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# HIV prevention among injecting drug users and their female sex partners

*Implementation gaps and barriers*

A STUDY IN PUNJAB, HARYANA AND CHANDIGARH



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## Preface

In recent years escalation of Injecting Drug Use (IDU) as well as the prevalence of HIV among IDUs in Punjab, Chandigarh and Haryana has been a significant concern. While the problem of drug use in these states has been recognized and documented for some time, in the recent past there has been an explosion of IDU and associated HIV in some parts of Punjab, Haryana and Chandigarh.

As a matter of fact, nationally too, IDU has become one of the most vital factors in the HIV transmission dynamics in India. Though the current number of IDUs in India is 200,000, the HIV prevalence among IDUs is very high. The surveillance data for 2008-09 shows that of the nine districts reporting more than 15% HIV prevalence among IDUs in the country, 3 districts are in Punjab alone (NACO, 2008).

There is a need to understand the scale of the response required to prevent any further escalation of the drug-HIV epidemic in the states of Punjab, Chandigarh and Haryana. Like Northeast India, there are chances of further increase in the concentration of HIV epidemics among people who inject drugs in these states. Immediate steps need to be taken to ensure that a package of services for IDUs and their sex partners is made available – services that are equitable, accessible, affordable, comprehensive and sustainable in keeping with universal access goals.

Further, some of the related key challenges also include improvement in the quality of services, expansion of services to reach individuals at a larger scale, services for Hepatitis C, tuberculosis and other health consequences of unsafe injecting drug use.

It is against this backdrop that UNODC commissioned this study to identify the gaps in the response to drug-IDU-HIV epidemic in the states of Punjab, Chandigarh and Haryana. UNODC also aims to recommend strategies to address these gaps by informing policy and decision-making and through advocacy with program implementers. For this purpose, this study included the broad principles of a rapid situation assessment, wherein the data (both secondary – in the form of published reports, and primary – in the form of interviews with key informants) were collected from various sources, triangulated, and used to generate the overall picture of the IDU-HIV epidemic and existing responses to it.

Conscious efforts have also been made to help understand the different contexts in which injecting drug use occurs and services for IDUs are delivered. It also involved identifying structural, societal and other factors that may impede the successful delivery of these interventions, and working towards creating a more supportive environment. The means by which identified gaps and barriers might be addressed have also been suggested.

In conclusion, we hope that this strategy will help the National AIDS Control Programme and development partners in augmenting the existing HIV response for IDUs by removing the barriers and thereby maintaining and increasing specific activities to a scale where they will effectively prevent HIV transmission among IDUs and assist in treatment, care and support, especially for those who need it most.

## Acknowledgement

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# Abbreviations

AAP	Annual Action Plan
AIDS	Acquired Immunodeficiency Syndrome
AIIMS	All India Institute of Medical Sciences
AOL	Art of Living (foundation)
ART	Anti-Retroviral Therapy
ASHA	Accredited Social Health Activist
CBO	Community Based Organization
CHC	Community Health Centre
CME	Continuous Medical Education
CMIS	Computerized Management Information System
DDAP	Drug De-addiction Program
DOTS	Daily Observed Treatment – Short-course
FINGODAP	Federation of Indian NGOs for Drug Abuse Prevention
FPAI	Family Planning Association of India
FSW	Female Sex Worker
GMCH	Government Medical College Hospital
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HRG	High Risk Group
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug Use
IDUs	Injecting Drug Users
MOH&FW	Ministry of Health and Family Welfare
MSJE	Ministry of Social Justice and Empowerment
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation

NACP	National AIDS Control Programme
NDDTC	National Drug Dependence Treatment Centre
NGO	Non-Governmental Organization
NRHM	National Rural Health Mission
NSEP	Needle Syringe Exchange Program
OST	Oral Substitution Treatment
PGIMER	Post-Graduate Institute of Medical Education and Research
RRTC	Regional Resource and Training Centre
SACS	State AIDS Control Society
SHG	Self Help Group
SPYM	Society for Promotion of Youth and Masses
STI	Sexually Transmitted Infection
STRC	State Training and Resource Centre
TI	Targeted Intervention
TOT	Training Of Trainers
TSU	Technical Support Unit
UNAIDS	Joint UN Program on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime



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## EXECUTIVE SUMMARY

The escalation of injecting drug use (IDU) as well as the prevalence of HIV among IDUs in Punjab, Chandigarh and Haryana has been a matter of concern in the recent past. There is a need to understand the adequacy of the response to the drug-HIV epidemic in these states. Thus, UNODC ROSA commissioned this study to identify the gaps in the response to the drug-IDU-HIV epidemic in this part of the country and to recommend strategies to address these gaps for the future programming. For this purpose, the study followed the broad principles of a rapid situation assessment, wherein the data (both secondary – in the form of published reports, and primary – in the form of interviews with Key Informants) were collected from various sources, triangulated and used to generate the overall picture of the IDU-HIV epidemic and existing responses to it.

### The Drug-HIV Situation and Responses to It

While the problem of drug use in these states has been recognized and documented for some time, in the recent past there has been an explosion of IDU and associated HIV in some parts of Punjab, Haryana and Chandigarh. The review of epidemiological studies indicated that:

- Injecting drug use is now a well established pattern of drug use in this part of the country
- Most of the IDUs are young employed men, many of whom are married
- Both married and unmarried IDUs alike report indulging in high risk sexual behaviours
- The spouses of IDUs remain at risk of transmission on account of lower levels of HIV awareness and husbands' risky practices

- Almost all IDUs predominantly inject pharmaceutical opioids and are opioid dependent

The HIV epidemic among the *general population* in these three states has remained largely stable – and at a low level – over the past few years. However, the HIV prevalence among *IDUs* is a different story; in Punjab and Chandigarh, the prevalence of HIV among IDUs remains consistently high. Thus, IDU remains the primary driving force behind the HIV epidemic in Punjab and Chandigarh.

As far as the drug treatment ('de-addiction') is concerned, there are many NGO-run de-addiction centres (supported by the MSJE), de-addiction centres associated with many government healthcare facilities as well as a number of private hospitals/practitioners or drug treatment centres. In Punjab particularly, there has been a rapid increase in the number of Government de-addiction centres in the recent past. However, as indicated by many data sources, drug treatment access and utilization remains poor in Punjab and Haryana among IDUs.

Under the National AIDS Control Programme (NACP)-III many Targeted Interventions (TIs) have been established in this part of the country. Other institutional mechanisms such as the Technical Support Unit (TSU) have also been established to provide assistance to TIs, including help on strategic planning. However, the TSU is present in Punjab but not in Haryana and Chandigarh. Additionally, there is also a common State Training and Resource Centre (STRC) for all three states – Punjab, Haryana and Chandigarh – for conducting training programs for NGOs implementing the targeted

interventions as well as for developing training resource materials.

In the recent past there has been a rapid increase in the number of IDU TI sites in Punjab (total 15 TIs), Haryana (total 3 TIs) and Chandigarh (total 2 TIs). While the issue of estimated size of IDU populations in Punjab and Haryana remains debatable, the coverage of IDU population with TIs, even with the most conservative estimates, remains poor; about 60% of IDUs in Punjab and about 90% of IDUs in Haryana remain uncovered by the TIs, which is an unacceptable gap in coverage.

## Gaps and Barriers to Response

In the area of Prevention of HIV, the following major gaps and barriers were found.

### Lack of comprehensive services

Detoxification/Drug treatment services are what many IDUs demand but are unable to access due to inadequate resources with the TIs. The gap is compounded by the inadequate numbers of drug treatment centres and the quality/standards of services they offer. A major missing link in the response has been lack of services for the sex partners/spouses of IDUs. As of now, the spouses and female sex partners of male IDUs remain largely ignored by the TIs and hence remain vulnerable to HIV infection and other consequences of spousal drug use. Also, at present the resources available for the TIs do not permit them to extend the benefit of accompanied referrals to an adequate number of clients, affecting the uptake and utilization of various essential services by the IDUs. Additionally, there is no mechanism to help the IDUs with vocational rehabilitation. The rising prevalence of HIV among IDUs – despite having TIs in place – indicates the need to expand the menu of options available. Thus, the biggest and most intensely felt gap is the lack of oral substitution treatment services in Punjab and Haryana.

### Lack of coordination

Various sectors are striving to implement programs to provide care and support to IDUs. However, very often these programs tend to operate as vertical structures with a distinct lack of coordination among them. This coordination is conspicuous by its absence both at the top-most levels as well as at the ground levels.

### Lack of optimum rate of response

In Punjab, it took reports of alarmingly high number of IDUs as well as high prevalence of HIV among IDUs to begin scaling-up the response. The current IDU-HIV situation should be seen as an early warning sign for Haryana, given its proximity to high HIV-IDU areas (Delhi on one side and Chandigarh, Punjab on another) as well as the presence of a sizable number of IDU populations. One major barrier in scaling up the TI coverage in these states has been the inadequate number of NGOs and/or inadequate capacities of the existing NGOs to initiate and implement the TI projects.

In the area of *Capacity Building*, the major barriers included lack of timely provision of training (partly due to overload on the single STRC catering to three states), concerns about division of labour and individual mandates/responsibilities of STRC/TSU/SACS, and lack of resource persons/material in local language.

While elaborate information management systems are in place, many TIs report being overwhelmed by the number and complexity of records they have to maintain. Additionally, there are concerns about lack of resources to comply with the reporting requirements.

## Recommendations

Based on the analysis of the situation and the gaps/barriers in the responses, certain recommendations have been put forward.

## Strengthening the institutional mechanisms

The primary institutional mechanisms for responding to the HIV epidemic, i.e. SACS, should be strengthened by either enhancing the capacities of SACS themselves through increasing the manpower and/or by having other institutions in place to assist SACS (like TSU in case of Punjab). Additionally, it is strongly felt that each SACS should have its own TSU and STRC.

To address the problem of finding suitable NGOs for implementing the TI projects, it would be important to make investments in the civil society. There should be a mechanism to engage with civil society even *before* it formally joins the drug-HIV program by either identifying the ‘budding’ NGOs and enhancing their capacities on the general NGO management issues and/or orientation/sensitization on drug-HIV issues of those NGOs that are working in other sectors.

## Expanding the ambit of TI program for IDUs

Since there is no provision or systematic guidelines at present for reaching out to female sex partners/spouses of IDUs, developing operational guidelines/training modules to reach out to female sex partners of IDUs is extremely important. It is felt that encouraging and supporting formation of self-help groups of women affected by family members’ injecting drug use may be very useful. Additionally, since the needs of IDUs are manifold and are not limited to the NSEP or condoms, a number of IDUs may have to be provided with logistic help to access drug treatment and help with vocational rehabilitation. This may, however, necessitate a relook at the operational and costing guidelines for IDU TIs.

One major recommendation would be to launch Opioid Substitution Treatment (OST)

for IDUs in Punjab at the earliest. The existing institutional arrangements as well as the general political will to address drug-HIV issues in Punjab make it the ideal state for initiating OST through government centres. Involving the government de-addiction centres in the OST program would ensure sustainability, improve access to other health-care facilities required by IDUs and expand the menu of services currently available at the government de-addiction centres.

## Tapping the available resources

Considerable resources in the states are waiting to be tapped for IDU-HIV programming. These include the Government de-addiction sector, the academic resources such as the PGIMER, the GMCH and the Punjab University, etc.

## Forging newer alliances and partnerships

A partnership between NACO/SACS and the MSJE and its institutions (such as the RRTC) at the top level may percolate to the bottom and provide an opportunity for a coordinated response by the service providers. Similarly, many spiritual organizations could also be roped in for a partnership; these could play important roles through employing innovative strategies. Encouraging the formation of a network of TI implementing NGOs could also help in increasing the member NGOs’ capacities, help them learn from each other’s experiences and enhance their collective bargaining power. Similarly, yet another avenue for partnership could be engagement with the professional/academic bodies such as the Indian Medical Association (IMA), the Indian Psychiatric Society (IPS), etc.

## Collection and management of information

Given the pace of the HIV epidemic among IDUs, it would be extremely important to

keep a tab on the trends of risk factors for this epidemic as well as on the performance of the responses to address it. In order to facilitate timely collection of comprehensive data, it would be important to provide necessary resources to the NGOs for doing so. Additionally, it would be extremely useful to collect data on certain behavioural parameters from the service

seekers. There must also be a provision for collecting the data through multiple sources and conducting triangulations. Other sources of data may also include those data collected by the non-NACO/SACS agencies such as the Drug Abuse Monitoring System (DAMS) through which the de-addiction centres (both MSJE supported as well as MOH&FW supported) collect periodic data.

## BACKGROUND

The escalation of injecting drug use in Punjab, Chandigarh and Haryana has been a matter of concern in the recent past. Similarly, the prevalence of HIV among IDUs has also been high in these states.<sup>1</sup> Though many Targeted Interventions for injecting drug users and addiction treatment programs are being implemented in these states, but there is a need to understand the adequacy of these programs to reduce HIV transmission and its impact among IDUs and their female sex partners.

With this background, UNODC ROSA commissioned this study to identify the gaps in the response to the drug-IDU-HIV epidemic in this part of the country. It is expected that the findings and the recommendations of this study will be useful for various stakeholders so as to plan and implement future interventions for IDUs in Punjab, Chandigarh and Haryana.

### Objectives

The twin objectives of this study were:

- 1) To identify the gaps in responses to the drug-IDU-HIV epidemic in Haryana, Punjab and Chandigarh
- 2) To recommend strategies to address these gaps for the future programming.

### Methodology

It must be understood that this study is an attempt to understand the drug-HIV epidemic in this part of the country at a macro level, and

provide recommendations for the response. The study is neither an attempt to conduct a mapping of various resources/services available nor is it an attempt to evaluate the existing services. For this purpose, the study followed the broad principles of a rapid situation assessment, wherein the data were collected from various sources, triangulated and used to generate the overall picture of the IDU-HIV epidemic and the existing responses to it.

