreed action points and, when they next meet, shares the results.

The Eye to Eye Framework



The InterAct Eye to Eye IPC framework shows the components that need to be put into place to develop successful IPC projects. All elements of the framework are equally necessary for effective IPC.

1) HIV content refers to the barriers to prevention for key populations and includes social and environmental factors, as well as epidemiological issues. Key populations will only be motivated by and spend time on issues that are relevant to their situation, so what is discussed in IPC must be specific to their needs. For example, a discussion about how to put abstinence messages into practice with sex workers may be less attractive to them than a discussion on how to manage a drunken client.

IPC facilitators should be able to respond to the hierarchy of key population needs (e.g., on a continuum from basic prevention skills and knowledge for new entrants to the key population community, to voluntary counselling and testing [VCT] and positive prevention for those who have been around longer). IPC facilitators should also be able to understand power and social relationships that affect the lives of key populations and why 'other people's behaviour' may be critical barriers to prevention.

2) Methods are processes used to stimulate InterAct IPC and are selected to make the best possible use of each IPC opportunity. They can be used both in 'one off' sessions, and as part of a more structured process over several sessions with the same group of key population members. Fifteen tried and tested methods are detailed in Section B of this toolkit and include simulation methods, diagramming, visual representations of different kinds, mapping, ranking, and storytelling. Key population IPC facilitators are also encouraged to develop their own methods. Criteria for being an InterAct IPC method include that the method:

- Moves beyond just giving messages about HIV prevention
- Helps key populations to find and share risk-reduction techniques
- Involves face-to-face interaction
- Uses dialogue and group discussion
- Strengthens critical reflection and problem-solving skills of key populations

Other criteria include that the method should be appropriate to use with different key populations in different contexts and in different project settings—such as during outreach, at treatment centres, at drop-in centres, and so on.

The method should be designed so that the group is taken from analysis of barriers through to generation and assessment of solutions and then on to action planning. Action planning is central to the InterAct approach so that barriers can be addressed in real life and not just in theory.

IPC methods are adapted to each situation but always promote discussion and problem solving. During IPC, key populations are encouraged to share how they protect themselves from HIV and what strategies they have used for successfully accessing care and treatment.

> *"I have discovered that there are no 'magic' methods. All the work I do with key populations can be stretched into an IPC process, but some methods make for more intensive discussion."*
>
> *IPC Facilitator Andhra Pradesh*

3) Facilitation skills focus on ways to promote real dialogue, discussion, and debate rather than merely giving messages. Developing new facilitation skills takes time. Practice in the field is necessary, as is help and feedback to individual facilitators to enable them to critically reflect on how their skills are developing.

Facilitation skills include helping key populations to draw out general principles for risk reduction to apply to other situations and the ability to challenge misconceptions and prejudices with confidence. Above all, IPC facilitators need to be comfortable with their own sexuality and with talking about sex.

IPC facilitators should be able to make a safe space for key populations to participate comfortably in IPC sessions and to be able to share sensitive issues without fear of reprisal. They need to work at times convenient to key populations, when it will not interfere with income generation activities.

IPC facilitators should be able to link key population members with other HIV prevention, care, and treatment services in the area. They should also be able to refer key populations to other services that are important to them (e.g., credit, childcare, education, etc.).

Key population members selected to be IPC facilitators must be credible and acceptable to their peers in the site, must know how to engage appropriately with their peers, and must be able to make a safe space to discuss important issues. They must understand not only power dynamics within key population relationships, but also their own power and how this can affect group discussions.

Capacity building in facilitation skills needs to happen over time, ideally with field mentoring from experienced IPC practitioners.

4) Attitudes and values deal with the appropriate attitudes and values for working with key populations and underlie all capacity areas essential to an organization implementing IPC components in their HIV projects. If we don't empathise with key populations and champion their causes, we will not be able to deliver meaningful services and interventions that are beneficial for key populations.

Organisations need to promote and sustain appropriate values and attitudes amongst all staff who are working with key populations. Crucially, organizations need to focus on strategies that help key populations reduce their own risk of infection rather than on making key populations 'less of a risk for the general population.' In other words, people working with key populations must be sensitive to key population vulnerabilities, be nonjudgmental about sexual practices and lifestyles of key populations, and work on behalf of the key populations.

For effective IPC, facilitators must be peers of the key populations. This means that they need to accept, respect, or share the same sexual norms and practices as the key populations they are working with. IPC facilitators may work part time with an NGO or CBO so that they continue to update their understanding of the key population context and maintain relationships within key population networks. All staff should treat key population members with respect and strive to maintain their dignity in all situations.

5) Project design looks at how the IPC component of the HIV project is organised to be both efficient and effective and how IPC can integrate with other project components. For example, it is important that the design allows for IPC facilitators to receive training and mentoring and to meet regularly and share information. IPC facilitators should be able to access regular refresher training, supervision, and feedback to update their skills and knowledge.

IPC facilitators should also have a consistent supply of condoms and lubricants and other risk-reduction commodities with them to demonstrate during sessions and to use as a focus for discussion. They should carry information about services and have sufficient supplies of paper, markers, and other materials needed to facilitate IPC methods.

IPC components of HIV projects should be designed so that new key populations and those who are hard to reach can be identified and strategies used so that those key populations most at risk are reached with IPC methods.

"Without an effective design backing us up, we can miss all kinds of good IPC opportunities. Without good training, IPC facilitators will not be able to make the most of opportunities that are there."

IPC Facilitator Maharashtra

Knowledge about things that affect key populations in terms of HIV needs to be updated on a regular basis since the context in which people live their lives is constantly changing. Regular feedback from IPC work in the field helps organisations to understand the changing needs of key populations in terms of HIV prevention, care, and treatment so that strategies can be adapted accordingly.

6) Monitoring and documentation are used to improve project processes and to share learning within and beyond the IPC component of HIV projects. Capacity standards developed for InterAct IPC are detailed in Section D of this toolkit, along with examples of self-assessment tools and formats for feedback meetings between NGO staff and IPC facilitators.

Indicators in the Indian National AIDS Control Programme should also be kept in mind when monitoring IPC. Effective IPC can contribute to a number of national indicators, including:

I.a.2 Number & percentage of specific HRG (high risk group) population reached by intervention.

I.a.3 Percentage of female and male sex workers reporting use of condoms with their most recent client.

I.a.4 Percentage of men reporting use of condoms in the last time they had anal sex with a male partner.

I.a.5 Percentage of IDU population reporting use of sterile injecting equipment at last injection.

I.a.6 Percentage of IDU reporting use of condoms at last sex.

I.a.7 Percentage of FSW, MSM, IDUs with STI symptoms, seeking services from qualified medical providers.

I.a.8 Percentage of sex workers or MSM who refused to have sex with a client/nonregular partner in the last 12 months because of not having or refusing to use a condom.

I.a.9 Percentage of PLHA registered in TI (targeted intervention) linked to basic AIDS care and support.

I.a.13 Number and percentage of TIs where CBOs are formed.

I.a.14 Percentage of TI projects reporting no interference from local power structures.