The most important source of data was the secondary data, i.e. the data already existing. This data was available in the form of published research reports as well as in the form of unpublished data (i.e. grey literature). Most of this data was accessed through internet as well as through the key service providers active in this part of the country. Additionally, primary data was also collected in the form of interviews with certain key informants (KIs). Most of these KI interviews were conducted in the first week of December 2009 as in-person meetings. In certain instances, due to paucity of resources and time, certain information was also obtained telephonically. An attempt was made to conduct these interviews with key informants from a variety of backgrounds – from the senior project managers to the service-provider staff working in the field, both at the national level as well as at the state levels. The list of contacted individuals and organizations has been provided in the acknowledgement section.

Both the primary as well as secondary data were analyzed and the findings were documented,

<sup>1</sup> Chandigarh is a Union Territory. For the sake of convenience it has been referred to as a state at some places in the document.

identifying the existing gaps. These findings have been used to formulate the strategic recommendations for future programming. While some of the recommendations have come directly from the key informants,

certain others have been drafted by the author on the basis of situation assessment and gap analysis. The box below lists some of the key questions this study attempted to find answers to.

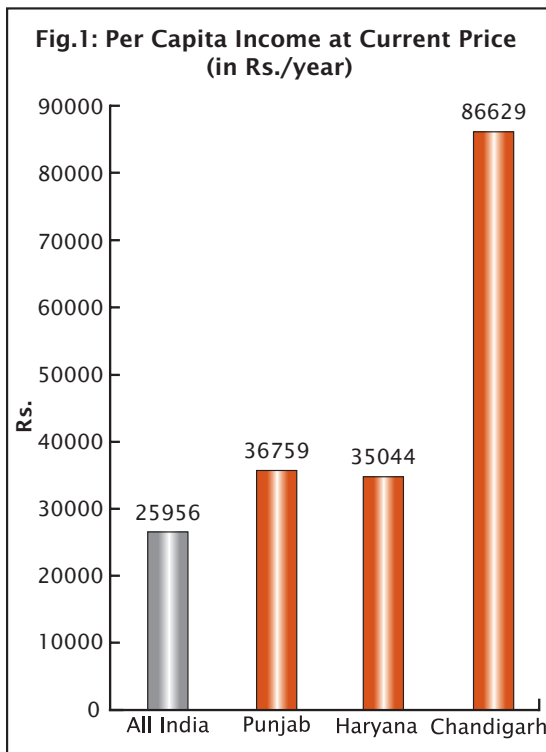
### **Box1: Key Questions**

- What is the nature of the drug-IDU-HIV epidemic in this part of the country?
- Is the epidemic here in any way (i.e. in terms of scale, intensity, rate of progression or qualitatively) different from other areas of the country?
- What has been the usual pattern of response to this epidemic so far?
- Is the response adequate in terms of its intensity and scope?
- Is the response rapid enough to be able to “halt and reverse” the epidemic?
- Who are the key players involved in this response?
- Are these key players empowered enough to be able to fulfil their roles to the desired level?
- Are these key players playing in tandem? Is there scope for strengthening the coordination among the players?
- Are there specific instances/examples of gross response gap? How can these gaps be addressed?
- Are there specific instances/examples of innovative strategies to respond? What are the untapped resources at the disposal? How can these untapped resources be utilized?
- What should be the broad outline of a future roadmap for the response?



## FINDINGS

This part of the country – Punjab, Haryana and Chandigarh – is among the most prosperous regions of the country. The per capita income in these three states is higher than the average for the country. In case of Chandigarh, it is about three times higher than the national average (see Figure 1).<sup>2</sup> In terms of ranking of states per capita income wise (current prices), Haryana tops the list in the country, while Punjab ranks third. Among union territories, Chandigarh tops the list.<sup>3</sup>



### 2.1 Drug Use in Punjab, Haryana and Chandigarh

The problem of drug use in these states has been recognized for some time. Most key informants familiar with this part of the country described how use of intoxicating substances has been historically a part of the culture of Punjab. In fact, in the words of a key informant, “Alcohol is no more considered an intoxicating substance; such is the ubiquitous nature of this substance.” Many key informants described consumption of raw opium as a common and well-known practice in agrarian society. Among the published studies, as early as in 1977, Mohan and colleagues<sup>4</sup> documented drug abuse in the rural areas of Punjab. Later as part of the National Survey on extent pattern and trends of drug use in India too, some data on drug use in this part of the country was collected. In the component Rapid Assessment Survey,<sup>5</sup> one of the sites was Amritsar from where 327 drug users were interviewed. The mean age was 28 years, while the median age was 25 years. About half of the respondents were married, about a fourth were illiterate and about a fifth were unemployed. As many as 32% drug users reported that they had started drug use with

<sup>2</sup> **Source:** Department of Planning, Government of Punjab, *State-wise Per Capita Income at Current Prices*, accessed at: <http://pbplanning.gov.in/pdf/Statewise%20Per%20Capita%20Income%20%20Current.pdf>

<sup>3</sup> **Source:** Department of Planning, Government of Punjab, *Ranking Of States Per Capita Income Wise-Current Prices*, accessed at: <http://pbplanning.gov.in/pdf/Ranking%20of%20States%20Current.pdf>

<sup>4</sup> Mohan D. *et al.*, 1977. A study of drug abuse in rural areas of Punjab: a preliminary report submitted to Ministry of Social Welfare, Government of India, New Delhi.

<sup>5</sup> Kumar S. *et al.*, 2002, *Rapid Assessment Survey (complete report)*, submitted to the United Nations Office on Drugs and Crime, Regional Office for South Asia, New Delhi.

pharmaceutical sedatives (highest among all other sites in the country). Primary drug of use was pharmaceutical products for about 40% drug users. About half of the sample reported drug use among their family members. About 16% reported injecting drug use; but worryingly, more than half of them reported sharing their injection equipment 'almost always'. As many as 76% reported sharing injection equipment on the last occasion of injecting. The drugs that were commonly injected in Amritsar were Buprenorphine and to a lesser extent Pentazocine. More than half of the sample reported sex with sex workers and barely about 10% reported consistent use of condoms. More worryingly, more than a third reported not having heard of AIDS.

An important aspect of the rapid assessment survey was that it documented injecting drug use and associated risk behaviours in Amritsar. Prior to this, Singh *et al* (1992)<sup>6</sup> had documented injection buprenorphine abuse in Chandigarh. Thus, the early warning signs regarding impending IDU epidemic were visible as early as in the 1990s. Many key informants also reported the reasons behind the rising phenomena of injecting drug use, particularly in Punjab. Since there already was an established pattern of opioid use, many dependent users were forced to switch to injecting route when the raw opium (used orally) or heroin (used by smoking or chasing) was in short supply. This finding also gains credence from the fact that most IDUs in Punjab and Haryana report having used drugs by other routes before switching to injecting.

Yet another important source of data on the profile of drug users in this part of the country has been the baseline Knowledge, Attitude and Practices study conducted by the Society for Promotion of Youth and Masses (SPYM), New

Delhi as a part of the peer-led intervention.<sup>7</sup> Altogether, this exercise was conducted at 286 sites across the country, out of which there were 11 sites in Punjab, 10 sites in Haryana and 3 sites in Chandigarh. Overall, in these 24 sites about 1,200 drug users were interviewed, among whom 411 were IDUs. About 70 to 80% of IDUs ('sharers') reported sharing injection equipment on the last occasion of injecting. Notably, the most common drugs injected were opioid pharmaceuticals (Buprenorphine, Pentazocine with/without other sedatives). Consistent condom use was very low.

While the above-mentioned studies did document the phenomenon of IDU as well as associated risk behaviours in this part of the country, there was a felt need to document the size of injecting drug use population in Punjab, Haryana and Chandigarh. In 2008, with support from UNAIDS, SPYM brought out the report on size estimation of Injecting Drug Use in Punjab, Haryana and Chandigarh.<sup>8</sup> This report was notable in many respects: It documented for the first time using a sophisticated methodology – the respondent driven sampling (RDS) coupled with the multiplier technique – the estimated size of the IDU population in these states (discussed later). At the same time, this study also explored certain behavioural parameters associated with injecting drug use; being based on the RDS technique for recruitment of IDUs, the findings of this study can be regarded as much more representative of the general IDU population of these states.

This study also confirmed the findings of some earlier studies that IDUs in these three states were largely young males, many were married, most were employed and importantly most IDUs injected pharmaceutical opioids. In this study too, a sizable proportion of IDUs reported sharing their injecting equipment.

<sup>6</sup> Singh R.A. *et al.*, 1992, Cases of Buprenorphine Abuse in India, *ActaPsychiatr Scand*, 1992, July, 86(1), pp. 46-8.

<sup>7</sup> Ambekar and Tripathi, 2006, *Baseline KAP Study* (a part of PLI under DFID), SPYM, New Delhi.

<sup>8</sup> Ambekar and Tripathi, 2008, *Size estimation of IDU in Punjab and Haryana*, UNAIDS and SPYM, New Delhi.

The 'end-line' behavioural surveillance survey (NACO 2007)<sup>9</sup> provides an opportunity to compare the IDUs in Punjab and Haryana with those of other parts of the country (such as Delhi, Chennai, Mumbai, Kolkata, Kerala and the northeast). As noted in the study, the proportion of respondents currently married and living with spouse was observed to be highest in Haryana (57%) and Punjab (55%) as compared to other sites. Interestingly, the proportion of respondents reporting sex with a sex worker in the past 12 months was also highest in Punjab. The study also documented use of alcohol among IDUs; it was found to be highest in Punjab and Haryana as compared to other sites; indeed, about half of the sample from Punjab reported drinking daily. This study also supported the finding of the UNAIDS/SPYM size estimation study that the IDU phenomena in Punjab was observed to be of relatively recent onset. In the sample from Punjab, more than half of the IDUs reported injecting '2-6 times a week' while another third reported injecting 'daily, once per day'. Just about 1 to 1.5% IDUs from Punjab and Haryana reported that they can obtain needles/syringes from NGOs (this proportion was lowest in Punjab and Haryana – understandably so, in the light of practically no coverage by IDU TIs when the study was conducted). Additionally, awareness that HIV can be transmitted through needles and syringes was lowest in Punjab. Similarly, Punjab and Haryana had the lowest proportion of IDUs who had received HIV testing as well as had been exposed to any HIV prevention intervention. Importantly, the proportion of IDUs who had 'never received any treatment' was highest in Punjab and Haryana as compared to other sites in the country.

While most of the studies described till now did mention the marital status and sexual risk behaviours of male IDUs, none of them

explored the issue of risks and vulnerabilities of female sex partners of IDUs. In the year 2009, SPYM brought out a report on risks and vulnerabilities of wives of male IDUs.<sup>10</sup> This study was simultaneously conducted at five sites in the country: two in northeast (Manipur and Nagaland) and three in northwest – Jammu, Patiala (Punjab) and Chandigarh. Among the unique aspects of this study was the fact that for the first time male IDUs and their female sex partners compare the situation in Punjab and Haryana with that in northeast. This study brought forth important issues like vulnerability of male IDUs to transmission of HIV through injecting route (i.e. evidence of sharing of injection equipment) and through sexual route (i.e. evidence of high-risk sexual behaviours) and risk of onward transmission of HIV from IDUs to their spouses (i.e. evidence of low condom use among married couples and low levels of HIV awareness among spouses of IDUs).

An alarming finding emerging from the key informant interviews has been that the IDU phenomenon exists in many smaller towns and even villages of Punjab. There are many small towns and villages with small clusters of IDUs, typically 50 to 200 in number. Additionally, many of the IDUs keep switching between the injecting and non-injecting routes or in some cases take drugs primarily through the non-injecting (i.e. smoking/chasing heroin) route but may be forced to inject on occasions when the drug supply is disrupted. It is known that Punjab alone accounts for roughly over one-fifth of the total recoveries of heroin in the country. In such a scenario, it is not difficult to fathom that a disruption in the supply of heroin (used through chasing route) may result in the inadvertent consequence of some drug users shifting to using pharmaceutical drugs through injecting route, as has been documented elsewhere in the country.

<sup>9</sup> NACO, 2007, *End-line Behavioural Surveillance Survey 2006: MSM and IDUs*, NACO, New Delhi.

<sup>10</sup> Ambekar *et al.*, 2009, *HIV Vulnerability Among IDUs, Their Spouses and Children*, SPYM and Plan, New Delhi.

## **Box 2: The Common – and Concerning – Findings Emerging from the Epidemiology of IDU in Punjab, Haryana and Chandigarh**

- Injecting Drug Use is now a well established pattern of drug use in this part of the country
- Most of the IDUs are young employed men, many of whom are married
- Both married and unmarried IDUs alike report indulging in high risk sexual behaviours
- The spouses of IDUs remain at risk of transmission on account of lower levels of HIV awareness and husbands' risky practices
- Almost all IDUs predominantly inject pharmaceutical opioids and are opioid dependent

Yet another finding – regarding supply of drugs in Punjab – has been that besides pharmacies, which are the principal source of pharmaceutical drugs for IDUs, many peddlers also sell pharmaceutical drugs along with the injecting equipment to IDUs.

However, there is a dearth of data on behavioural parameters of IDUs who are currently receiving various services. For instance, while there are currently thousands of IDUs receiving TI services in the state, little data is available on their risk-behaviours.

Even the KIs found it difficult to provide an opinion on level of sharing or condom usage among their clients. One finding which came across consistently was that the level of condom uptake by IDUs is very low (typically ranging between two to five condoms per IDU per month).

Overall, there appears to be a fertile ground for explosion of HIV epidemic among male IDUs and from them onwards to their spouses in Punjab, Haryana and Chandigarh.

Table 1: A Summary of Some Epidemiological Studies in Punjab, Haryana and Chandigarh

Study (Author, Title, Year)	Geographical area	Methodology	Key findings	Remarks
<b>Ambekar &amp; Tripathi, 2006</b> <i>Baseline KAP Study</i> (A part of PLI under DFID), SPYM, New Delhi	11 sites in Punjab	Purposive, community-based sample, 547 male drug users	<ul style="list-style-type: none"> <li>▪ Married – 58%</li> <li>▪ IDU – 41% (n=226)</li> <li>▪ Sharing, last occasion – 81%</li> <li>▪ Commonly injected drugs:               <ul style="list-style-type: none"> <li>• Buprenorphine</li> <li>• Sedatives</li> <li>• Pentazocine</li> </ul> </li> <li>▪ Multiple partners – 28%</li> <li>▪ Consistent condom use – 12%</li> <li>▪ High HIV/AIDS awareness</li> </ul>	High prevalence of sharing and non-consistent use of condoms, a cause of concern
<b>Ambekar &amp; Tripathi, 2006</b> <i>Baseline KAP Study</i> (A part of PLI under DFID), SPYM, New Delhi	10 sites in Haryana	Purposive, community-based sample, 511 male drug users	<ul style="list-style-type: none"> <li>▪ Married – 67%</li> <li>▪ IDU – 30% (n=151)</li> <li>▪ Sharing, last occasion – 81%</li> <li>▪ Commonly injected drugs:               <ul style="list-style-type: none"> <li>• Buprenorphine</li> <li>• Sedatives</li> <li>• Pentazocine</li> </ul> </li> <li>▪ Multiple partners – 9%</li> <li>▪ Consistent condom use – 15%</li> <li>▪ Aware that HIV spreads by contaminated syringe – 70%</li> </ul>	High prevalence of sharing and non-consistent use of condoms, together with low HIV transmission awareness, a cause of concern
<b>Ambekar &amp; Tripathi, 2006</b> <i>Baseline KAP Study</i> (A part of PLI under DFID), SPYM, New Delhi	3 sites in Chandigarh	Purposive, community-based sample, 151 male drug users	<ul style="list-style-type: none"> <li>▪ Mean Age – 27 years</li> <li>▪ Married – 48%</li> <li>▪ IDU – 22% (n=34)</li> <li>▪ Sharing, last occasion – 70%</li> <li>▪ Commonly injected drugs:               <ul style="list-style-type: none"> <li>• Buprenorphine</li> <li>• Sedatives</li> </ul> </li> <li>▪ Multiple partners – 39%</li> <li>▪ Consistent condom use – 9%</li> </ul>	High prevalence of multiple partners and non-consistent use of condoms, in young men, a cause of concern
<b>Ambekar &amp; Tripathi, 2007</b> <i>A National Survey of Size Estimation of IDUs at Multiple Sites in India</i> (A part of PLI under DFID), SPYM, New Delhi	217 sites in country (3 in Punjab, 1 in Chandigarh, 3 in Haryana)	Size estimation using nomination technique	Over 400 IDUs identified at small geographical areas	Report documented existence of IDUs in even smaller areas like Kaithal, Faridkot, Moga
<b>NACO 2007, End-line BSS 2006</b> , NACO, New Delhi	10 sites in the country including Haryana and Punjab - Chandigarh	Behavioural survey involving about 270 IDUs in each site	<ul style="list-style-type: none"> <li>▪ Highest in Punjab/Haryana (as compared to other sites):               <ul style="list-style-type: none"> <li>• Proportion of IDU married and living with spouse</li> <li>• Proportion of IDUs reporting sex with a sex worker.</li> <li>• Proportion of IDUs drinking daily</li> </ul> </li> <li>▪ Lowest in Punjab/Haryana:               <ul style="list-style-type: none"> <li>• Proportion reporting ever received treatment for drug use or intervention for HIV</li> </ul> </li> </ul>	Report provides comparison with other IDU locations in the country
<b>Ambekar &amp; Tripathi, 2008</b> <i>Size Estimation of IDU at Punjab and Haryana</i> , UNAIDS and SPYM, New Delhi	7 districts in Punjab, 7 districts in Haryana and Chandigarh (including Panchkula)	Size estimation using RDS and multiplier technique (interviews with over 3300 male IDUs)	<ul style="list-style-type: none"> <li>▪ Majority young adults, employed, married, injecting for 3-10 years</li> <li>▪ Commonly injected drugs:               <ul style="list-style-type: none"> <li>• Buprenorphine</li> <li>• Sedatives</li> <li>• Pentazocine</li> </ul> </li> <li>▪ Majority reported sharing</li> <li>▪ Very small minority reported receiving in-patient treatment and NSEP</li> </ul>	Report documented estimates of size of IDU population in smaller towns as well as for the entire states

contd...

Study (Author, Title, Year)	Geographical area	Methodology	Key findings	Remarks
<b>Ambekar et al, 2009</b> , <i>HIV Vulnerability Among IDUs, their Spouses And Children</i> , SPYM and Plan, New Delhi	Chandigarh and Patiala	Purposive, community-based sample of 50 couples at each site where husband was current IDU	<ul style="list-style-type: none"> <li>▪ IDU men reported injecting Buprenorphine with or without other sedatives</li> <li>▪ Majority of IDUs reported sharing</li> <li>▪ Majority of IDUs reported sex with sex workers</li> <li>▪ Condom use with wife was very low</li> <li>▪ Awareness of wives on HIV much lower than IDU husbands</li> </ul>	First report from this part of the country looking at female sex partners/spouses of male IDUs Report documented vulnerability of spouses of IDUs
<b>Kaur and Gulati</b> <i>Drug Abuse: Trends and Issues, International Marketing Conference on Marketing &amp; Society, 2007</i> , accessed at <a href="http://dSPACE.iimk.ac.in/bitstream/2259/348/1/387-395.pdf">http://dSPACE.iimk.ac.in/bitstream/2259/348/1/387-395.pdf</a>	Punjab	Review of published reports (including media reports) on drug abuse in Punjab	<ul style="list-style-type: none"> <li>▪ Households affected by drug abuse:                             <ul style="list-style-type: none"> <li>• 61% in Majha</li> <li>• 64% in Malwa</li> <li>• 68% in Doaba</li> </ul> </li> <li>▪ High opium use by farm labourers</li> <li>▪ High psychotropic use by college students</li> </ul>	Documentation of other drugs besides IDU, including in rural areas
Submission by Secretary, Department of Social Security, Punjab Government, in High Court	Punjab	Constellation of findings from various surveys	<ul style="list-style-type: none"> <li>▪ Every third male and every tenth female student has taken drugs on one pretext or the other</li> <li>▪ 67% of rural households in Punjab has at least one drug addict</li> <li>▪ Over 16% population is addicted to hard drugs</li> <li>▪ Punjab alone accounts for roughly over one-fifth of the total recoveries of heroin in the country</li> </ul>	Documentation of other drugs besides IDU, including in rural areas

## 2.2 The HIV Epidemic in Punjab, Haryana and Chandigarh

The HIV epidemic among the general population in these three states, as indicated by the seropositivity among ANC clinic

attendees, has remained largely stable – and at a low level – over past few years, as seen in Table 2.

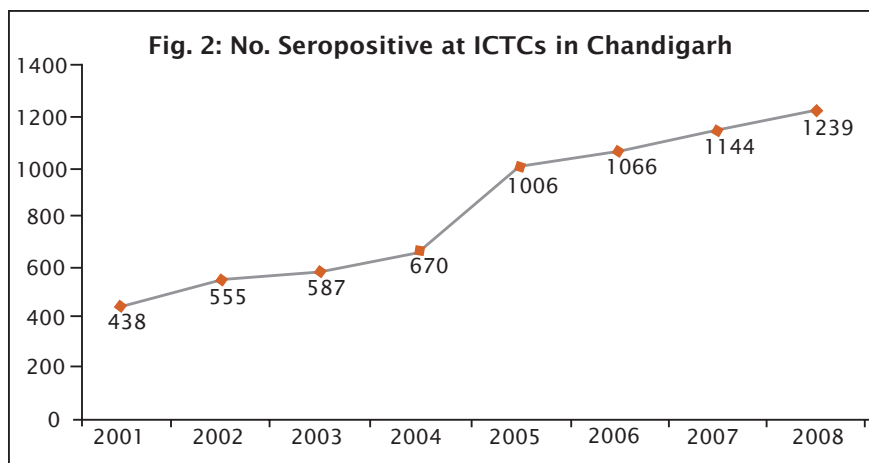
**Table 2: HIV Prevalence Among ANC Clinic Population**

State/UT	2003	2004	2005	2006	2007
Chandigarh	0.50	0.50	0.00	0.25	0.25
Haryana	0.26	0.00	0.13	0.13	0.13
Punjab	0.00	0.25	0.13	0.00	0.00

Source: *HIV Sentinel Surveillance and HIV Estimation 2007: A Technical Brief*, NACO, 2008.



However, the number of seropositive cases in the ICTC centres is continuously on the rise (as shown in Figure 2, an example from Chandigarh). This may partly be a reflection of the increasing number of people accessing ICTC services as well. Similarly, among the other HRGs (i.e. the MSM and the FSW) too, the HIV prevalence has remained at a low level and has not, so far, touched the concentrated epidemic mark (5% seropositivity).



Source: Website of Chandigarh SCAS.

### 2.3 HIV Prevalence Among IDUs

The HIV prevalence among IDUs is a different story. As has been a well known phenomenon in other parts of the country too, the epidemic of HIV among IDUs tends to progress rapidly and often explosively. In Punjab and Chandigarh too, a similar story appears to be unfolding. In the year 2006, Chandigarh, Bhatinda and Ludhiana emerged as the 'IDU hotspots' for the country (see map on next page). Since then, the HIV seropositivity among IDUs in Chandigarh

and Punjab remains quite high, as can be seen in Figure 3.

Since the HIV prevalence among other high-risk groups (FSWs and MSM) has never reached the concentrated epidemic (5%) mark in these states, **IDU remains the primary driving force behind the HIV epidemic in Punjab and Chandigarh.** The HIV prevalence among IDUs in Haryana, however, has remained much lower than its neighbouring states (Delhi, Punjab and Chandigarh).

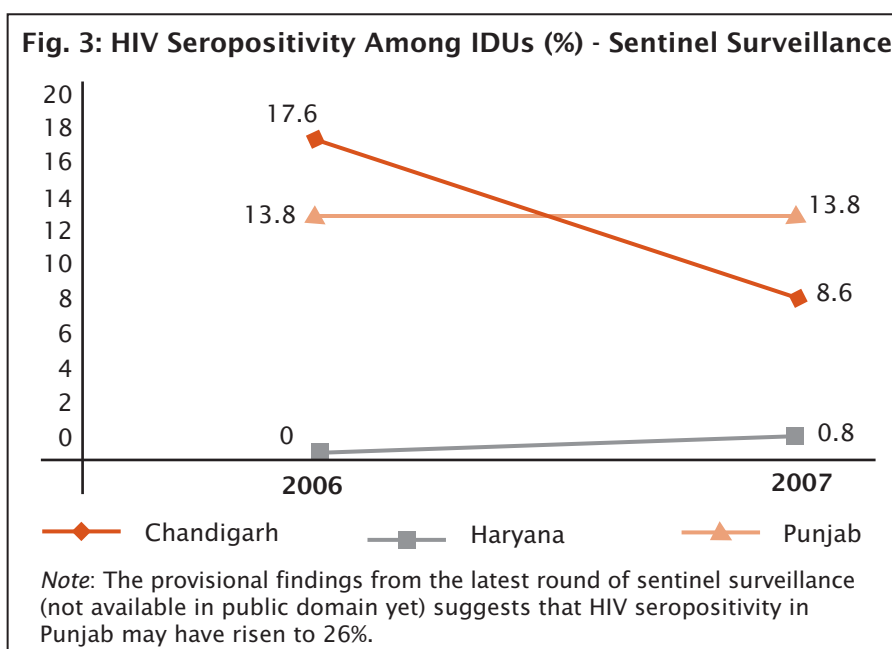
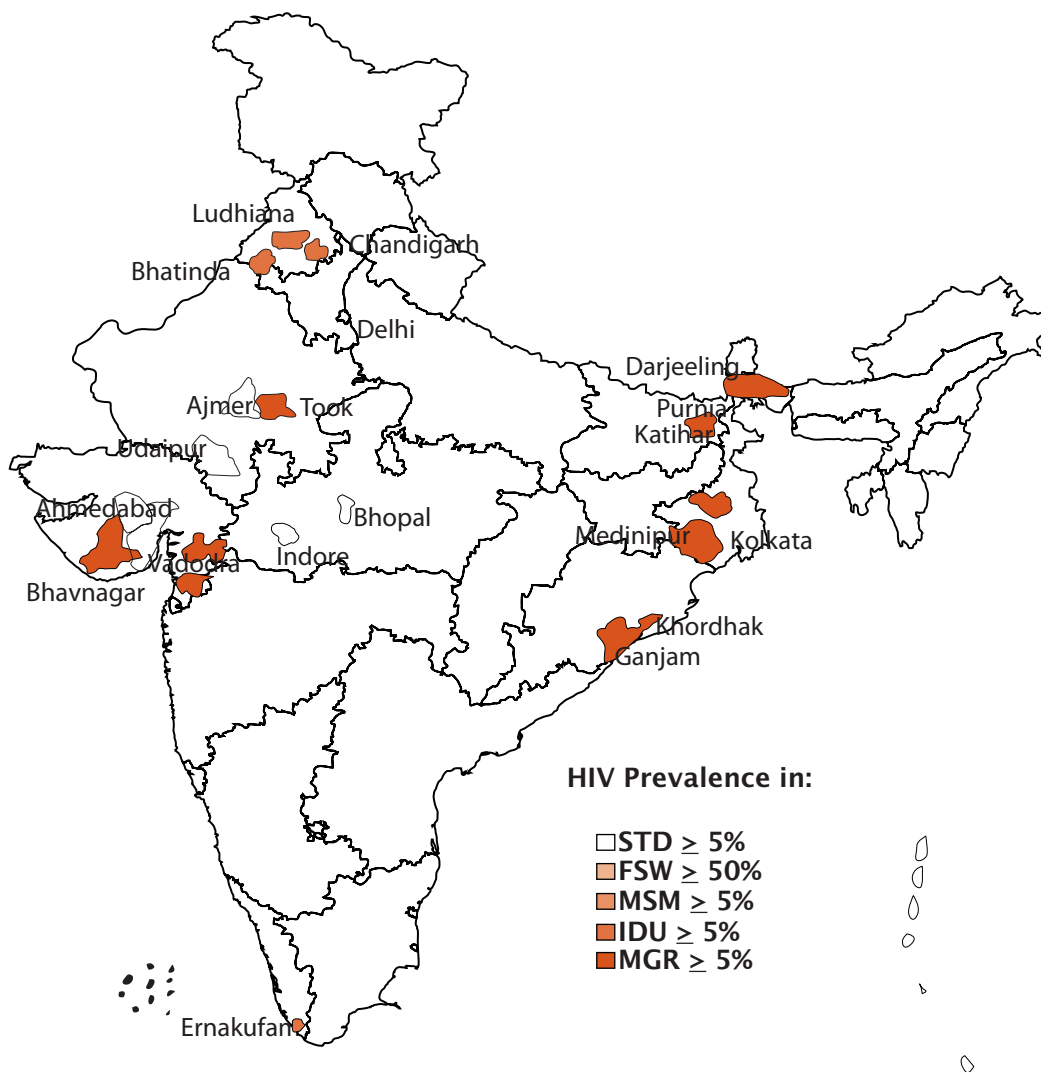