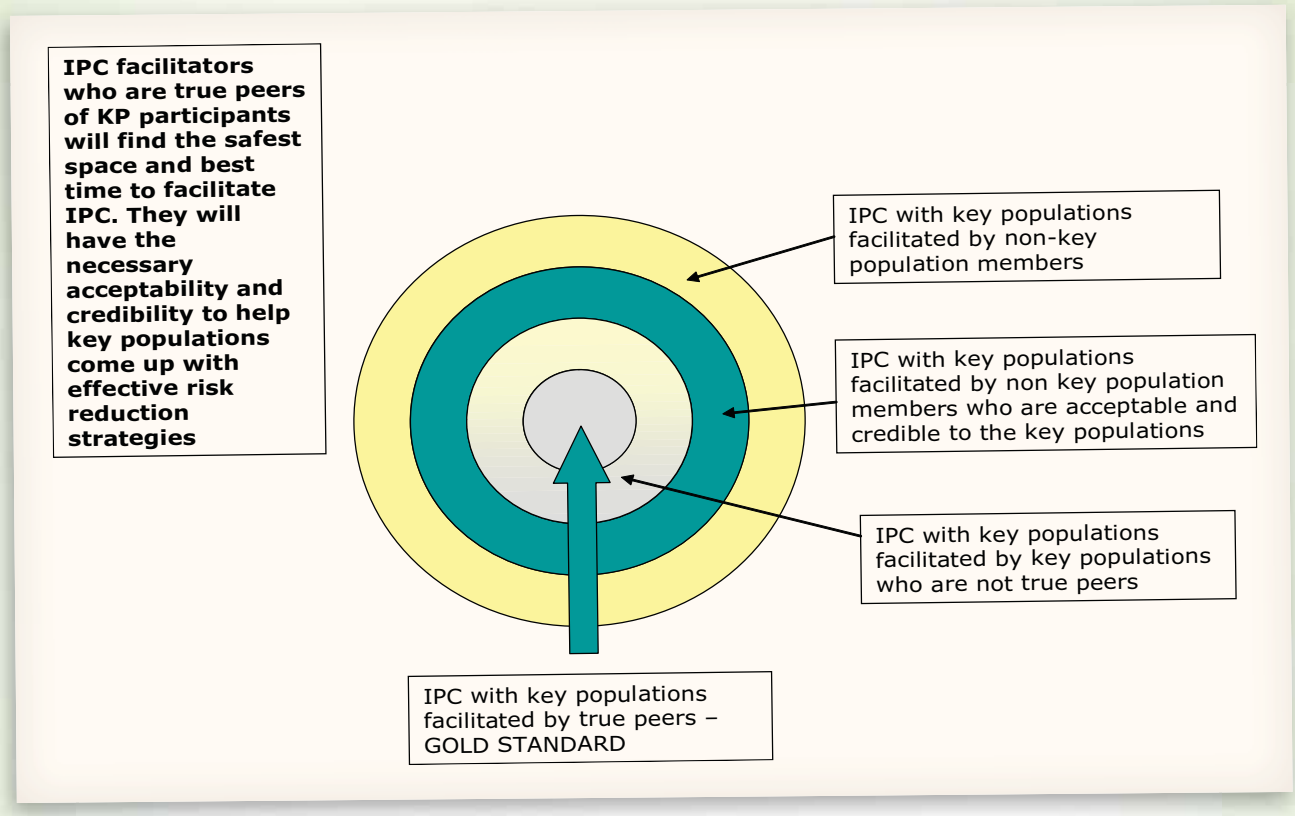
Why InterAct IPC is carried out by key populations

One of the ways to ensure that key populations are able to analyse their situation in relation to HIV in an open manner without fear of judgment, is to have IPC facilitators who are also from the key populations. InterAct IPC is directly implemented by key population members—rather than by non-key population outreach workers—for the following reasons:

"Peer" is defined as anyone who accepts, respects, or follows the sexual norms and/or drug using practices of a particular key population.

- Key population members best understand and empathise with their peers and are able to win their confidence so that information can be shared and analysed without fear or prejudice.
- They are able to communicate well with other key population members and use familiar, colloquial language.

- Key population members can help groups and individuals to discuss 'secret' and taboo behaviours in depth.
- The use of key population members as peer IPC facilitators paves the way for the mobilisation of key populations and builds a sense of ownership.
- Building the capacity of key populations to conduct InterAct IPC results in the creation of a core group of committed resource people who can provide valuable information about how the project can better meet the needs of key populations in the area.



Why are visual methods used?

Visual methods are used in InterAct IPC because:

- They do away with the need for technical jargon and enable key populations to use language with which they are familiar.
- They also enable people with low literacy skills to engage fully in the sessions.
- Visual representations (situations) rather than individual (personal) behaviours are discussed; therefore, risk behaviours can be discussed as "general practice" rather than as personal behaviour.
- They help key populations move smoothly from problem identification to solutions and action plans.
- They provide a transparent record of discussions for post-session use by key populations and the IPC facilitators.

- They foster ownership and internalisation of discussion. Key populations learn through practice—by using their pictoral representations as a basis to problem-solving and working around barriers to HIV prevention, care, and treatment.
- Misinformation/myths can be corrected and gaps in information plugged during analysis of the visual representation.
- They can help build the problem-solving skills of key populations.

Although the methods can be used with individuals, InterAct IPC works best when facilitated with groups of key populations.

Why facilitate InterAct IPC with groups?

Working with groups in general is a more effective use of time for higher coverage at lower cost. In addition, working with a group can be a good way to address myths and misconceptions and can reinforce messages by having multiple credible sources. Sharing thoughts and experiences with peers can normalise discussion about sensitive issues so that discussion can continue beyond the session. This can create a ripple effect as key population members feel empowered to discuss issues from sessions they have attended with their friends.

Working with a group enables sharing of positive and negative experiences of reducing risk and accessing care and treatment and can provide a very rich source of strategies that can be analysed by the group. Having a group can also enhance creative problem solving, generating more and better solutions to barriers. It can create peer support for HIV prevention, care, and treatment and also create social capital—between and amongst key populations.

Finally, knowing that you are not alone with your problems, and having an understanding of shared vulnerability, of shared responsibility, and also of shared power and advocacy possibilities means that there is a greater likelihood that action will be taken by the individual or group.

Section B:
Methods Used in InterAct IPC

A range of participatory, visual methods can be used in InterAct IPC. The following pages detail 15 easy-to-use IPC methods to help key populations reduce their risk of HIV. These methods can easily be adapted for use in analysing barriers to care and treatment. The methods are of different types as detailed in the table below:

Simulation	Visual Representation	Diagramming	Mapping and Ranking	Stories
Play Safe Key Population Advisors Statues Margolis Wheel	Key Population Drawings Graffiti Body Mapping	Why Is It So? Chakra Wheel Love Life I, Me, Myself	HIV Services Map How Hot Is the Spot	Story with a Gap Key Population Storytelling

Method (1) Play Safe

Purpose of the method	To help participants explore different safe sex techniques
Requirements for facilitation	Good knowledge of safe sex strategies and techniques; comfort with talking about sex and with explicit demonstrations of safe sex
Material required	Enough space for participants to act out different situations
Degree of privacy	High
Time required	30–45 minutes
Method	1. Divide participants into two teams. Participants can be divided into male-only and female-only groups. 2. Ask each team to prepare and simulate a situation where they demonstrate sex acts that are safe. 3. One group demonstrates. 4. After the demonstration, the other group analyses the simulation to check: ▪ Whether the sex acts demonstrated are really safe. ▪ Whether they are realistic and practicable. ▪ Whether they can be practised in any situation or would they require special circumstances. ▪ Whether anything can be done to make the act even safer. 5. The second group demonstrate and the other group analyses using the same set of criteria. 6. Based on the assessments, the groups are awarded points. 7. Finish the session by asking the group to reflect on what they have shared and learned during the session that will be useful for them.
Adaptation for repeat use	For repeat use, the groups can be asked to demonstrate sex acts of particular categories, such as vaginal, anal, oral, non-penetrative, etc.

Method (2) Margolis Wheel

Purpose of the method	To help key populations identify and plan ways to address barriers to HIV/STI risk reduction
Requirements for facilitation	Good knowledge of what makes key populations vulnerable to HIV in the particular context; knowledge of strategies to reduce risk of HIV
Degree of privacy	Low
Material required	None
Time required	60 minutes with 16 participants
Method	1. Settle the group in with an icebreaker. 2. Put the group into pairs. Ask each pair to brainstorm situations that might make people vulnerable to HIV/STI infection. Give an example relevant for the key population group. Go round the pairs, correct misconceptions, challenge prejudices, and make sure that each pair has a different situation. 3. Arrange the group so that there is an inner and outer circle with pairs facing each other. Explain that the inner group are 'consultants' and the outer group have come to get their advice. The outer group have 2 minutes with each consultant to explain their particular situation that makes people vulnerable to HIV infection and ask them for advice on how to change the situation to reduce the risk. 4. Start the clock. After 2 minutes ask all those in the outer circle to move round to the next consultant and ask for advice. Repeat this until those in the outer circle are in their original places. Now ask the pairs to swap round so that those in the outer circle now become the consultant. Repeat the activity. 5. Finish the session by asking people to share the best advice they got for their particular situation. Ask if anyone did not get satisfactory advice and ask the group to comment. 6. Finish the session by asking the group to reflect on what they have shared and learned during the session that will be useful for them.
Adaptation for repeat use	Ask the group to brainstorm situations in their personal life or work life. Ask the advisors to give solutions that can only be done by an individual or by a group of peers.

Method (3) Statues

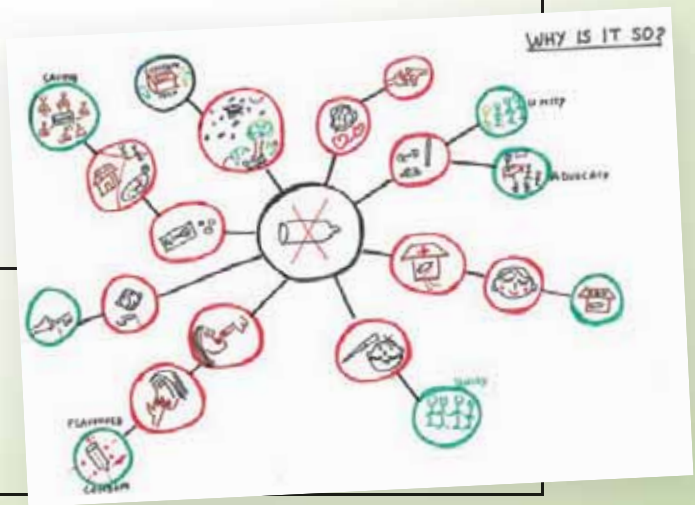
Purpose of the method	To help key populations identify and plan ways to address barriers to HIV/STI risk reduction
Requirements for facilitation	Good knowledge of HIV/STI risk reduction strategies that key populations can realistically use within their own context
Degree of privacy	Quite high; this method can attract onlookers, which can inhibit participants
Material required	Polaroid cameras can be used to snap the statues. The pictures are for the key populations to take away with them.
Time required	45–60 minutes
Method	1. Settle the group in with an icebreaker. 2. Ask the group to brainstorm ways in which you can get HIV. Correct any misconceptions and challenge any prejudices. 3. Now split the group into sub-groups of 3 or 4 people. Ask each group to decide on a 'freeze frame' (arranging themselves in a particular way then standing as still as statues, not saying anything) showing one way to reduce the risk of HIV. 4. Go round the groups if necessary to clarify what you want them to do. 5. Now ask each group in turn to show their statue arrangement. Facilitate a discussion amongst the remaining participants about each tableau. ▪ What does the statue arrangement show? ▪ Will this reduce the risk of HIV? ▪ If so, how easy would their suggestion be to put into practice in real life? ▪ Are there any changes that could be made to the statue arrangement to make their risk reduction suggestion more effective? 6. If there are suggestions for change, if everyone agrees let the group amend their statue arrangement accordingly. 7. Finish the session by asking the group to reflect on what they have shared and learned during the session that will be useful for them.
Adaptation for repeat use	Alternatively, ask for statue arrangements that depict risky practices and then ask the participants to rearrange each set of statues so that the risk of HIV/STI infection is reduced.

Method (4) Graffiti

Purpose of the method	To help participants explore different kinds of sex acts that the key populations usually engage in with their sexual partners (whether intimate partners or paying or paid ones) and the HIV/STI risks associated with them, so that they can work out ways of making sex safer
Requirements for facilitation	Good knowledge of safe sex strategies and techniques; comfort with talking about sex in some detail
Material required	Chart papers and coloured markers
Degree of privacy	High
Time required	30–45 minutes
Method	1. Ask participants to draw the different sex acts they usually practice with their sexual partners on chart papers. Once the drawings are done, discuss with the participants the degree of risk of HIV/STI transmission that each sex act entails. Ask them to put symbols (ticks, numbers, or any other) against drawings of each sexual act to denote the degree of risk (high, low, or no risk). 2. Discuss with participants if they can suggest any other way of having sex that is safer. Give examples of safe sex practices that are not mentioned by them. 3. Through all the steps, ensure that the participants are not feeling inhibited or uncomfortable. 4. Finish the session by asking the group to reflect on what they have shared and learned during the session that will be useful to them.
Adaptation for repeat use	On different occasions, ask participants to draw either intimate sexual partners or paying or paid partners.

Method (5) Why Is It So?

Purpose of the method	To help key populations analyse why risk behaviour occurs and what can be done to reduce it
Requirements for facilitation	Knowledge of what are risk behaviours, knowledge of the difference between risk behaviours and vulnerability factors, knowledge of key population context
Material required	Chart papers and coloured markers
Degree of privacy	Low
Time required	30–45 minutes
Method	1. Ask participants to name the different kinds of behaviours that put people at risk of HIV/STI infection. Correct any misconceptions. 2. Pick one of the risk behaviours. 3. Ask participants to draw a symbol of this risk behaviour in the centre of the flipchart inside a circle. 4. Ask 'why is it so?' and ask them to draw or write the reasons for the risk behaviour in balloons. 5. Keep asking 'why is it so,' adding further reasons in connecting balloons until they can think of no more. 6. Ask the participants what the diagram says about: ▪ What are the most important reasons (vulnerability factors) for risk behaviour? ▪ What are the ways that the key population group already uses to reduce risk behaviour? ▪ What would further help the key population group avoid the risk behaviour in the diagram? 7. Finish the session by asking the group to reflect on what they have shared and learned during the session that will be useful to them.
Adaptation for repeat use	Pick different risk behaviours (for example, unprotected anal sex, unprotected vaginal sex, sharing drug preparation and drug use equipment).