Fig. 4: Emerging Hotspots, by Sentinel Group and District, India, 2006



As early as in 2006, Ludhiana, Bhatinda and Chandigarh emerged as IDU-HIV hotspots in the country, Source: *Annual Sentinel Surveillance Country Report*, NACO, 2006



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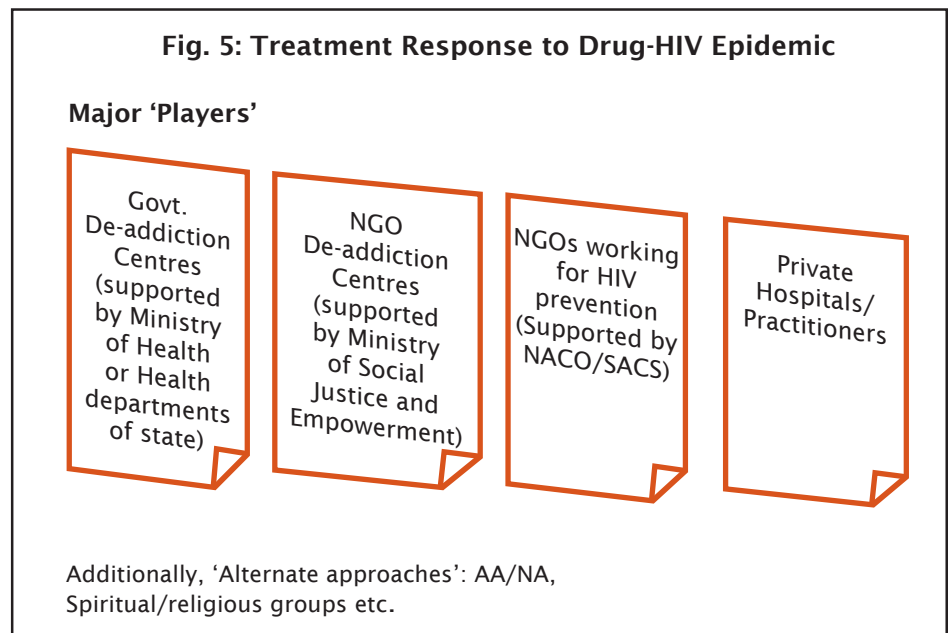
## THE RESPONSE TO DRUG-HIV EPIDEMIC

### 3.1 Drug Treatment Services

As elsewhere in the country, the response to the drug-HIV epidemic in these states also lies with three or four major players. As far as drug treatment ('de-addiction', as it is commonly referred to in India) is concerned, there are over 40 NGO-run de-addiction centres - supported by the Ministry of Social Justice and Empowerment (MSJE), Government of India - operating in various towns and cities of Punjab, Haryana and Chandigarh. Besides this, there are de-addiction centres associated with many government healthcare facilities as well, supported by either the Union Ministry of Health & Family Welfare (MOH&FW) or by the state Departments of Health. For capacity building of de-addiction centres, the MSJE has an institution at the national level - the National Institute of Social Defence (NISD). Additionally, eight Regional Resource and Training Centres (RRTCs) have been established in various parts of the country. The doctors working in the government de-addiction centres are trained by institutions under the MOH&FW, such as the National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences (AIIMS), New Delhi. A number of private hospitals/practitioners or drug treatment centres are also providing drug treatment services (See Figure 5). While there are legitimate

concerns about the adequacy or standards of services being provided at these centres, one aspect which comes across very clearly from the information obtained through various KIs is that these centres do not operate in tandem. In particular, there is a distinct lack of coordination between these centres and the NGOs providing the TI services under the National AIDS Control Programme (described later). Similarly, the five year action plan (2009-13) to "combat drug trafficking and drug abuse" of the Government of Punjab also does not envisage an effective coordination on drug demand reduction and harm reduction issues (See Table 3).

An area of concern has been the low utilization of drug treatment, particularly the in-patient detoxification/rehabilitation services for the IDUs. While the de-addiction centres supported by the Ministry of Social Justice and Empowerment have been active for some time, it has been found that very few of the patients treated by these centres happen to



**Table 3: Data From NGO Treatment Centres on Number of Clients Admitted in Past 6 Months**

Site	Total number of clients admitted in last 6 months	Number of IDUs admitted in last 6 months
Ambala	79	8
Chandigarh-Panchkula	81	7
Faridkot-Moga	83-91	7-11
Gurdaspur	252	33
Jind	92	7
Kaithal - Kurukshetra	89-77	9
Ludhiana	93	9
Patiala	87	11
Rewari - Narnaul	79-86	6
Ropar - Mohali	87	11
Sonepat - Kharkhoda	86-92	6

Source: Ambekar and Tripathi, 2008, UNAIDS & SPYM, New Delhi.

be IDUs. For instance, in the UNAIDS/SPYM IDU size estimation study (Ambekar and Tripathi, 2008) involving survey of 17 NGO run de-addiction centres, it was found that on an average just about one or two IDUs were treated in these centres per month – representing less than 10% of the clientele (See Table 4). Similarly, in the same study, when IDUs were asked whether they had been admitted to any NGO drug treatment centre

in the past six months, only a minuscule minority replied in the affirmative. This finding gets boost from the finding of the National Behavioural Surveillance Survey by NACO in 2007, which also reported that about 88% IDUs in Punjab reported having *never* received any treatment for drug use. Thus, both the sets of data taken together indicate that drug treatment access and utilization among IDUs remains poor in Punjab and Haryana.

### Box 3: Government De-addiction Centres in Punjab

In the recent past, a new vigour is visible in the health department’s response to the problem of drug addiction in Punjab. The Government of Punjab has formulated a comprehensive five year action plan (2009-13) to “combat drug trafficking and drug abuse”. Many new de-addiction centres have been established, most of which are associated with the government healthcare facilities. While three of these (at Patiala, Faridkot and Amritsar) are associated with the Government Medical Colleges, the rest (eight in number) are associated with the civil hospitals. All of these centres are being supervised by psychiatrists. The Department of Health has also arranged “training of trainers” for about 20 psychiatrists of Punjab at the National Drug Dependence Treatment Centre, AIIMS, New Delhi to enable them to function as Master Trainers in the state. The Department plans to further increase the number of centres to at least 20 in the 11<sup>th</sup> Five Year Plan and also to establish a State Level Drug Dependence Treatment Centre.

Source: Submission by the Secretary, Department of Social Security, Punjab Government, in Punjab & Haryana High court, Chandigarh, May 2009.

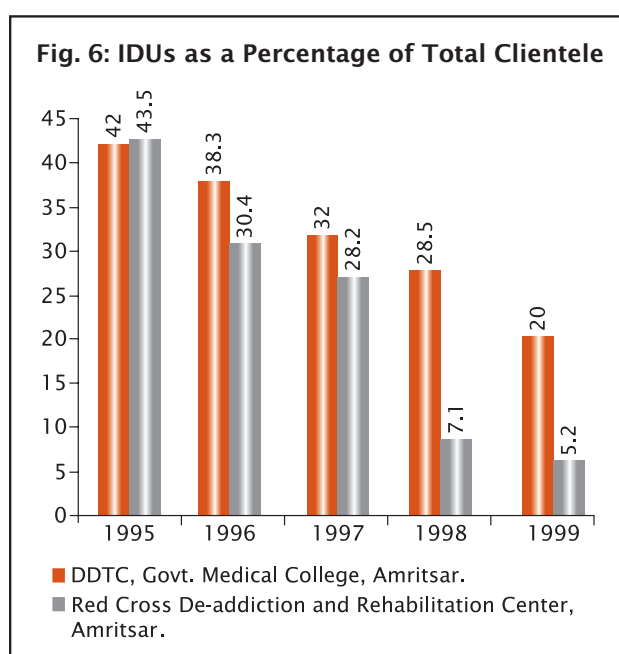
**Table 4: Proportion of IDUs Reporting In-patient Treatment at the Nearest NGO Centre in Past 6 Months**

Site	Received in-patient treatment in past 6 Months in the nearest NGO centre (%)
Ambala	3.5
Chandigarh - Panchkula	0.90
Faridkot Moga	0.10
Gurdaspur	4
Jind	4
Kaithal - Kurukshetra	8
Ludhiana	3
Patiala	1
Rewari - Narnaul	0.5
Ropar-Mohali	1.2
Sonepat-Kharkhoda	0

Source: Ambekar and Tripathi, 2008, UNAIDS & SPYM, New Delhi.

Even in the government run de-addiction centres, the IDUs are frequently not treated. As early as in 2002, it has been documented that very few IDUs access in-patient treatment services in Amritsar (See Figure 6 which shows IDUs as percentage of total clientele of the centres). As can be seen here, while the proportion of IDUs among total patients is low for both the centres, it is much lower for the NGO centre as compared to the Government centre. Impressions of the psychiatrists who are in-charge of government run de-addiction centres also suggest that while some IDUs

do access these centres, they hardly receive any referrals from the IDU TIs. Many key informants reported that while many IDUs do express the need to undergo detoxification, they are reluctant to seek treatment at de-addiction centres because they are perceived as too formal or too structured. The Drug Abuse Monitoring System (DAMS) data (collected by all the MSJE supported as well as MOH&FW supported centres) is not available in the public domain, and hence could not be utilized for analysing the trend of IDUs seeking treatment from these centres.



Source: Kumar *et al.*, 2002, RAS Report From Amritsar, UNODC, New Delhi.

### Box 4: The Drug Treatment Standards (or Their Lack of) in Punjab, Haryana and Chandigarh

Many instances of serious human rights violations have recently come to the fore in certain drug treatment centres in this part of the country. In fact, the Mohali district administration took a very serious view of the newspaper reports of deaths of patients in one of these centres, and the matter has ultimately reached the High Court where it is currently being argued. Recently, a workshop of IDUs (who reported having received treatment at such de-addiction centres) was organized where almost all the IDUs reported horrendous tales of torture and abuse in these centres. Not only are patients kept confined at such places against their will and consent, they are often tied, beaten up and forced to starve. In some instances of alleged disciplinary breeches, inhuman punishments are meted out to them. They are not even allowed to meet their family members. And on top of all this, they are charged heavily for this so-called “treatment”!

*(Tripti Tandon, Lawyers Collective – personal communication)*

While there are certain standards (“minimum standards of care”) being followed by the NGOs operating under the MSJE, the standards being followed by the private de-addiction centres remain unknown. The tendency to club these private de-addiction centres (many of whom masquerade as NGOs) with the MSJE-supported NGO centres often creates problems for the latter.

*(Rajesh Kumar, SPYM – personal communication)*

### 3.2 The Targeted Interventions for IDUs

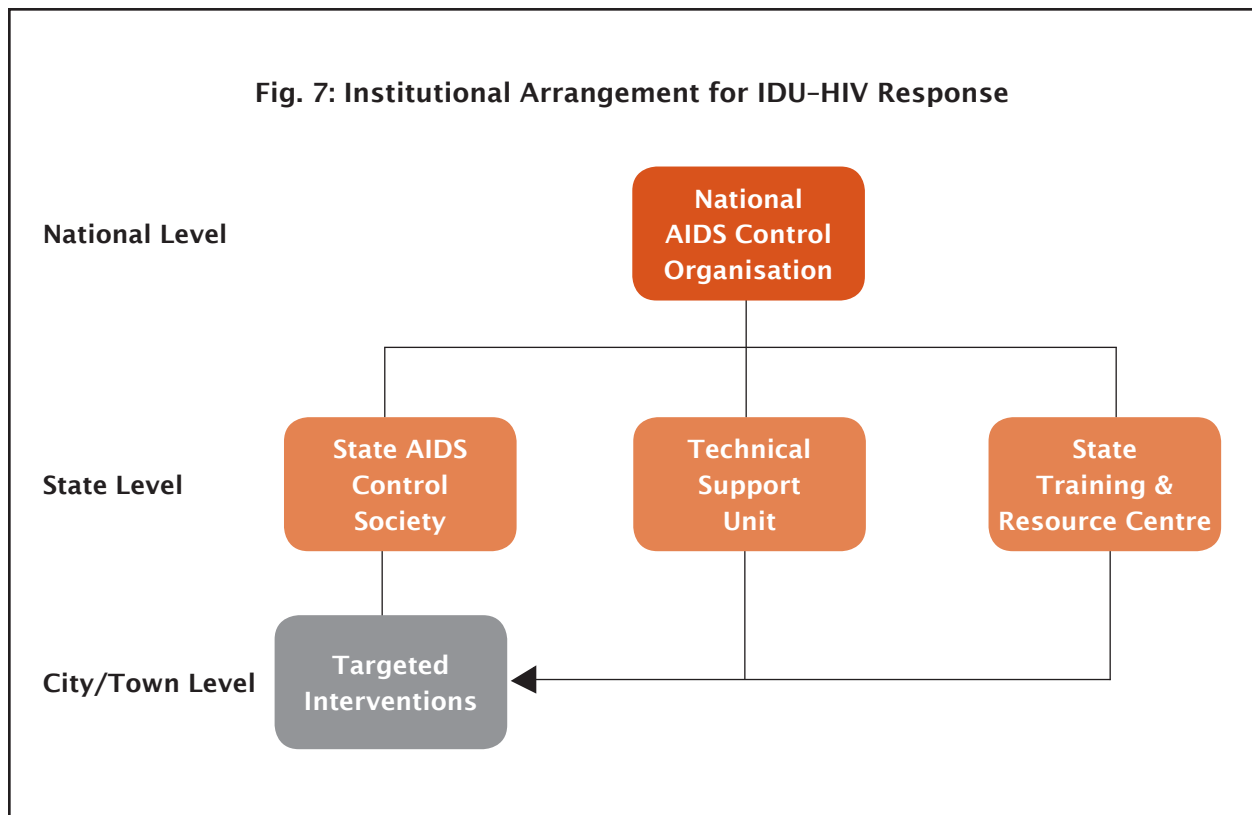
One of the most important components of the National AIDS Control Programme (NACP)-III is the Targeted Intervention (TI). With an aim to interrupt HIV transmission among highly vulnerable populations (such as FSWs, MSM and IDUs), these TI projects – implemented by NGOs – provide various services to IDUs. Figure 7 shows the institutional arrangement adopted for the IDU-HIV response.