Method (6) Chakra Wheel

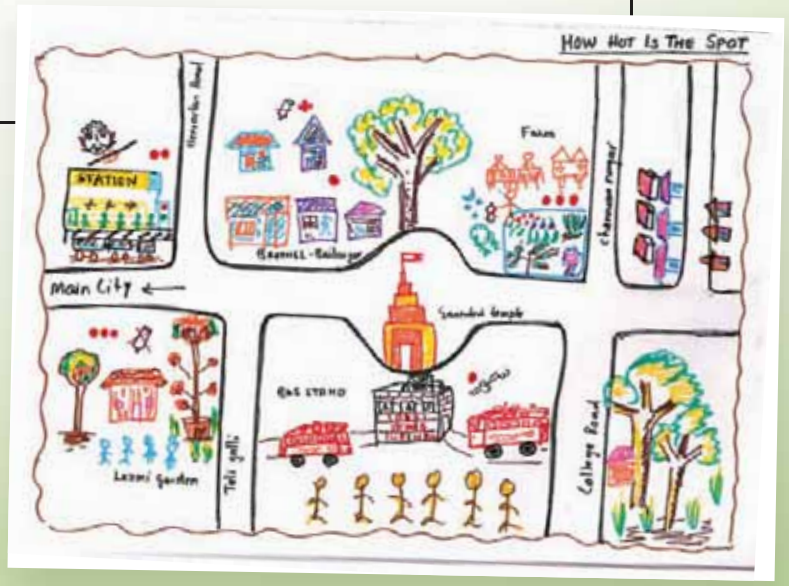
Purpose of the method	To help key populations identify and plan ways to address barriers to HIV/STI risk reduction
Requirements for facilitation	Knowledge of HIV/STI prevention methods and of key population context in relation to HIV/STI risk reduction
Degree of privacy	Can be done outdoors in impromptu locations if there are not too many people around location is not right within the public domain.
Material required	The wheel can be drawn in the dust with a stick or with chalk on concrete; alternatively use markers and flipchart.
Time required	45–60 minutes
Method	1. Settle the group in with an icebreaker. 2. Ask the group to brainstorm ways in which their key population group or sub-group can reduce the risk of HIV/STIs. Correct any misconceptions and challenge any prejudices. Get the group to settle on eight important risk reduction methods or strategies. 3. Ask the group to draw a circle and divide it into eight. Assign one risk reduction method or strategy to each segment of the wheel using a symbol or object agreed by the group. Now ask the group to discuss how difficult it is for their key population group or sub-group to use these methods or strategies and shade in the segment accordingly. If it is very difficult for the key population group to use the method or strategy, then only a small part of the segment is shaded in. 4. When the wheel is complete, ask the group to reflect on the segments that have least shading. What action would need to happen to make it easier for the key population group to use that risk reduction method or strategy? Who would need to be involved in that action? What first steps could be taken immediately and by whom? 5. Finish the session by asking the group to reflect on what they have shared and learned during the session that will be useful for them. If necessary, offer one-to-one work with people who may have specific and personal concerns.
Adaptation for repeat use	Keep the original charts or ask the key populations to keep them and work on a different risk reduction method at each meeting.

Method (7) HIV Services Map

Purpose of the method	To help participants map, assess, and learn how to access formal and informal HIV/STI services available to key populations in the project site
Requirements for facilitation	Knowledge of types of formal and informal services important for key population use in HIV/STI prevention
Degree of privacy	Low
Material required	Chart paper and coloured markers
Time required	30–45 minutes
Method	1. Ask the participants to draw a map of the area including a few main landmarks. 2. Ask the participants to include in the map any places or people that their key population group could visit to get support for HIV/STI prevention and treatment. 3. Ask the participants to put against each intervention: ▪ What each service provides. ▪ How each service helps reduce risk of HIV/STI infection. ▪ A symbol for if the service is very important in HIV/STI prevention. 4. Ask them to identify factors that make a particular service attractive to them (such as distance, cost, behaviour of service providers, confidentiality, effectiveness of services provided, availability and timing, and so on). 5. Now ask the participants to rank the services marked as important in terms of how accessible they are to key populations like themselves (high, medium, low). 6. Now ask them to discuss the services ranked with 'low' accessibility. What could be done to make these important services more accessible to key populations like themselves? 7. Finish the session by asking the group to reflect on what they have shared and learned during the session that will be useful for them.
Adaptation for repeat use	This activity is long and can be broken up with repeat use. Keep the chart papers to continue the discussion in the next session. Use original papers after some time and ask participants what may have changed in the site.

Method (8) How Hot Is the Spot?

Purpose of the method	To help key populations identify and plan ways to address barriers to HIV/STI risk reduction
Requirements for facilitation	Knowledge of key population context and of relative risk of particular behaviours
Degree of privacy	This activity generates information that may cause sensitivities between key populations and the authorities, so some privacy is required.
Material required	Marker pens and chart papers
Time required	45–60 minutes
Method	1. Settle the group in with an icebreaker. 2. Ask the group to draw a map of the local area, including any local landmarks to orient the map. Now ask them to use a symbol to indicate on the map the locations where behaviour occurs that puts their key population group at risk of HIV/STI infection. 3. Now ask the group to rank the locations using symbols for high, medium, or low according to the level of risk behaviour in each location (in terms of numbers of people or frequency of risk behaviour occurring). 4. Ask the group to look at the locations ranked as high risk. Ask them to discuss what change needs to happen generally to make the location into a medium or low risk. Then ask what individual key populations or small peer groups could do to reduce risk behaviour in these locations. 5. Finish the session by asking the group to reflect on what they have shared and learned during the session that will be useful to them.
Adaptation for repeat use	This activity is long and can be broken up with repeat use. Keep the chart papers to continue the discussion in the next session. After some time, bring out original papers and ask participants what may have changed in the site.



Method (9) Story with a Gap

Purpose of the method	To help key populations plan ways to address barriers to HIV/STI risk reduction
Requirements for facilitation	Knowledge of key population HIV/STI vulnerability factors and risk reduction strategies; ability to facilitate planning
Degree of privacy	Low
Material required	Markers and chart paper, when using the variation with drawing
Time required	45–60 minutes
Method	1. Ask the participants to quickly draw two different pictures of 'someone like themselves.' After they have finished these drawings, tell the group that one drawing represents someone who has risk behaviours and is vulnerable to HIV. If necessary, explain what is meant by risk behaviour. Ask them to choose which drawing this will be. 2. Now ask them details about the imaginary person in the drawing. Help them to build up a story around the drawing: ▪ What is the name of the imaginary person? ▪ Where do they live? ▪ What is their life like? ▪ Why are they vulnerable to HIV? 3. Tell them the other drawing is of someone who does not have any risk behaviour and who is not very vulnerable to HIV. Ask them similar questions and help them to build a separate story around the imaginary person in the second drawing. This time ask them why the person is not very vulnerable to HIV. 4. When the two stories are complete, ask the group to think of things that would help the person in the first drawing become more like the person in the second drawing. After some discussion, ask them to settle on one (or more, depending on the time available) change that would really help the person to reduce their HIV risk. It does not necessarily have to be a change that the person in the drawing would make themselves—it might be a change that other people have to make. 5. Now ask the group to make a series of brief drawings outlining the steps necessary for the change to happen. 6. Finish the session by asking the group to reflect on what they have shared and learned during the session that will be useful to them.
Adaptation for repeat use	A good story can be revisited several times to plan how change can happen. Alternatively, new stories can be generated with the same group.

Method (10) Key Population Storytelling

Purpose of the method	To enable key populations to reflect on options and choices in particular situations that may reduce the risk of HIV/STI infection
Requirements for facilitation	Good knowledge of situations that may lead to key populations having HIV/STI risk behaviours, and knowledge of realistic strategies to reduce this risk for key populations
Degree of privacy	Can be done in public depending on the nature of the situation chosen by participants for the story
Material required	Any prop that can act as a 'trigger' for the story
Time required	45–60 minutes
Method	1. Settle the participants with an icebreaker 2. Ask participants to list situations in their daily lives that might lead to behaviour that puts them at risk of HIV/STI infection. Discuss priorities and settle on a particular situation for the story. 3. Use the trigger, saying that the object (book, watch, shoe, etc.) belonged to someone who was in the potentially risky situation chosen (i.e., having group sex, measuring out drugs, etc.) 4. Ask the participants to come up with a short story (in groups or altogether) about a person in the potentially risky situation they have chosen. They should give the story characters names, describe them, and explain events leading up to the potentially risky situation. 5. Now ask participants to volunteer to role play the story. Just before the risk behaviour occurs, ask them to 'freeze' the action. Make sure that the volunteers are frozen in a comfortable position. Ask the participants if they know of anyone who has been in a similar situation and ask them to describe what happened next. 6. Now ask: what options do the people at the freeze point have to avert or reduce the risk of HIV/STI infection? Once the group has agreed on some realistic options, ask different volunteers to role play them to see how they might work in practice. Discuss the outcomes—did the options help to reduce risk of HIV/STI? If not, why not? 7. Now ask: Is there anything the people could have done to avoid the potentially risky situation altogether? Discuss these options for acceptability and for how realistic they might be for key populations to put into practice. 8. Finish the session by asking the group to reflect on what they have shared and learned during the session that will be useful to them.
Adaptation for repeat use	This activity can be interrupted and continued later, starting the next time with participants being asked to summarise the story and discussion from the previous meeting.

Method (11) Key Population Advisors

Purpose of the method	To enable key populations to discuss who they can go to for advice and to build skills in assessing advice given on HIV/STI risk reduction
Requirements for facilitation	Knowledge of key population context and social networks; knowledge of what the group needs to gain in terms of knowledge and skills for HIV/STI risk reduction
Degree of privacy	Medium—can be done in public depending on the nature of the dilemma being discussed
Material required	Props or labels to remind people who the advisors are
Time required	45–60 minutes
Method	1. Settle the group with an icebreaker. 2. Split the participants into small groups and ask them to come up with a barrier to HIV/STI risk reduction that is a problem for their key population group/subgroup (e.g., police harassment, fear of HIV testing). Share the problems from each group and decide together which one is a priority to analyse. 3. Ask the participants to list 'people their key population group/subgroup go to for advice, people whose advice is trusted and respected.' Choose five or six of these key population advisors and ask for volunteers to role play the advisors. Note that there should be a diverse range of types of advisors selected. 4. Ask the group who came up with the problem chosen for analysis to quickly present the dilemma to the advisors. They should do this by telling a short story about a fictional character who has the problem, giving the character a name and presenting some imaginary background information. 5. Ask each advisor in turn to give solutions to the problem presented. Ask the participants to say which advisor has given the best solution. Briefly ask volunteers to act out this solution and discuss how/if it worked and if not, why not. 6. Now ask the participants if they know of anyone in real life who has faced this problem. What happened? 7. Finish the session by asking the group what they have shared and learned during the session that will be useful for them.
Adaptation for repeat use	This activity can be repeated using different dilemmas and different advisors.

Method (12) Key Population Drawings

Purpose of the method	To enable key populations to discuss how HIV/STI risk can be reduced in the context of their everyday lives
Requirements for facilitation	Good knowledge of HIV/STI risk behaviours and risk reduction techniques and strategies for key populations
Degree of privacy	Low
Material required	Chart papers, makers
Time required	45–60 minutes
Method	1. Settle participants in with an icebreaker. 2. Give each participant a chart paper and markers. If there are many participants, split them into groups and give each group paper and markers. 3. Ask each group to draw a scene from the lives of their key population group/subgroup. It can be anything they want to portray from the time of waking up to going to bed. It can be part of work or personal lives. 4. Ask each group to present their drawing to the rest. 5. Ask all the participants to look at the drawings and to pick out aspects of key population lives that might make them vulnerable to HIV. Correct any misconceptions and challenge any prejudices. 6. Now ask the groups to take back their drawings and to make one change to their drawing that would lessen the risk of HIV/STI. 7. Discuss the changes to assess them for how realistic and acceptable they are to the key population group/subgroup. 8. Finish the session by asking the group what they have shared and learned during the session that will be useful for them. Let the participants keep their drawings.
Adaptation for repeat use	This activity can be repeated by specifying the type of scene to be drawn—with relatives/family, with close friends, with the authorities, etc.

Method (13) Body Mapping

Purpose of the method	To enable key populations to explore HIV/STI vulnerability factors relating to the body and to discuss nonpenetrative sex techniques
Requirements for facilitation	Good knowledge of HIV/STI vulnerability factors relating to the body
Degree of privacy	Medium to high
Material required	Chart papers and markers, or chalk for drawing on concrete
Time required	45-60 minutes
Method	1. Settle the participants in with an icebreaker. If necessary split them into (peer, same sex or gender) groups 2. Ask for a volunteer in each group to lie on the ground and have someone trace the outline of his/her body on the ground or on the chart paper. 3. Ask participants to treat the outline as a naked body and to draw in the details. 4. Now ask participants to discuss the following questions: ▪ Where are the places on the body that feel good when touched? ▪ Which parts of the body are vulnerable to HIV? How can the virus enter the body? What makes it easier for the virus to enter the body? Correct any misconceptions ▪ What options are there for safer sex, particularly non-penetrative sex? ▪ Finish the session by asking the group to reflect on what they have shared and learned during the session that will be useful for them. Let the participants keep their drawings.
Adaptation for repeat use	Body mapping can be repeated to look at the symptoms of different STIs or to focus on what gives pleasure in sex. It can also be used to look at drug injection sites and to discuss ways in which to reduce harm associated with injecting.

Method (14) Love Life

Purpose of the method	To enable key populations to analyse their practices with a range of sexual partners and identify where action needs to be taken to reduce the risk of HIV. The method can also help to estimate the volume of penetrative sex and the need for condoms within particular key populations.
Requirements for facilitation	Good knowledge of key population sexual networks and strategies for reducing HIV risk
Degree of privacy	High
Material required	Chart papers and markers
Time required	30 minutes to 1 hour
Method	This method can be facilitated in a group or with an individual key population member. 1. Ask a key population member to draw himself/herself at the centre of the chart. 2. Ask him or her to draw pictures of their sexual partners all around their own picture and describe the partners (without naming them)—who are they, what do they do, how old are they. 3. Ask how many partners they had sex with in the last week and ask them to mark this on the chart. 4. Explore how many times they had sex with each of these partners and how many penetrative (vaginal or anal) sex acts they engaged in. 5. Ask them to analyse sexual practices with each partner and identify where there is most risk of HIV. Help them determine why there is more risk of HIV with particular partners and what could be changed to minimise this risk. 6. Finish the session by asking the group what they have shared and learned during the session that will be useful for them. Let the participants keep their drawings.
Adaptation for repeat use	In a group, this exercise could be done to discuss community norms and how to minimise risk.

Method (15) Me, I, Myself

Purpose of the method	To enable key populations to understand the risks associated with drug injection, what might be barriers to safer practices and how to address these barriers.
Requirements for facilitation	Good knowledge of drug injection practices in the area and good understanding of how risk or harm to people who inject drugs can be reduced.
Degree of privacy	Very high
Material required	Chart papers and markers
Time required	30 minutes to 1 hour
Method	This method can be facilitated in a group or with an individual key population member. 1. Ask each participant to recall the number of injecting episodes during the last week and make a symbol for each one in a column drawn on the chart paper. 2. Ask them to put additional symbols in a second column next to each injecting episode to show if equipment was shared and if shared what materials were shared. 3. Using a third column, ask them to note if equipment was cleaned before sharing for each injecting episode and what was used for cleaning. 4. In a fourth column participants note what circumstances influenced their decisions about sharing/cleaning of injecting equipment 5. Ask the group to discuss barriers and solutions in the particular circumstances described
Adaptation for repeat use	In a group, this exercise could be done to discuss drug user norms rather than recalling their own behaviour, and talk about how to minimise risk.