While the overall responsibility of looking after the program at the state level remains with the State AIDS Control Societies, other institutional mechanisms have also been established to assist the SACS in certain technical aspects. The Technical Support Unit (TSU) provides

assistance to Targeted Interventions as well as to the SACS on strategic planning issues. The guidance provided by the TSU to TIs includes technical guidance and hand-holding in the field (‘on-site’ support) as well as supporting the documentation and reporting. The State Training and Resource Centres (STRCs) assist the SACS in conducting training programs for NGOs implementing the targeted interventions as well as in developing training resource materials in the local language. However, the TSUs/STRCs do not exist in all the states (See Table 5).

**Table 5: Presence of TSUs and STRCs**

States	TSU	STRC
Chandigarh	Absent	Present
Haryana	Absent	Present
Punjab	Present	Present



As of now, there is one agency (the SPYM, Chandigarh) which has been established as a TSU for Punjab. There is no TSU in Haryana and Chandigarh. Another agency (the School of Public Health, PGIMER, Chandigarh) has been mandated to function as the STRC for all three states - Punjab, Haryana and Chandigarh.

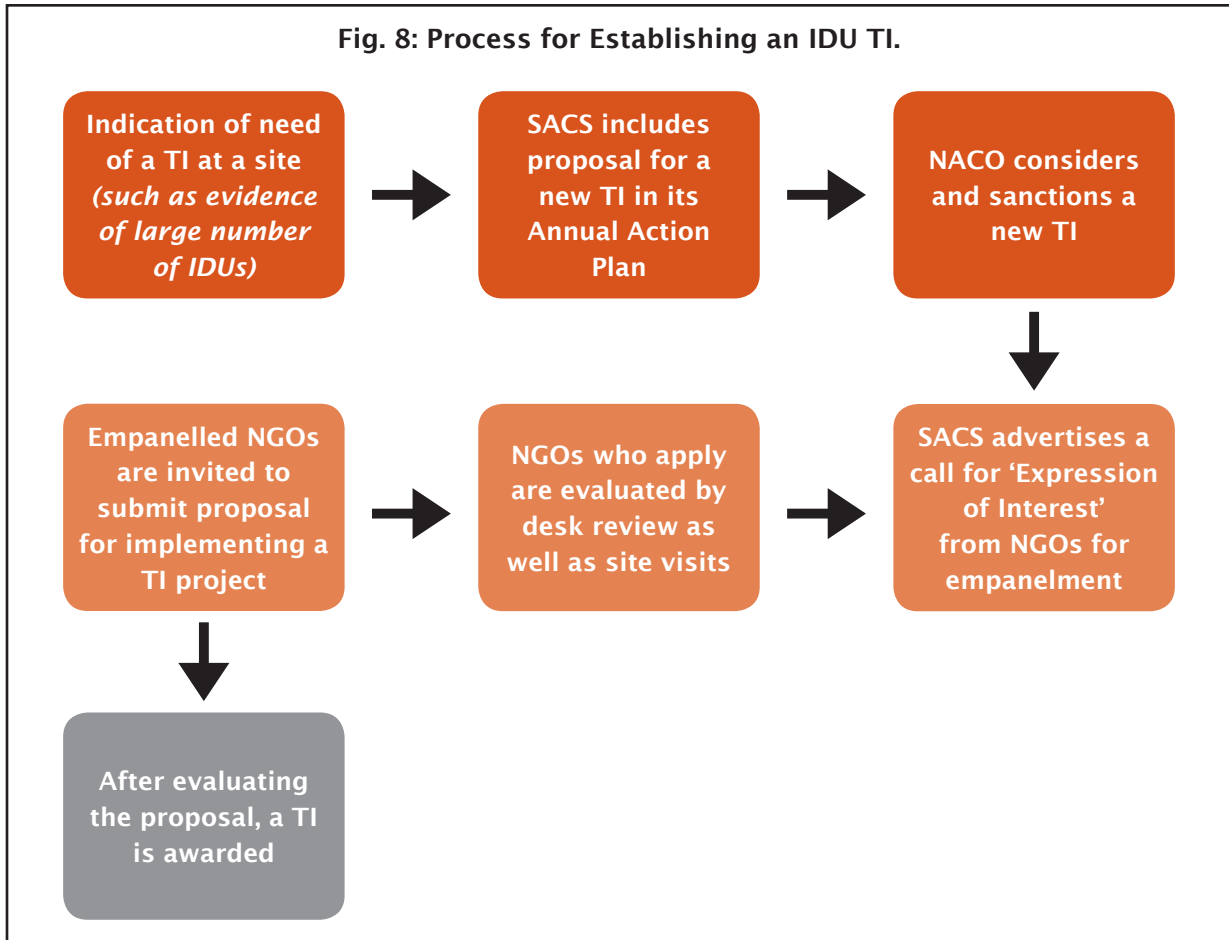
Various operational guidelines and reporting formats exist for the NGOs to implement the targeted interventions. While a detailed description of these documents is beyond the scope of this report, it is clear that the targeted interventions remain the backbone of HIV prevention program among IDUs. Various services provided by a TI include outreach, needle-syringe exchange, behaviour change communication, abscess management, condom distribution, counselling and referral and linkage services.

The process of establishing an IDU TI is a long-drawn process as shown in simplified form in Figure 8. The entire process takes about six months to one year.

### 3.3 IDU TIs in Punjab, Haryana and Chandigarh

After the sentinel surveillance reports (showing high prevalence of HIV among IDUs in Punjab and Chandigarh) and the UNAIDS/SPYM size estimation report (showing high number of IDUs in Punjab, Haryana and Chandigarh) were available, a need of urgent response was felt. Indeed, one key informant described the findings of these studies as 'startling'. This has resulted in a rapid increase in the number of TI sites in Punjab, Haryana and Chandigarh (as well as in other parts of the country). Considering the long process behind establishing a new TI, the pace with which nine IDU TIs have been established in Punjab is indeed noteworthy. Table 6 shows the number of targeted interventions for IDUs in these states as of November 2009.

The larger point, however, does not concern the exact numbers of IDUs in a given state but the gross level of 'coverage', i.e. proportion of IDUs for whom TI services are



available. It must be stressed that the term ‘coverage’ should be limited to only the proportion of IDUs currently able to access TI services, i.e. IDUs who reside in a town/city where an IDU TI is functional. The term ‘coverage’ should not be used to denote proportion of IDUs receiving services out of the target of the TI (as appears to have been the case as shown in Table 7 accessed from the website of Punjab SACS). This table misleads the reader into believing that the coverage in Punjab is more than 100%. The better term to describe this

data - in the author’s opinion - is ‘target achievement rate’.

Thus, upon calculating the coverage on the basis of the recent mapping and size estimation data, it would be clear that there are still a number of IDUs who need be brought under the TI coverage net. Though this coverage gap is much larger in Haryana (See Table 8) than in Punjab, in the case of the latter it is more worrisome given the high HIV seropositivity among IDUs in Punjab.

An additional matter of concern for Punjab is the presence of smaller clusters of IDU populations

**Table 6: Number of Targeted Interventions for IDUs**

State	No. of IDU TIs (Core)	No. of composite TIs (with IDU component)	Total number of TIs	Total target (to be covered)	Achievement (Approximate)
Chandigarh	2	0	2	1100	975
Haryana <sup>11</sup>	3	0	3	1000	800
Punjab	9	6	15	4500	4200

<sup>11</sup> It is learnt that Haryana is in the process of enhancing its IDU TI program, with as many as seven more IDU TIs in the pipeline.

Table 7: IDU TI Targets and Achievements – Punjab SACS

Components	District of TI	Target as per Action Plan*	Target achieved till Feb 2009	Coverage (%)
IDU (exclusive)	Amritsar	500	641	128
	Mohali	500	490	98
	Patiala	500	485	97
	Jalandhar	500	517	103
	Tarn Taran	300	191	64
	Moga	300	216	72
	Ludhiana	300	302	101
IDU (as part of composite TI)	Hoshiarpur	150	196	131
	Pathankot	100	111	111
	Mansa	200	228	114
	Phagwara	100	140	140
	Fatehgarh Sahib	100	54	54
	Abohar	100	48	48
	Ropar	200	336	168
<b>TOTAL</b>		<b>3850</b>	<b>3955</b>	<b>103</b>

Source: Table as displayed on the website of the Punjab State AIDS Control Society.

\*These targets have been decided as per the older mapping data.

### Box 5: How many IDUs?

A major debatable issue in these states has been the size of the IDU population. Two different size estimation/mapping reports have been available for Punjab and Chandigarh in the recent times. The first is the UNAIDS/SPYM size estimation study and the second is the Mapping and size estimation of high-risk groups (NACO). While the UNAIDS/SPYM study did provide the estimations of size of IDU populations for the entire states and succeeded in drawing attention to the IDU epidemic, it did have certain limitations. Firstly, for the sake of operationalization, it justifiably combined Chandigarh, Panchkula (part of Haryana) and Mohali (part of Punjab) as one single unit. Secondly, this study did not provide the “mapping” data, i.e. information on location of IDU hotspots in various towns and cities. This information has been captured in the recently concluded exercise, Mapping and size estimation of high-risk groups. This exercise was commissioned by NACO in 17 states/UTs of the country (including Punjab and Chandigarh).

In the case of Chandigarh, both these reports – UNAIDS/SPYM size estimation study and the Mapping and size estimation of high-risk groups (NACO) – have generated almost similar figures regarding the size of the IDU population, i.e. about 900 to 1,100 IDUs (rounded off). In the case of Haryana only the estimates from the UNAIDS/SPYM size estimation study are available, since the mapping and size estimation of high-risk groups was not conducted in Haryana. The former study estimated the size of IDU population to be ranging between a lower estimate

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of 2,300 and a high estimate of 15,800 (rounded off). In the case of Punjab, however, the final report of the Mapping and size estimation of high-risk groups (NACO) is yet to be made available. The draft report shows the estimated size of IDU population in the entire state to be about 15,000 (rounded off), grossly comparable to the estimate provided by the UNAIDS/SPYM size estimation study (18,000 as upper limit).

**Table 8: Coverage of IDU Population by TIs**

State	Mapping by SACS/ NACO	Mapping by SPYM/ UNAIDS	Current TI coverage (as per median of mapping estimates)	Gap (approx.)	Remarks
Chandigarh	1,100	800-1200	100%	0%	Excellent coverage so far. However, in future, likelihood of diffusion/ migration of IDUs from neighbouring states cannot be ruled out
Haryana	-	2300-16000	10%	90%	Difficult to comment on coverage in the absence of recent mapping data. There is an urgent need to scale up
Punjab	15,000	2500-18,000	40%	60%	Despite rapid progress made in the recent past, a large proportion of IDUs remains out of coverage

typically ranging between 50–200 in many smaller towns and even villages of Punjab, as reported by the key informants. A TI is awarded usually when the population of IDUs is about 150 or more in a given town/city. Thus, for such smaller towns with IDUs in smaller numbers, the ‘composite interventions’ (i.e. the same NGO providing services to more than one type of high-risk groups such as FSWs, MSM or IDUs in varying combinations and proportions). However, if these smaller towns do not have any sizable numbers of other HRGs (i.e. FSWs or MSM) they are likely to fall out of the TI net. For such towns, certain other innovative strategies may be required. Yet another problem in the coverage is the existence of substantial number of ‘shadow users’ (the term used to denote IDUs who do not inject daily or regularly). It is well known that many drug users keep switching between the injecting and non-injecting routes of drug consumption. Such drug users, however, continue to remain at the risk of contracting and transmitting the infection on account of their injecting practices.

### 3.4 Monitoring and Evaluation of Targeted Interventions

Elaborate mechanisms are in place to monitor and evaluate the functioning of the targeted interventions under the NACP-III. For this purpose, a very comprehensive list of indicators has been developed; and with the help of a Computerized Management Information System (CMIS), data on performance is regularly collected and reviewed. In addition, NACO and SACS are also involved in the regular monitoring of various TIs, often aided by the TSU (where it exists). Based on the data from the CMIS and the monitoring and evaluation reports, mid-course corrections are also made.

As mentioned earlier, this report has restricted its ambit to the broad issues related to response to the drug and HIV epidemic, since it is expected that the internal monitoring and evaluation mechanisms established at the national level under the NACP-III are already performing their tasks. Indeed, the process of mid-term review of the NACP-III was ongoing during the period this study was conducted (November 2009).