Section C: Integrating IPC Into Existing HIV Projects

Achieving project objectives

InterAct IPC can contribute to a variety of different objectives that HIV prevention projects may want to achieve.

Project Objective	Role of InterAct IPC
1. Reducing individual key population risk of HIV/STI	Promotes sharing of experiences, builds skills in critical reflection, helps to put messages into practice, generates awareness of shared vulnerability, generates practical solutions and reinforces messages, creates social capital for risk reduction, addresses myths and misconceptions, separates person from the issue.
2. Increasing key population mobilisation for HIV prevention	Helps identify barriers to mobilisation and opportunities for mobilisation, and motivates people to mobilise. Helps politicise the issues (for common cause and rights).
3. Creating an enabling environment to support HIV prevention	Helps increase confidence levels and collective power and solidarity of key populations and can mobilise a collective voice across key populations. Helps to identify the strategies for advocacy and to prioritise issues for advocacy.
4. Strengthening key population ownership of services	Helps identify the need for key population control and ownership of the response to HIV, identifies what they can contribute, creates structures/functions for key population involvement, motivates key populations to become involved and to take responsibility.
5. Strengthening demand creation for services and commodities	Helps to prioritise services and commodities, helps key populations to see the need for services, helps to identify barriers to access of services and commodities and to address these barriers.
6. Ensuring that appropriate HIV prevention services are in place	Identifies the need for different or new services, motivates key populations to take action to put services in place, motivates key populations to advocate for services.
7. Assuring quality of services for key populations	Identifies what key populations think of services, generates ideas to improve the quality of services and ways to address barriers to providing quality services.
8. Increasing coverage of key populations	Helps to identify new and hard to reach key populations. IPC sessions also create a 'ripple effect' as key population members who have participated in sessions relate their discussions back to their friends.

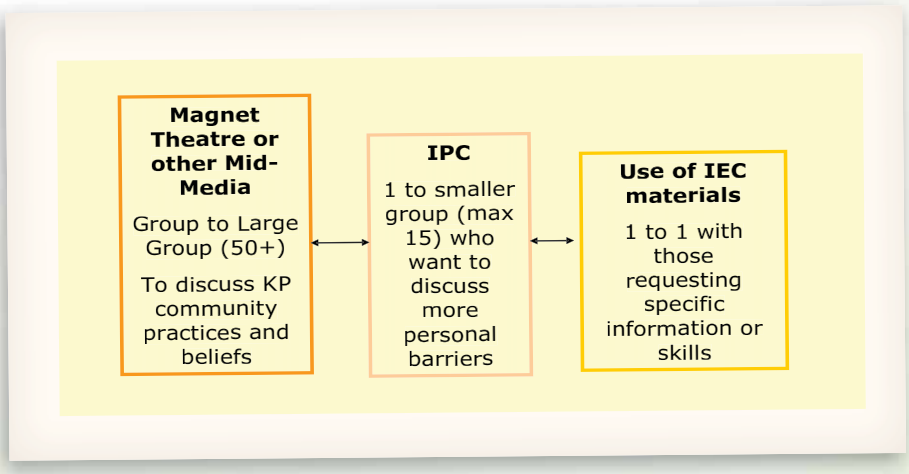
Integrating IPC into the work of peer educators

Peer educators are an important component in HIV prevention activities with key populations. They are the direct link between the project and the community and can make a big difference to the success of a project.

Peer educators can:

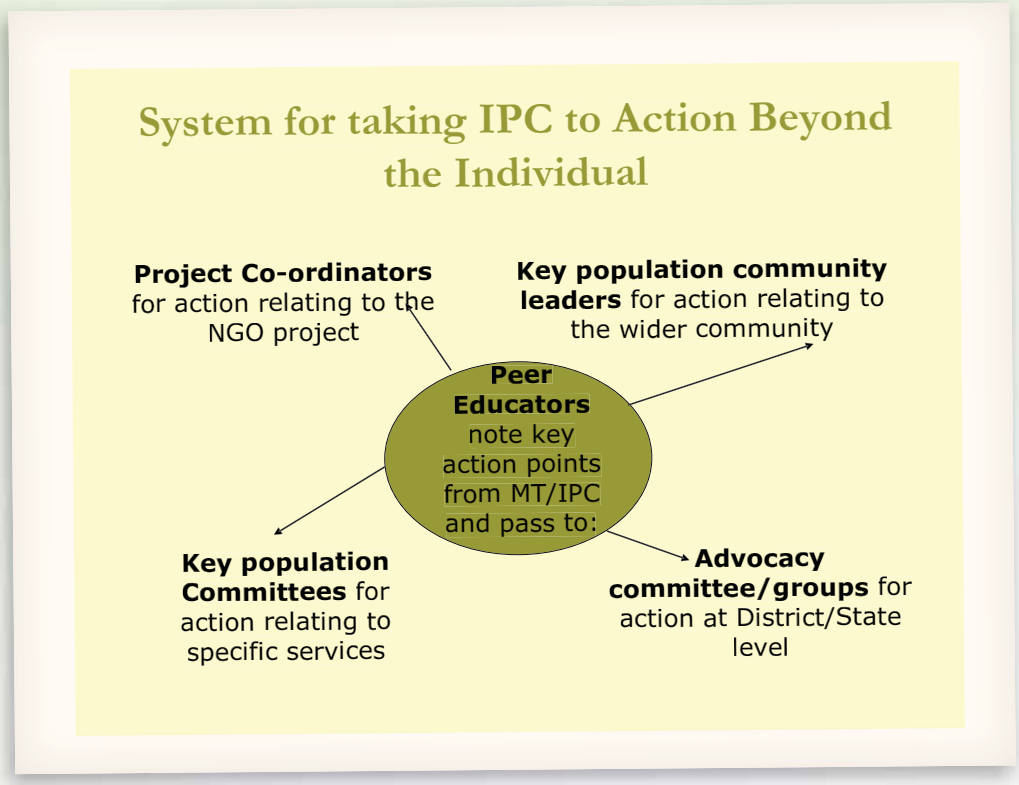
1. **Promote and organise** events such as social, cultural, and other activities.
2. **Build rapport** and encourage new key populations to IPC/mid-media activities and to other services.
3. **Distribute condoms**, lubricant, and other commodities.
4. **Advertise and promote** project services.
5. **Facilitate group-to-group dialogue-based mid-media** (like magnet theatre) and use appropriate facilitation to plug information gaps.
6. **Facilitate one-to-group InterAct IPC,** and use appropriate facilitation to plug information gaps.
7. **Implement one-to-one sessions with IEC** for more detailed information and skills transfer with individuals who request this after group sessions (condom demonstrations, information on STI symptoms, etc.).
8. **Implement one-to-one sessions using InterAct IPC** for risk reduction where it is more effective (i.e.. with home-based sex workers, after group sessions, etc.).
9. **Promote action** by making referrals and accompanied referrals, feeding information back to the NGO or CBO to provide more effective services and interventions, to the community for advocacy, and to other service providers for improving their services.

The potential synergy between mid-media, IPC, and IEC is shown in the diagram below.



Feedback systems for IPC

Peer educators should be recognised as the "eyes and ears" of the project to inform the organisation about changes in practices or in the environment. It is also their job to feed suggestions from key populations back to the organisation to improve the project. To do this, it is necessary to have a feedback system both into the project and also from the project to other service providers (see diagram below).



A case study showing how InterAct IPC was integrated into an HIV prevention project with truck drivers in India

Project Kavach is a national HIV prevention program for truck drivers implemented by the TCI Foundation and funded by Avahan, the India AIDS Initiative. Project Kavach works in 17 major halt points with about two million long-distance truck drivers. This highly fragmented long-distance trucking community in India has had minimal access to quality medical services over the years. Truck stops are generally located outside cities and have minimal medical infrastructure. Often the only health service providers are quacks offering quick fixes of questionable quality. Moreover, truck drivers spend most of their time on highways and have little time between journeys to access services outside truck stops. In addition, outreach work in trucker interventions in India has been impeded by the idea that trucker mobility makes it impractical to train and retain truck drivers as peer educators. Using non-peer educators has resulted in low credibility of outreach workers, message fatigue, and disengagement with program activities.

Project Kavach has used the mobility of truck drivers to its advantage by replacing NGO-trained social workers with truck driver peers at each intervention site. In 2007, 350 truck drivers trained in InterAct IPC conducted 5,000 monthly group discussions on vulnerability reduction and HIV prevention, reaching out to 60,000 truck drivers. A team of 28 supervisors schedules, builds capacity, and monitors field activities. Feedback from these IPC group helps distil the most relevant information gaps, myths, and misconceptions around HIV/AIDS, safe sex, and STIs. This feedback is used to develop issue-based mnemonics and thematic street theatre which addresses key issues. Feedback from IPC was further used to amplify communication through audiocassettes and "health games" at information kiosks. These communication themes are periodically re-focused based on review between NGO staff and IPC facilitators. Peers, supervisors, medical staff, and NGO management jointly review program activities and plan the next period every fortnight.

Project Kavach also re-organized clinics on a hub-and-spoke model of static and mobile satellite clinics with community input on clinic branding and hours of operation. General health services were added to STI treatments. The program co-located IPC sessions, street plays, and information kiosks with participatory games to create a "buzz" around program services. Creative signage depicting active truck drivers as role models used positive messaging to promote healthy behaviour. Fortnightly meetings between program medical teams and the 350 peer IPC facilitators ensures continuous feedback and clarification on myths and misconceptions around HIV/AIDS and STIs. With these changes, clinic attendees rose from 97,080 to 188,693; STI treatments increased from 22,690 to 43,621; and condom sales increased from 654,315 to 1,306,837 in comparative annual periods. In 2007, truck drivers referred by IPC facilitators comprised 40 percent of all clinical treatments.

Section D: Maintaining the Quality of Interact IPC

This section gives examples of tools that can be used to help assess the quality of IPC and determine how NGOs and CBOs can help IPC facilitators to make their work more effective.

InterAct IPC capacity standards

The following is a list of 13 basic standards for conducting InterAct IPC. The standards are useful only to the extent that users are committed to honest and critical reflection, and can be used by organisations to identify their own capacity-building needs, plan technical support, and monitor and evaluate their IPC progress.

These standards are not "indicators" that can be objectively measured; rather, they are designed to stimulate discussion within the organisation so that creative ways to optimise their IPC implementation can be found. The capacity standards should be used in planning, and then checked throughout implementation.

All IPC sessions have moved beyond giving messages to the key populations, and IPC facilitators now involve key populations in discussion, debate, and critical reflection about reducing their risk of HIV/STIs.

- Do the IPC facilitators provide enough space, security, and stimulation to enable participation of key populations in discussing 'their' issues of HIV/STI risk reduction? How?

In all IPC sessions, key populations are helped by the IPC facilitator to do the following three things:

1. Analyse their barriers to risk reduction.
2. Find acceptable and realistic solutions to these barriers.
3. Plan how they will put the solutions into practice.

- Do the IPC facilitators take the participants through the stages of IPC?
- Do the facilitators pick barriers from those identified by the key populations for analysis or provide their own list of barriers?
- Do the facilitators suggest solutions and have discussion on what is acceptable and practical for the key populations?
- Do the facilitators discuss ways in which to take the solutions to action?

During IPC sessions, key populations are always encouraged by the IPC facilitators to share their own practical risk-reduction techniques and assess the effectiveness of these techniques.

- Do the key populations share their risk reduction techniques?
- How often do the IPC facilitators need to 'push' the discussion rather than facilitate it?

The organisation promotes and sustains appropriate values and attitudes for working with key populations amongst all staff, and particularly amongst IPC facilitators (e.g., they are sensitive to key population's vulnerabilities, are nonjudgmental about sexual practices and lifestyles of key populations, and work on behalf of the key populations).

- Have there been any incidents of IPC facilitators being treated 'differently' by the organisation as they belong to a particular key population group?
- Do the IPC facilitators hesitate in introducing themselves as key population members?
- Do facilitators find some of the sexual behaviours practiced by a key population member unacceptable?
- In the role of IPC facilitators, do they feel different from the key populations?

IPC facilitators who are selected are acceptable and credible to the key populations in the site.

- How does the organisation select, train, and support IPC facilitators?
- Is the process of selection transparent and capable of selecting the desired IPC facilitators?

- Do the IPC facilitators face difficulty in mobilising a group for a session?
- Do they enjoy credibility in the group because key populations respect them or is there any other reason for that?
- How many IPC facilitators are true key populations?

IPC facilitators meet regularly to share information and are able to access regular training, supervision, and feedback to update their skills and knowledge.

- Is there a mechanism by which regular interactions take place between the IPC facilitators? What is it?
- How does the organisation identify training needs of IPC facilitators?
- How often are training programs organised for them?
- How does the organisation provide feedback and supervision?

IPC facilitators have consistent supplies of condoms and lubricants and other risk-reduction commodities and information for demonstration and discussion purposes. They also have sufficient supplies of paper and markers and other materials needed for IPC methods.

- Do IPC facilitators have adequate supplies to enable smooth implementation of IPC?
- If there is a shortage what do they do?

IPC facilitators are able to make a safe space for the maximum number of key populations to participate in IPC sessions. They can facilitate sessions in which key populations feel comfortable to share sensitive issues. They use methods that help key populations be creative in finding solutions to problems. They work at times convenient to key populations, and which do not interfere with income generation.

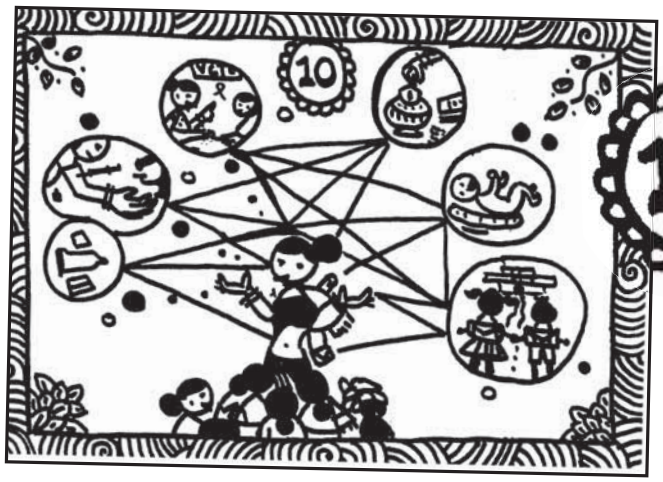
- Do they know how and when and where to work with key populations?
- Have there been instances of public interference or opposition or violence during or after the IPC sessions?
- Are the key populations comfortable discussing sex and sexuality with the IPC facilitators?
- What is the proportion of sessions where the facilitator 'does' the method for the group?

IPC facilitators keep informed about key HIV/ STI risk-reduction issues that are relevant for the key populations in the site.

- Are Facilitators able to respond to the hierarchy of key population needs (e.g., on a continuum from basic prevention skills and knowledge for new entrants to the key population community, to VCT and positive prevention for those who have been around longer).