# 4

## GAPS AND BARRIERS

After providing a brief overview of the drug-IDU-HIV situation in this part of the country and an overview of the response mechanism to deal with it, the report would now attempt to point towards certain gaps in the response. As mentioned in the section on methodology as well, this study did NOT attempt to evaluate the functioning of various services; rather an attempt has been made to explore the glaring and broad gaps in the response. For this, both categories of evidences have been relied upon – the secondary data (i.e. review of literature) as well as the primary data (i.e. opinion of the key informants and stakeholders). For the sake of convenience these gaps have been organized as per the four broad pillars of the National AIDS Control Programme – Phase III (NACP-III): *Prevention, Treatment Care and Support, Capacity Building and Strategic Information System*. Finally, a matrix has been presented which summarizes the gaps/barriers, provides recommendations as well as suggests a mechanism for response in the future.

### 4.1 Prevention

In the area of prevention of HIV among IDUs, the UNAIDS, UNODC and WHO have together defined and endorsed a *comprehensive package* for the prevention, treatment and care, informed by evidence and expert opinion regarding effectiveness (WHO 2009).<sup>12</sup> These include: Needle Syringe Exchange Program (NSEP), Oral Substitution Treatment (OST), other drug treatment, HIV Testing and Counselling, Anti-Retroviral Therapy (ART),

and condom provision for IDUs. While almost all of these interventions are in place – to varying degrees of scale and intensity – in the current response of the country, this report has attempted to explore gaps in provision of this comprehensive package of interventions in Punjab, Haryana and Chandigarh.

#### Gap 1 – Lack of comprehensive services

It is quite clear that it would not be possible for any single agency to be able to provide all the services listed as part of the comprehensive package. However, attempts could still be made to make all these services accessible to drug users by referral/linkages. In this regard, the agency which is primarily in-charge of locating/identifying the drug users (i.e. through outreach activities) must take the lead in making the various services available/accessible to drug users. If the agency is not able to provide all the services on its own, it should at the very minimum have resources to be able to refer the drug users to appropriate services. Thus, since the TIs are the agencies who are most likely to be the first service providers the drug users come in contact with, it naturally follows that it should be the primary responsibility of the TIs to make all services available and accessible. While many of the required services (such as outreach, NSEP, condoms, etc.) are provided by the TIs, there are still some gaps as far as other services are concerned.

- **Detoxification/drug treatment services** are what many IDUs appear to be demanding. As one key informant reported, he is often

<sup>12</sup>WHO, UNODC, UNAIDS *Technical Guide for Countries to Set Targets for Universal Access to HIV prevention, Treatment and Care for Injecting Drug Users*, WHO, 2009

asked by the clients, “Do you want us to keep injecting forever?” In other words, the felt need of the IDUs to undergo treatment – in order to quit drugs completely – remains unfulfilled. While TIs can and do refer their clients to drug treatment centres, there is no provision for providing financial help for undergoing drug treatment. Even though the drug treatment services offered by the MSJE supported de-addiction centres are free of cost, the patients still need to pay for/ arrange their food, which is not an option available to many patients from financially weaker backgrounds.

### Box 6: Case Example – Drug Treatment

A TI centre in Mohali reported the case of an IDU who displayed an inclination to stop taking drugs and undergo drug treatment. The NGO with its advocacy and linkage efforts managed to get him admitted to an NGO drug treatment centre. However, upon discovering that the IDU was Hepatitis B positive, the treatment centre staff called the NGO TI staff and insisted that the patient may be immediately taken away. On top of it the patient was allegedly asked to even carry away his bed linen, implying that his bed linen may be contagious to others. The TI staff insists that this is not an exceptional case.

- Yet another gap which comes across very prominently is the inadequate numbers of drug treatment centres and the quality/ standards of services they offer. Concerns have been expressed by key informants about the standards of drug treatment services outside the government sector in Punjab, which has resulted in a legal case currently being argued.<sup>13</sup> While the Department of Health, Government of

Punjab has been rapidly expanding the numbers of drug treatment centres in the government healthcare delivery system, Haryana and Chandigarh may also want to display the same level of urgency.

- An often overlooked vulnerability among IDUs is the vulnerability to acquire and transmit Hepatitis C infection. The prevalence of Hepatitis C in the blood banks of Punjab (detected during routine screening) has been found to be much higher than the national average. This indicates the role the IDU epidemic may be contributing to progression of the HCV epidemic. However, this remains a relatively under-researched and poorly-understood issue in Punjab, Haryana and Chandigarh. Additionally, IDUs affected by HCV infection (with or without co-morbid HIV infection) would require care, support and treatment, which is currently a missing component in the response.
- One major missing link in the response has been a service which is currently not available to the optimum level in the TIs – services for the female sex partners/spouses of IDUs. There is strong evidence that many male IDUs in these states are married and staying with their partners. While the operational guidelines for TIs do mention (fleetingly) the need to reach out to the sex partner of IDUs, there is no specific program in place for doing the same. Thus, as of now, the spouses and female sex partners of male IDUs remain largely ignored by the TIs and hence remain vulnerable to HIV infection and other consequences of spousal drug use. It is known that the outbreak of HIV among the IDUs does lead to passing on the infections to their female sex partners, ultimately resulting in a generalized HIV epidemic.
- A major problem being faced by the TI staff is lack of adequate resources for accompanied referrals to various services (such as ICTC). While many IDUs require to be referred to various services, in order to ensure that they are able to access these services, it often becomes necessary for a peer educator to

<sup>13</sup> Author’s disclosure: The Honorable High Court of Punjab & Haryana has constituted a seven-member committee to look into the functioning of drug de-addiction/rehabilitation centres in Punjab and Haryana. The author is one of the members.

accompany them. At present the resources available for the TIs do not permit them to extend the benefit of accompanied referrals to an adequate number of clients. This has been affecting the uptake and utilization of various essential services by the IDUs.

- Another concern voiced by many key informants at the TI level has been the lack of any mechanisms to help IDUs with vocational rehabilitation. The decline in occupational functioning with a long drug using career is well-known. Consequently, many IDUs need some support for vocational rehabilitation which may greatly enhance their adherence to the program offered by the TI. The adjoining box highlights a case where a small help in vocational rehabilitation provided by an NGO has helped an IDU turn around his life.
- However, the biggest and most intensely felt gap is the lack of oral substitution treatment services in Punjab and Haryana. Almost all the respondents interviewed strongly believed that OST is the need of the hour in Punjab. Given the large estimated numbers of IDUs in the state and the rapid pace at

which the HIV epidemic is progressing among them, this is not at all surprising. Further support to the need of OST in Punjab comes from the observation that almost all IDUs are opioid dependent (which is a pre-requisite for OST). Additionally, rising prevalence of HIV among IDUs – despite having TIs in place – also indicates the need to expand the menu of options available.

While NACO is currently supporting about 50 OST projects throughout the country (implemented almost everywhere by NGOs), none of these are located in Punjab or Haryana. Chandigarh SACS was one of the first SACS in the country to establish and implement OST services. Unfortunately, however, the number of IDUs on OST at Chandigarh, as of now, is too little (about 30 IDUs at each of the two IDU-TIs in Chandigarh). It is learnt that NACO is currently looking at options to involve the government healthcare delivery systems in its OST program. Given the readiness and preparedness of government drug treatment mechanism in Punjab, this state could be the ideal state for initiating OST through government centres. The crucial first step – taking the initiative – is, however, sorely being missed. As a senior NACO official so succinctly puts it, “All the ingredients are available. Someone just needs to enter the kitchen and cook the dish.”

### **Box 7: Case Example – Vocational Rehabilitation**

A TI centre in Mohali reported the case of an IDU who showed an inclination to start working. The NGO, with its advocacy efforts, helped him open a small tea-shop. Gradually, other IDUs started coming to his shop as customers; and the business grew, turning the tea shop into a full-fledged dhaba (eatery). The tea-shop owner eventually became a peer-educator and started providing peer education to other IDUs while serving them tea and food. Currently, he also stocks needles and syringes at his shop. At one time when the stock of needles and syringes at the NGO TI was dwindling, he also managed to procure some needles and syringes from a pharmacy on credit!

### **Gap 2 – Lack of coordination**

As mentioned earlier, various sectors are involved in providing care and help for drug users (including IDUs) in Punjab and Haryana. While most of these sectors are striving to implement programs to provide care and support to IDUs, very often these programs tend to operate as vertical structures with a distinct lack of coordination among them. This coordination is conspicuous by its absence at the top-most levels (such as between NACO and MSJE/NISD), at the state levels (between SACS and departments of health/

social welfare) as well as at the ground levels (between service providers providing drug treatment services and TI services). Indeed, NGOs that are running both MSJE supported de-addiction centres as well as NACO/SACS supported TIs also find it difficult to integrate their two programs! This lack of coordination is also evidenced by the fact that while many referrals from the TIs to other services (ICTC, ART, DOTS, drug treatment) do take place, there are hardly ever, if any, referrals *received* at the TIs from these services.

### Gap 3 – Lack of optimum rate of response

It would appear that we are currently ‘chasing the epidemic’ as far the response

is concerned. In Punjab, it took reports of alarmingly high number of IDUs as well as high prevalence of HIV among IDUs to begin scaling-up the response. Since Chandigarh had already shown high prevalence of HIV (and accordingly had scaled-up its program), it could have been perceived as an alarm bell for the neighbouring Punjab. However, the scale-up in Punjab occurred (and is still taking place) only when Punjab itself showed alarmingly high HIV prevalence among IDUs. This should be seen as an early warning sign for Haryana. In Haryana, while the HIV prevalence among IDUs remains low, it could rise rapidly given its proximity to high HIV-IDU areas (Delhi on one side and Chandigarh, Punjab on another) as well as presence of a sizable number of IDU populations. As suggested by UNAIDS, all HIV

### Box 8: Case Example – Coordination (or Lack of it)

The Government of Punjab has formulated a comprehensive five year action plan (2009-13) to “combat drug trafficking and drug abuse”. The four major components of this action plan are: Supply reduction, Demand reduction, Research & Evaluation, and Coordination. For coordination, the plan envisages following “an integrated approach involving all departments that could complement and supplement their initiatives.” For this purpose, an Apex Level State Co-ordination committee has been constituted.

(Source: Submission by the Secretary, Department of Social Security, Punjab Government in Punjab & Haryana High Court, Chandigarh, May 2009).

Clearly, if mechanisms exist for coordination at the top most level, it should not be difficult to address issues related to HIV prevention and de-addiction among IDUs in a coordinated manner. The absence of any visible manifestation of coordinated services despite the existence of such coordination mechanisms indicates a missed opportunity or an untapped resource.

Other examples of missed opportunities for a coordinated response are visible at certain TI sites (like in Amritsar and Ludhiana) where either the TI and the government drug treatment centre (along with the ICTC, STI clinic) are situated in very close proximity or, in one particular case, the same NGO is running the TI project for NACO/SACS and the de-addiction centre for the Ministry of Social Justice and Empowerment. However, since there is no link between the two government programs/schemes, the service providers find it difficult to offer their services in a coordinated manner.

prevention interventions are most effective when they are implemented early in the course of epidemic<sup>14</sup>. Thus, this is the most opportune time for the state of Haryana to follow suit and scale-up its response to the IDU-HIV epidemic. As reported by a key informant, the process of scale-up in Haryana is going to begin soon. However, inadequate capacity of institutional mechanisms in Haryana (an understaffed SACS, absence of a TSU) appears as a strong barrier to scale-up the response.

One major barrier in scaling up the TI coverage in these states has been the inadequate number of NGOs and/or inadequate capacities of the existing NGOs to initiate and implement the TI projects. The difficulty in selecting appropriate NGOs to award TI projects was reported by certain key informants. The response to the advertisements by the SACS urging NGOs to apply for/express their interest for initiating TI projects is, at best, lukewarm. Even among those who do apply, it is a challenge to select appropriate NGOs. One of the reasons behind this (as cited by some key informants) is relatively underdeveloped NGO sector in this area as such. There are many NGOs with stronger population-base and acceptability among masses. However, often these NGOs have strong spiritual/religious inclination. Some such NGOs do address drug use in an oblique manner (emphasizing abstinence as a desirable way of life), but it may be a challenge to engage with them for adopting 'harm reduction' strategies.

## 4.2 Care, Support and Treatment

**Lack of enough ART centres:** Many key informants expressed concern about rising HIV prevalence among IDUs in Punjab. The implication would be that there are now many IDUs requiring ART services, which at present are not available in all the districts in Punjab.

## 4.3 Capacity Building

As described earlier, a very important institutional mechanism – the State Training

and Resource Centre – does exist for Punjab, Haryana and Chandigarh. A very able institution, the School of Public Health, PGIMER, Chandigarh, is the STRC entrusted with the task of assisting SACS on capacity building issues for all three states combined. However, certain key informants expressed concerns about the overall scenario of capacity building in these states.

- **Lack of timely provision of training:** While the service providers who have received training do express satisfaction with it, there are concerns about the timing of these trainings. It has been found that many newly established TIs often have to wait for a long time before their staff can receive training. Given the need for a rapid scale-up in these states, the importance of timely training cannot be overemphasized.
- **Role definition of STRC:** In a typical scenario, the SACS identifies the need to organize a training program based on the inputs received from the TSU. This is followed by the SACS contacting the STRC and requesting a time-slot for the training program to be organized. The STRC must accommodate the requests of all three states – Punjab, Haryana and Chandigarh – and prepare its training calendar accordingly. The SACS then identifies the trainees (with inputs from the TSU) and the resource persons. The STRC finalizes the agenda with the help of the SACS and looks after the logistics of the training program. Thus, there is a need for all three agencies to coordinate with each other (i.e. the SACS, TSU and STRC), which itself is a challenge. Even the funds for training are received by the SACS and utilization of these (through training programs to be organized by the STRC) is a challenge and is hindered by many extraneous factors (such as limited availability of time with the STRC). In view of this, some key informants have questioned the utility of this institutional mechanism (STRC) in general, given that a lot of responsibilities surrounding the training have to be carried out by SACS and TSU.

<sup>14</sup>UNAIDS 2005. Intensifying HIV prevention, UNAIDS, Geneva



- Lack of resource persons/material in local language: Yet another gap identified by the key informants is the absence of resource persons who can provide training in the local language. As yet, there does not exist a pool of trainers from these states who are fluent in the local language. Consequently, the resource persons are always ‘imported’ from other states; and sometimes, the communication between the trainer and the trainees does get affected due to the language barrier. Similarly, the dearth of resource materials/IEC materials in the local language has been expressed as a concern by key informants. It must be mentioned that there exist rich academic resources in the states (the PGIMER, the GMCH, the Punjab University, etc.) which so far have not been fully utilized for the purpose of capacity building. Similarly, the psychiatrists working in the Government sector in Punjab – trained by the NDDTC as Master Trainers in a TOT program – are also not being utilized.

#### 4.4 Information Systems

- **Excessive documentation:** The CMIS established by NACO is a very robust system for collection and management of data. The importance of collecting comprehensive data on program-related indicators in a timely manner cannot be overemphasized. However, many TIs report being overwhelmed by the number and complexity of records they have to maintain. Every IDU TI is expected to maintain as many as 17 different registers/records. As a KI said, “These days our staff members hardly have any time to spend with the clients. Most of the time they are busy with paper work.”
- **Lack of resources to comply with the reporting requirements:** Typically, extra assistance for the TIs for reporting and documentation (in the form of a Monitoring and Evaluation officer) is provided on the basis of ‘targets’ (i.e. the number of HRGs

### Box 9: Strengths, as Observed

Besides discussing gaps/barriers, certain strengths have also been observed that could be utilized for the IDU-HIV response:

- All three states are relatively resource-rich.
- There appears to be a strong political will to address concerns related to drugs and HIV.
- By and large, the states have remained largely peaceful and conflict free (as opposed to the northeastern states like Manipur and Nagaland, which deal with the IDU-HIV epidemic as well as insurgency).
- So far, there has been no obvious resistance from any section of society on “harm-reduction” issues.
- The geographical terrain is not unfavourable to mount a response to the drug-HIV epidemic (again as opposed to hilly and difficult-to-access areas in the northeastern states like Manipur and Nagaland).

the TI is expected to reach out to). However, most TIs perceive that given the number of documents they need to maintain, there should be provision for a Monitoring and Evaluation Officer for all TIs, irrespective of their targets. Similarly, frequent changes in the documentation formats has also meant that the NGOs have to print their report forms repeatedly, which they find difficult.

Table 9: Matrix of Gaps/Barriers in Response and Recommendations (Summary)

NACP III component	Major Gaps/Barriers	Recommendations	Suggested mechanism and stakeholders who should respond
Prevention	Detoxification/ Drug treatment services are not available/ accessible to IDUs	Provision of funds in the TI budget for facilitating access to drug treatment services for IDUs	NACO may want to consider a relook at the costing guidelines for TIs
	Concerns remain about standards of Detoxification/ Drug treatment services	Strengthening of drug treatment mechanisms in the government healthcare delivery systems in states	<ul style="list-style-type: none"> <li>▪ Department of Health, Punjab has already taken this initiative, which should continue. Departments of Health in Chandigarh and Haryana should follow suit</li> <li>▪ The Drug De-addiction Programme (DDAP), MOH&amp;FW can provide technical help and resources through NDDTC, AIIMS or PGIMER, Chandigarh</li> </ul>
		A common 'minimum standards of services' document, applicable to all drug treatment facilities, along with establishment of mechanisms to ensure capacity-building and monitoring	MOH&FW and MSJE should jointly initiate this process along with consultations with various stakeholders (service providers, activists, affected individuals etc.). UNODC/WHO can organize the initial consultations and bring stakeholders together
	Female sex partners of IDUs are not being reached. No specific guidelines in the program for the same	Developing specific operational guidelines and training manual for the service providers on issues related to female sex partners of IDUs	UNODC has initiated the process of assisting NACO in drafting training manual; process should be extended to assistance to NACO in drafting operational guidelines
	Absence of the important evidence-based intervention - the OST (particularly in Punjab)	OST can be initiated in Punjab with a collaborative mechanism between IDU TI (who would conduct outreach) and the government health-care delivery systems (who would provide OST). The Government de-addiction centres can implement OST as a service among other services. Many Government de-addiction staff have already been oriented and sensitized to OST by the NDDTC, AIIMS	The SACS Punjab can take the initiative and involve Department of Health, Punjab. The Drug De-addiction Programme (DDAP), MOH&FW can provide technical help through NDDTC, AIIMS
	Many areas in Punjab with small pockets of IDUs, including in many villages	As an innovative strategy, the model adopted by the NRHM can be utilized, by deploying field workers like ASHAs for delivery of certain services (like health education, NSEP, condom distribution, referral etc.). The attached CHC can coordinate the services and function like a 'mini TI'	NACO can initiate the discussion with the relevant sector in MOH&FW at the national level, for planning and implementation process. The SACS Punjab can take the initiative and involve Department of Health, Punjab.
	Not enough resources for accompanied referrals to various services (such as ICTC)	Enhancing the budget for peer educators for accompanied referrals	NACO may want to consider a relook at the costing guidelines for TIs

contd...

NACP III component	Major Gaps/ Barriers	Recommendations	Suggested mechanism and stakeholders who should respond
	<ul style="list-style-type: none"> <li>▪ Rate of scale-up an area of concern</li> <li>▪ Lack of NGOs with adequate capacity who could initiate TIs</li> </ul>	<ul style="list-style-type: none"> <li>▪ Investments may have to be made in the civil society, even before they become sex partners in the response (i.e. to enable them to apply for and qualify for implementing TI projects)</li> <li>▪ NGOs based primarily in other states (but with local involvement) may be encouraged to initiate TIs in Punjab</li> </ul>	<p>UNODC (in collaboration with MSJE) should enhance capacity of drug treatment NGOs on TI issues so that they could be encouraged to apply for and initiate IDU TIs in Punjab</p>
	<p>Lack of mechanisms for vocational rehabilitation for IDUs and their sex partners</p>	<ul style="list-style-type: none"> <li>▪ Provisions should be made in the costing/operational guidelines for access to vocational rehabilitation services for IDUs</li> <li>▪ Encouraging and forming SHGs of women family members of male IDUs (which could address the financial/ vocational issues should be made a part of the TI mandate</li> <li>▪ The initiative taken by one of the TI projects in Chandigarh (SEHAT) can be refined, scaled-up, and replicated elsewhere</li> </ul>	<p>NACO may want to consider a relook at the operational and costing guidelines for TIs</p>
Treatment	<p>Numbers of ART centres not enough</p>	<p>All districts must have at least one ART centre</p>	<p>NACO/SACS may want to expedite the process</p>
Capacity Building	<ul style="list-style-type: none"> <li>▪ Concerns about utility of STRC</li> <li>▪ Lack of local resource persons</li> <li>▪ Timely trainings not being provided</li> <li>▪ Lack of IEC material in local languages</li> </ul>	<ul style="list-style-type: none"> <li>▪ A recommendation (which has come from the KIs) is to give additional mandate to the TSU for capacity building (with modification of the TOR for the TSU) or to establish a capacity building cell in the SACS itself</li> <li>▪ Training of trainers programs for Punjab and Haryana are urgently required</li> </ul>	<ul style="list-style-type: none"> <li>▪ NACO may want to consider a relook at the very concept of STRCs or make suitable adjustments and modifications in the existing Terms of Reference for STRCs/TSUs</li> <li>▪ Strong academic/technical resources exist in Punjab, Haryana and Chandigarh (such as PGIMER, Chandigarh, PGIMER Rohtak, GMCH, Chandigarh, Punjab University etc.). These remain under-utilized in the capacity building programs so far. These must be engaged with to tap their full potential</li> </ul>
Information systems	<p>An overload of documentation and reporting on TIs</p> <ul style="list-style-type: none"> <li>▪ Lack of resources for NGOs to efficiently comply with reporting requirements</li> <li>▪ Frequent changes in reporting formats</li> </ul>	<ul style="list-style-type: none"> <li>▪ Provision of more resources for the TIs (such as staff, funds for printing reporting</li> <li>▪ Finalization of reporting formats as soon as possible formats)</li> </ul>	<ul style="list-style-type: none"> <li>▪ NACO may want to consider a relook at the operational and costing guidelines for TIs</li> <li>▪ NACO may want to expedite the process</li> </ul>



# 5

## RECOMMENDATIONS

As described in the previous pages, there are certain issues regarding the IDU-HIV situation in this part of the country that are staring us in the face. Firstly, there is a definite epidemic of drug addiction (including injecting drug use) in Punjab. Not only is there an evidence of sizable numbers of IDUs in Punjab, it appears that many of them indulge in risky practices and are vulnerable to HIV transmission, as evidenced by rapidly rising HIV prevalence among IDUs. Finally, while a response to this problem has been mounted, there remain certain gaps due to which it has been difficult to scale up the response to the required level – in order to be able to ‘halt and reverse’ the HIV epidemic.

In the following section, an attempt has been made to provide certain recommendations which could enhance the intensity and the scope of response. The overarching guiding principles behind framing these recommendations have been pragmatism and plausibility. Thus, the recommendations should not be seen as a ‘wish-list’ for an ideal situation but as a set of suggestions which can be actually implemented. For the sake of easy understanding, these recommendations have been thematically organized, though it is understood that there is considerable overlap among these. Most of the recommendations presented in this section have been culled from the matrix of gaps/barriers and recommendations presented earlier, in which suggestions have also been put forward regarding the stakeholders who should respond, as well as the strategy/mechanism for implementation. The report has deliberately avoided being very concrete and prescriptive in its approach; instead, certain ideas have been generated and leads provided, which could be explored further.

### 5.1 Strengthening the Institutional Mechanisms

- The primary institutional mechanism for responding to the HIV epidemic, i.e. SACS should be strengthened. This can be accomplished by enhancing the capacities of SACS themselves through increasing the manpower (for example, in Haryana, the SACS is reportedly severely understaffed with just one person responsible for overseeing the entire TI program) and/or by having other institutions in place to assist SACS (like TSU in case of Punjab). All KIs opined that TSU could play a very valuable role, as has been the case with Punjab. While a smaller SACS (in terms of area of operation) like Chandigarh may not need a TSU, Haryana would definitely require one, given the scale-up of program which is in the pipeline.
- One issue worth mentioning is that, the same organization is having to assist more than one SACS (e.g. the same organization is functioning as STRC for all three states). While this strategy may appear to be cost-effective, more often than not it has meant that at any given point in time, the needs of more than one state compete for the STRC’s attention. This inevitably leads to prioritizing one state’s needs over the other. Thus, most KIs believe that each SACS should have its own TSU and STRC, failing which the SACS should be strengthened enough not require STRC (such as by enhancing the technical manpower in the SACS).
- The standards of treatment services provided at drug treatment centres are in immediate need of improvement. There are certain standards in place for the NGO treatment centres operating under MSJE; such systems should exist for the government de-addiction centres as well.

Indeed, ideally, there should be common minimum standards for providing drug treatment services, which should apply to all kinds of drug treatment sectors: NGO, Government and Private.

- Another important way to strengthen the institutional mechanism could be through making investments in civil society itself. While elaborate systems are in place to increase the capacities of NGOs after they enter into a partnership with SACS, at present there is a dearth of NGOs who could even be considered for such a partnership. Thus, there should be a mechanism to engage with the civil society even before it formally joins the drug-HIV program. One way of achieving this could be to identify the 'budding' NGOs and enhance their capacities on the general NGO management issues. Additionally, even those NGOs that are working in other sectors should be

oriented/sensitized on drug-HIV issues. For instance, the NGOs working with drug users (under the MSJE scheme) and sex workers (TI program under NACO) could be oriented/sensitized towards the need of working with IDUs and encouraged to get involved in the IDU TI program.

- In some parts of the country, collectivization of HRGs and enhancement of their capacities has led to a significant Community Based Organization (CBO) movement. Some very early signs of at least some IDUs in Punjab getting more aware of their rights and realizing the importance of collectivism and activism are visible. It will be interesting to see whether a CBO movement of IDUs in Punjab and Chandigarh does materialize.

## 5.2 Expanding the Ambit of TI Program for IDUs

- As described in the section on gaps/barriers, at present there is no provision or systematic guidelines for reaching out to female partners/spouses of IDUs. This is a major gap particularly in this part of the country, since many IDUs tend to be married/otherwise sexually active; and the sexual transmission of HIV from IDUs to their partners may contribute to increasing feminization of the epidemic. Thus, developing operational guidelines/training modules to reach out to female sex partners of IDUs is extremely important. It is learnt that this process has begun and UNODC is currently assisting NACO in developing a training manual for service providers (i.e. female outreach workers) on this issue.<sup>16</sup> Additionally, the needs of spouses/female sex partners of IDUs are not just limited to condoms. They may require avenues for social/psychological/financial support as well.<sup>17</sup> In this regard, encouraging and

### Box 10: Case Example – Finding NGOs to Implement IDU TI Project

To some extent, the problem of inadequate number of NGOs with required capacity to implement IDU TI projects has been addressed by encouraging NGOs based primarily outside the states but with some local involvement to implement TIs in Punjab and Haryana. SHARAN, an NGO based in New Delhi is implementing an IDU TI project in Jalandhar (Punjab) and Faridabad (Haryana). Similarly, JK-SPYM (based primarily in Jammu) is implementing an IDU TI project in Gurudaspur (Punjab).

<sup>16</sup>Disclosure: The author is currently assisting the UNODC/NACO to develop a training manual for service providers for reaching out to partners of IDUs.

<sup>17</sup>Ambekar *et al.*, 2009, *HIV Vulnerability Among IDUs, Their Spouses and children*, SPYM and Plan, New Delhi.

supporting formation of self-help groups of women affected by family members' injecting drug use may be very useful (See Box 11).