IPC facilitators can link key populations with other prevention services in the site (e.g., STI treatment, VCT, condoms, lubricant, injecting equipment, counselling, mutual support opportunities, etc.) They also are able to refer key populations to other services that are important to them (e.g., credit, childcare, education, etc.).

- Do the IPC facilitators have a knowledge of most (if not all) of the HIV/ STI prevention services available in their site?
- Do the IPC facilitators have a knowledge of most (if not all) of other (than HIV/ STI prevention) services available in their site?
- How many referrals do they make every month (average)?



The organisation is aware of and able to reach key populations who are hardest to reach with IPC methods and actively targets new key populations and those key populations most at risk.

- What are the ways by which the IPC facilitators get information about new key populations?
- What's the ratio of new to old participants in a session?

Regular feedback from IPC work in the field helps the organisation to understand the changing needs of key populations in terms of risk reduction and to adapt other intervention strategies accordingly.

- How does the organisation learn about changes in the site and about issues that affect the vulnerability of different key populations?
- How often do the IPC facilitators meet with the NGO coordinator?
- Does the organisation have committees with significant key population representation in it?

The organisation contributes to, and learns from, the implementation of a state-level communication strategy using information collected on a regular basis from their IPC monitoring.

- How is the information gathered from IPC sessions collected from the IPC facilitators and documented by the organisation?
- How has the information collected from the implementation of IPC helped the organisation in tuning their programs/interventions to the needs of the key populations? Examples?
- How often does the organisation share the information generated from IPC sessions with other stakeholders, policymakers, etc.?

Examples of self-assessment tools for InterAct IPC facilitators

1) Basic IPC Facilitator Self-assessment Tool

On a score of 1 to 4, mark yourself on the following pointers					
Score Card - 1-Poor, 2-Average, 3-Good, 4-Excellent					
		SCORE			
No	Pointers	1	2	3	4
1	I am able to reach a maximum number of key populations in the area without disrupting their regular work.				
2	The place where I conduct the session is considered 'safe' by the key populations who participate in the session.				
3	The participants share personal information on issues like sex and sexuality, personal sexual behaviors, etc. with the group.				
4	The participants ask questions about sensitive issues without hesitation.				
5	The methods I use allow or help the group to think of creative/innovative solutions to their problems.				
6	In the session, the key populations share their own practical risk-reduction techniques.				
7	In the session, the key populations analyse their barriers to risk reduction, identify acceptable and realistic/practical solutions, and plan how the solutions will be adopted.				
8	I am able to refer to or link key populations (as per their immediate need) with other prevention services such as STI clinics, condom depots, VCT centres, injecting equipment, etc. in the area.				
9	I am able to answer all the questions around HIV/STIs that come up during the discussion.				
10	I always have enough condoms, lubricants (for demo and distribution if applicable), and materials (charts, markers) for the sessions.				
11	I am able to communicate clearly the steps involved in facilitating the IPC methods.				
12	I regularly feed back the findings/information from the IPC sessions to the organisation.				
13	During my sessions, I encourage the participants to draw and represent their concerns/information the way they want.				
14	I have the ability/skills to get all key populations to participate in a manner that they choose and to the full extent possible.				
15	While conducting the sessions I am able to draw out relevant points for discussion.				
16	At the end of each session, I note the summary of discussion in my diary for my records.				

17	I have the ability to select IPC methods and sequence them in a way that makes the group comfortable and open to talk and share.				
18	I am open about explaining the purpose of the exercise and the objective of using the IPC methods.				
19	After discussing the group's risk-reduction strategies, I share other risk-reduction strategies being adopted by other key population groups that are relevant to the group in question.				
20	I have complete knowledge about the living conditions of different key populations and the relationships between them (e.g., between sex workers and truckers or MSM or IDUs, etc.).				
21	When I meet the key populations I do things such as introduce myself as one of them, listen to them, respect them, and talk to them in their vocabulary to make sure that my status of being an IPC facilitator does not inhibit the participation of others.				

Discussion points:

1. How did you overcome the difficulties?

2. To make the IPC session more effective in the future, what would you do differently?

3. Were you able to reach the difficult-to-reach key populations such as home-based sex workers, female IDUs, transgenders, hirjas, panthis, etc.? If yes, how?

2) Example of format to follow during IPC facilitator and NGO feedback meetings

Discussion on technical issues concerning IPC implementation in the field					
Which were the top three IPC methods implemented amongst the key populations in the past 15 days?					
What were the main key population issues or concerns that emerged out of the IPC sessions with special focus on:	List of issues or concerns that emerged	What was the support requested to the NGO by the IPC facilitator to address the issues and concerns emerging out of the IPC sessions?	What action did the NGO undertake on the support requested by the IPC facilitators?	What action did the IPC facilitators undertake to address the issues and concerns emerging out of the IPC sessions?	If the issues cannot be addressed immediately in the meeting, outline how the NGO and IPC facilitator plan to address the issue and its timeline
a. Myths and misconceptions					
b. Utilisation of HIV/STI services					
c. Perception of HIV/STI risk					
d. HIV/STI risk-reduction strategies					
What were the technical challenges faced by IPC facilitators while doing the IPC sessions? (example of technical challenges: HIV/ STI knowledge, key population timings and availability, safe space, cooperation by brokers and transport owners, demands from the truck drivers/helpers that is not covered by the project)					

What were the technical challenges faced by the IPC facilitators in the skill domain (based on the IPC facilitator self-assessment format)					
Discussion on IPC facilitators administrative issues					
List the administrative, logistical, and financial issues discussed in the meeting					
Action taken by the NGO and IPC facilitator combined, to address the administrative, logistical, and financial issues?					
What was the criterion adopted for scheduling of units among the IPC facilitators?					
Is the criterion acceptable to IPC facilitators. Explain why or why not (elaborate the points of discussion on scheduling of units).					
Date for the next meeting					

Initials:

Key population facilitator(s) _____

NGO staff _____

Section E: Sample Interact IPC Training Schedule

Agenda for training of trainers in InterAct IPC

Day	Session 1	Session 2	Session 3	Session 4
1	Welcome participants, introductions, expectations and objectives of the workshop, ground rules, house keeping	Introduction to InterAct IPC with the help of IPC method – Key Population Drawing, and a showing of the film on IPC	Introduction to the Eye to Eye IPC Framework Key points for trainers	Introduction to IPC method – Services Map
2	Facilitation skills— what is facilitation, what are the skills needed to be a good IPC facilitator	IPC method – Why Is It So? Steps in facilitating InterAct IPC	IPC method – How Hot Is the Spot?	Field work
3	Field experience sharing	IPC method – Graffiti HIV/STI question and answer session	IPC method – Margolis Wheel How to take solutions to action	Field work
4	Field experience sharing	Other IPC methods – Body Mapping, Statues, Love Life	How to use IPC Capacity Standards and self assessment tools	Next steps, planning, workshop evaluation

Agenda for training of peer facilitators in InterAct IPC

Day	Session 1	Session 2	Session 3	Session 4
1	Welcome of participants, introductions, expectations and objectives of the workshop, ground rules, house keeping	Introduction to InterAct IPC with the help of IPC method – Key Population Drawing, and a film on IPC	Introduction to the Eye to Eye IPC Framework	Introduction to IPC method – Services Map
2	What is facilitation, what are the skills needed to be a good IPC facilitator	IPC method – Why Is It So? Steps in facilitating InterAct IPC	IPC method – How Hot Is the Spot?	Field work
3	FieldeExperience sharing	IPC method – Graffiti HIV/STI question and answer session	IPC method – Margolis Wheel	Field work
4	Field experience sharing	Other IPC methods – Body Mapping, Statues, Love Life	Next steps	Workshop Evaluation