### Box 11: Case Example – Reaching Out to the Spouses of IDUs

A TI centre in Chandigarh (project SEHAT) has taken a unique initiative (with initial support from UNODC). A female peer educator has been placed to contact the families of IDUs in the area. With sustained efforts, a self-help group of women (mostly wives) belonging to the families of IDUs called 'Nari Sehat' has been formed. The group meets fortnightly, has opened a bank account and has initiated micro-credit services for the members. However, the most unique activity of the group is the creation of a Food Bank. Containers have been placed at the NGO office where the group meets, in which the group members deposit small amounts of food grains like lentils, wheat flour, rice, etc. on a purely voluntary basis. A family in need is encouraged to borrow the required amount from this food bank. The NGO staff wants to scale up this initiative to provide this benefit to a larger number of families.

- Even if the existing operational guidelines for IDUs are diligently followed, there may remain concerns about attractiveness of the TI program in bringing IDUs closer and retaining them. The needs of IDUs are manifold and are not limited to the NSEP or

condoms (which are being provided by the TIs). As discussed in the previous pages, many IDUs demand help for accessing drug treatment. Furthermore, it appears that providing this help on a limited scale – just in the form of referrals – may not be sufficient. A number of IDUs may have to be provided with logistic help to access drug treatment. Similarly, many IDUs also require help with vocational rehabilitation. Unemployment is a known risk factor for drug use, and availability of vocational rehabilitation services may make the TIs more attractive for the IDUs. This may, however, necessitate a relook at the operational and costing guidelines for IDU TIs.

- One major recommendation would be to launch Opioid Substitution Treatment (OST) for IDUs in Punjab at the earliest. It is becoming increasingly clear that the existing programs for IDUs are not able to provide the “comprehensive package of services” since a crucial component – the OST – is missing. The following factors augur well for feasibility of implementing OST programs in Punjab.
  - a) A strong political will to address drug treatment and HIV prevention issues
  - b) Availability of drug treatment services in the government health sector (which are rapidly expanding)
  - c) Presence of staff in the government drug treatment centres which has been already oriented to/trained in implementing OST programs<sup>18</sup>
  - d) Availability of strong technical resources in the states (e.g. the PGIMER and GMCH in Chandigarh)

<sup>18</sup>NDDTC, AIIMS has provided training on OST to not only doctors but even other staff categories like nurses and paramedical staff from various Government de-addiction centres in Punjab.

It is learnt that NACO is currently looking at options to involve the government healthcare delivery systems in its OST program. Given the readiness and preparedness of government drug treatment mechanism in Punjab, this state could be the ideal state for initiating OST through government centres. Involving the government de-addiction centres in the OST program would have multiple advantages: (a) it will ensure sustainability, (b) it will improve the access to other health-care facilities required by IDUs (such as the ICTC, STI treatment, ART, etc.) and (c) it will expand the menu of services currently available at the government de-addiction centres.

### 5.3 Tapping The Available Resources

- Considerable resources are available in the states, waiting to be tapped for IDU-HIV programming. Curiously, the Government de-addiction sector, which is evolving rapidly in Punjab (as described earlier), is yet to be integrated into HIV programming even though the same department (i.e. health) of the state government is looking after both! An ideal situation can be easily hypothesized where IDUs are contacted first by the IDU TIs through outreach, provided basic health-care as well as preventive education and thereafter, depending upon the mutually identified priorities, referred for detoxification/drug treatment in the government de-addiction centres. Even if there is no TI in the locality, the government de-addiction centre could itself be utilized for providing harm-reduction services as well as a sentinel surveillance site. While accessing drug treatment services at the government de-addiction centres, the IDUs may also find it easier to access ICTS and STI services as these are usually offered by the same government hospital (civil hospitals in most cases). In other words this would be akin to adopting a 'one-stop shop' approach for the IDUs.

- Similarly, there are many academic resources available in the states which could be utilized for capacity building services. Institutions such as PGIMER, GMCH and Punjab University, Chandigarh could play a very important role in developing human resources in the area of drug-HIV issues.

### 5.4 Forging Newer Alliances and Partnerships

- A strong civil society does exist in the states, though it is yet to be fully oriented and sensitized to the drug-HIV issues. There are about 40 de-addiction centres in Punjab, Haryana and Chandigarh being run by the MSJE supported NGOs. All of these are oriented to issues related to drug use and have experience of dealing with this population. These NGOs could be effective partners in the response to the drug-HIV epidemic. Indeed, there are examples in the state where the same NGO is implementing the IDU TI project as well as running a de-addiction centre under the MSJE support. However, in the absence of any mechanism to integrate the two government schemes, such NGOs also find it difficult to integrate their services. Thus, a partnership between NACO/SACS and the MSJE and its institutions (such as the RRTCs) at the top level may percolate to the bottom and provide an opportunity for a coordinated response. This will ensure that the clients do not fall through the programmatic gaps.
- Similarly, many spiritual organizations could also be roped in for a partnership; these could play important roles through employing innovative strategies. Contrary to the popular misconception, even organizations which are based primarily on spiritual constructs can be sensitized on 'harm-reduction' issues. The adjoining box shows an example of a spiritual organization (the Art of Living Foundation) which has been trying to develop a unique model of drug treatment service-delivery in Punjab (See Box 12)

## Box 12: Case Example – A Spiritual NGO’s Initiative to Improve Treatment Access for Drug Users

The Art of Living (AOL) Foundation, a spiritual organization, has been active in many community-level developmental issues. The organization took up an initiative aimed at improving the treatment access for drug users in smaller towns and rural areas of Punjab through bringing the services closer to them. In a typical scenario, a village is identified in which volunteers of AOL (with local community support) organize an “outpatient detoxification camp.” This camp is organized with multi-sectoral collaboration: the AOL and its volunteer force, the local community and the resources at its disposal, the nearest government healthcare facility and the nearest medical college. The camp lasts for about 10-14 days, during which the doctors and other medical staff provide drug treatment related services, the AOL volunteers keep patients engaged with the spiritual/devotional activities, and the local community looks after the food and other logistics. Since it is an “outpatient” camp, the patients spend only the day at the camp and sleep at their homes at night. Once discharged from the camp, the follow-up and long-term treatment services are provided by the government health-care facility. The AOL has organized about 35 such camps in various districts of Punjab with very encouraging results in terms of acceptability among communities and service providers alike. More importantly, the AOL does not seek to interfere with the professional (i.e. medical/psychological) aspects of drug-dependence treatment.

(Deepak Yadav and Anju Dhawan, NDDTC, AIIMS and AOL – personal communication)

The example illustrates the untapped potential resource represented by the spiritual organizations in Punjab. With innovative strategies, such spiritual organizations can be made key partners in the response.

- The issue of forging alliances and partnerships is relevant not only for the government sector but also for the NGO service providers. For instance, all the NGOs in the country that have been running de-addiction centres with MSJE support have formed a huge national network among themselves named FINGODAP (Federation of Indian NGOs for Drug Abuse Prevention). This collectivization of NGOs has helped them in increasing their capacities and learning from each other’s experiences. It has also enhanced their collective bargaining power with the Government. Encouraging the formation of a similar network of TI implementing NGOs could help them in a similar manner, which would ultimately be beneficial for the program.
- Yet another avenue for partnership could be engagement with the professional/academic bodies. The medical community has not been fully roped in the response to the drug-HIV epidemic. The beginning could be made by at least sensitizing the professional medical societies (or their state chapters) such as the Indian Medical Association (IMA), the Indian Psychiatric Society (IPS) and so on. Once the initial sensitization is over, dialogues can



### **Box 13: Case Example – Sensitizing the Medical/ Professional Community**

The Department of Forensic Medicine and Toxicology of the GMCH, Chandigarh recently organized the National Conference of the Indian Association of Toxicology (TOXOCON). On this occasion, the Chandigarh SACS organized a CME on the topic – Injecting Drug Use. Experts from throughout the country addressed the gathering of forensic and toxicology specialist on IDU, HIV as well as associated medico-legal issues. An interactive session of conference delegates with some TI staff and IDUs was also organized. The event represented an excellent opportunity for sensitizing a large gathering of medical (forensic) professionals and initiating a dialogue for further cooperation.

then begin on how the various sectors can work together. A very good example of this was reported recently by the Chandigarh SACS (See Box 13).

## **5.5 Collection and Management of Information**

- Since the HIV epidemic among IDUs continues to grow unabated, it would be extremely important to keep a tab on the trends of risk factors for this epidemic as well as the performance of the responses to address it. While a robust CMIS is in place, it appears that it has still not fully evolved. In order to facilitate timely collection of comprehensive data, it would be important to provide necessary resources to the NGOs for doing so.
- While so far one of the limiting factors behind inadequate number of sentinel

surveillance sites has been the inadequate number of IDU TI sites, the rapid scaling-up of the program warrants that the number of IDU sentinel surveillance sites will be increased accordingly. Additionally, as described earlier, the government de-addiction centres can also be utilized as sentinel surveillance sites.

- Additionally, it would be extremely useful to collect data on certain behavioural parameters from the service seekers (i.e. IDUs receiving TI services) at periodic intervals. Also, the issue of Hepatitis C among IDUs needs to be adequately researched. Operational research would also be very helpful in assessing the effectiveness of existing programs. Many micro-management issues involving the TIs need to be further explored. This would help in re-strategizing the TI services in order to halt the progression of the epidemic.
- It would also not be enough to rely just on the data collected by the TIs through the CMIS mechanism. There must be a provision for collecting the data through multiple sources and conducting triangulations. Some such beginnings may have been made (See Box 14); these should be subjected to refinement and replication elsewhere in the country. Other sources of data may also include the non-NACO/SACS agencies. The NGOs running the de-addiction centres are supposed to collect data on all patients seeking treatment through the Drug Abuse Monitoring System (DAMS). Similarly, the government de-addiction centres under the MOH&FW also collect data from all new treatment seekers through the DAMS mechanism, coordinated by the NDDTC, AIIMS. Importantly, the DAMS format of MOH&FW has certain questions which could be valuable in the light of the IDU-HIV epidemic (such as questions on injecting, sharing, STIs, HIV testing, etc). All these sources of data should be tapped into, triangulated with the data available through the SACS/NACO mechanisms and be utilized for further programming.

**Box 14: Case Example – “District Prioritization” in Punjab**

The Technical Support Unit (TSU), upon the request of Punjab SACS, is attempting to generate a list of the priority districts in terms of HIV epidemic and its responses. For this purpose, in each district, various factors have been taken into account: Overall burden of HIV (as measured by number of people estimated to be living with HIV in the district), the HIV prevalence among various population sub-groups (i.e. ANC, FSW, MSM, IDU), the risk profile of the district (as evidenced by the estimated size of high-risk populations), the existence of services for prevention (i.e. TIs) and treatment (i.e. ART). Based on these factors, scores have been assigned to each district and the total of all the scores has been used to generate a ranking of the districts. This model should be subjected to further examination, scrutiny, testing and finally replication elsewhere



# 6

## ADDENDUM: RECOMMENDATIONS FOR UNODC

The initiative taken by UNODC vide this study is indeed laudable. Since UNODC has taken this initiative to explore the barriers and gaps in the response to the IDU-HIV epidemic in Punjab, Haryana and Chandigarh, it appears prudent to suggest a few activities which UNODC may consider taking up, considering its mandate to assist the government and the civil society to counter the problems posed by the drug and HIV epidemic.

### 6.1 Disseminate this Report

This report would serve its purpose only when it is shared with all the stakeholders in the drug HIV response in this part of the country. It must be noted that the intended target audience of this report extends well beyond the agencies primarily responsible for responding to the HIV epidemic, i.e. the NACO/SACS. These may include (but are not limited to) the NACO, the MOH&FW (the DDAP division), the NDDTC, AIIMS, the SACS of Punjab, Haryana and Chandigarh, the MSJE, the FINGODAP, the RRTC-North, the TSU of Punjab, the STRC of Punjab, Haryana and Chandigarh, the departments of health and social welfare at Punjab, Haryana and Chandigarh, the technical/academic resource institutions in the states (like the PGIMER, the GMCH, the Punjab University), the representatives of activists/rights-based organizations, etc. Additionally, besides sharing the report individually with the above-mentioned stakeholders, it would also be useful to organize consultation workshops where the findings of this report as well as the future strategies could be discussed.

### 6.2 Act as a Facilitator

As has been clearly brought out in this report, there are many vertical programs in Punjab, Haryana and Chandigarh addressing the issue of drugs and HIV with variable approaches and with varying degree of intensity. The first and foremost step in this regard would be to bring various stakeholders together in order to catalyze a coordinated planning and programming process. Since the UN system enjoys the reputation of an 'honest broker' among all stakeholders, UNODC may be the ideal agent to set this process into motion.

### 6.3 Bring in the International Learning and Experience

UNODC is operating at a global scale, and indeed the ROSA itself operates in six countries in South Asia. It is possible that situations similar to Punjab, Haryana and Chandigarh exist in other countries too, with the government and the civil society facing similar challenges. If there are examples of certain good practices and demonstrably effective approaches to deal with such challenges in the South Asian region or elsewhere, UNODC must share those with its counterparts in India.

### 6.4 Replicate the Exercise In Other Parts of the Country

Today, other than the northeastern states and the metro cities of the country (which have been known to be 'hotspots' for IDU-HIV),

many parts of the country are witnessing a rapidly evolving HIV epidemic among IDUs. Notably, the trends from Kerala, Orissa and parts of Uttar Pradesh are worrying. A national strategy and approach often needs to be modified and suitably adopted as per the prevailing local situations. In such parts of the country, a similar initiative to explore the barriers and gaps in response would help in adopting suitable approaches and strategies.

## **6.5 Catalyze to Enhance the Rate of Response**

UNODC is expected to be in a position to bring-in the required level of expertise and experience to catalyze the process of building up a response. While the primary ownership and responsibility to mount a response resides with the government and the civil society, supplementing some of the resources to fill in the gaps would indeed be welcome and help to enhance the pace of response.

