

**National AIDS Control Programme
Phase IV**

Working Group

Theme: Targeted Intervention
Sub Group: Injecting Drug Use

NACP IV WORKING GROUP ON INJECTING DRUG USE

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INTRODUCTION

Injecting Drug Use (IDU) has emerged as an important route in the HIV transmission dynamics in India. Though the current number of Injecting drug users (IDUs)¹ in India is 200,000, the HIV prevalence among IDUs is very high as is evident from the recent surveillance exercise by NACO, wherein the HIV prevalence among IDUs was > 9% (NACO, 2010). Additionally, there are nine districts which have reported > 15% HIV prevalence among IDUs in the country (NACO, 2008).

The increased burden of HIV among IDUs and other blood-borne infections caused by hepatitis B (HBV) and hepatitis C (HCV) viruses is due to risk behaviours related to sharing of contaminated needles and syringes as well as through high-risk sexual behaviours such as unprotected sex, unsafe sex under the influence of drugs /alcohol and sex for exchange of drugs. HIV epidemic, initially started by the sharing of contaminated injecting equipment, is spread through sexual transmission from IDUs to others including regular and other sexual partners; the interface between drug use and sex work serves as a fuel to the spread of HIV epidemic from the IDU population to sex workers and finally to the general population.

Evidence supports a comprehensive package of biomedical and behavioural interventions as the optimal HIV prevention strategy for halting HIV among IDUs. The technical guide developed jointly by the World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC), the Joint United Nations Programme on HIV/AIDS (UNAIDS) for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users has recommended a comprehensive package of core public health interventions. This package includes nine components of services ranging from Needle syringe programme (NSP), Opioid substitution therapy (OST), Voluntary Counselling and Testing (VCT), Anti-Retroviral Therapy (ART), Sexually Transmitted Infections (STI) prevention, Condom programming for IDUs and partners, Targeted Information, Education and Communication (IEC) for IDUs and their sexual partners, Hepatitis prevention, diagnosis, treatment (Hepatitis A, B and C) and vaccination (Hepatitis A and B), and Tuberculosis (TB) prevention, diagnosis and treatment. There is strong evidence that each of these interventions are effective in reducing risk behaviours, preventing HIV infections, and accessing essential care and treatment services for IDUs. However, it is also proven that any single intervention will not provide the desired results, and a combination of interventions is required to be totally effective in HIV prevention among IDUs.

The National AIDS Control Organisation (NACO) has adopted the harm reduction (HR) strategy in NACP - III to prevent HIV amongst the IDUs and scaled up interventions through targeted interventions (TI) by non government organizations (NGOs). By reaching out to a significant proportion of estimated IDU population, NACP-III has laid the foundation for an effective, and evidence-based comprehensive response for halting and reversing the HIV epidemic among IDUs. However, the increasing HIV prevalence among IDUs shows that the programme needs to be accelerated with provision of comprehensive package of services with emphasis on quality of services delivered.

¹ IDUs are also termed as 'People Who Inject Drugs (PWID)', which is being used in international nomenclature more often than IDUs. However, in India, the term 'IDU' is more commonly used and understood by even those not working in the field of drugs too. The term IDUs and PWID are therefore, used interchangeably.

NACP III was conceived with a five year cycle for funding and programming. With the NACP III reaching the final year of implementation, the planning for the next phase of the National AIDS Control Programme (NACP IV) has been initiated. Various themes have been identified for discussion and formulation of strategy for NACP IV. A working group has been constituted for each theme comprising of individuals nominated for this purpose. The mandate of the working group is to take stock of the existing programme, examine the gaps and finally provide recommendations for NACP IV.

Current Status of NACP III

The primary objective of NACP-III is to halt and reverse the spread of HIV epidemic by 2012. The aim is to cover 80% of the high risk groups such as IDUs with targeted interventions (TIs).

- IDUs have been defined in NACP III as an individual who has injected drugs at least once in the **last three** months.
- The services by the TIs are provided in three tiers: tier 1 services are outreach based interventions and NSP constituting the backbone of the interventions. Tier 2 is OST based interventions, and tier 3 provides linkages to other important services that are not directly provided under TIs such as DOTS, ICTC, ART, reproductive health services and drug use related services.

Considerable progress was made under NACP III with respect to the scale-up of interventions for IDUs as well as quality assurance in the country.

- During the NACP-III planning stage, a secondary analysis of existing data on the estimates of IDUs was carried out. Further, detailed field mapping of High risk groups in 20 states was carried out during NACP III implementation. Subsequent revalidation through existing TIs and monitoring mechanisms provides the number of IDUs as defined in NACP III to be **177,000**.
- The sites for sentinel surveillance exercise aimed at determining HIV prevalence among IDUs has substantially increased. In the last round of sentinel surveillance conducted, 63 sites were chosen for determining HIV prevalence among IDUs.
- Much of the focus has been on expanding the availability of TI services for IDUs throughout the country. Consequently, there has been a threefold increase in the number of exclusive IDU TIs in the country, with currently 261 TIs providing services to the IDUs. Majority of the expansion has taken place in the non north-eastern parts of the country.
- Resultant to the increase in the number of IDU TIs in the country, there has been an increase in the number of IDUs registered in the TIs – 80% IDUs reached out at least once (one time coverage).
- Opioid substitution therapy (OST) was initiated for the first time in NACP III as was planned in the strategy-cum-implementation document for NACP III. The OST strategy was implemented after obtaining due endorsement from other ministries, including from Ministry of Social Justice and Empowerment, Ministry of Home, Narcotics Control Board and the Director General of Health Services. Currently, OST is being provided in 52 OST TI centres covering 4810 clients.

Additionally, OST is also being piloted in 5 sites in Punjab using a unique model of collaboration between Government hospitals and non-governmental organizations. Currently, about 500 clients are targeted to be covered under this initiative.

- Analysis of the CMIS reports show that there has been an increase in the service utilization provided in the TIs. These include services such as needle-syringes distributed and returned, condoms distributed, BCC conducted, referrals to ICTC and ICTC uptake, STI service referrals and uptake.
- To ensure quality, capacity building of service providers and to bring about standardisation of service provision, resource materials have been produced. This includes: guidelines for waste disposal management, training module on harm reduction, counselling module, SOP for OST, practice guidelines for OST, Manual for working with partners of IDUs, etc.

GAPS IN NACP III RESPONSE

Even though there has been considerable progress made in the implementation of IDU TI programme, there are also gaps in the strategies and response in NACP III. This is clearly evident from the fact that the HIV prevalence among IDUs has continued to increase in the recent years.

- As per the recent sentinel surveillance report, HIV prevalence among IDUs is 9.2%, which is the highest for any population group. While the HIV prevalence among IDUs has continued to be high in the older pockets/sites, newer sites where IDU epidemic has been detected, also show a high prevalence of HIV among IDUs. The sites are located in states such as Punjab, Orissa and Bihar.
- As the current definition for IDUs for NACP III stands as 'those who have injected within the last three months', other IDUs who inject less frequently than once in 3 months, and non-IDUs remain vulnerable to HIV infection in the absence of service provision to this population.
- With the rapid increase in the number of TIs for IDUs in the country, the one time coverage of about 80% has been achieved. However, there is no accurate information on the regular coverage (and thereby ensure that IDUs use a new/safe needle syringe every time they inject) and is generally perceived to be very low.
- Needle and syringe distribution from TI sites have increased substantially. However despite an increase in distribution of N/S, low coverage (<100 needles per drug injector per year) still remains a challenge. Attention towards increasing the coverage of distribution of needle and syringes should continue to remain a high priority.
- Salary of the staff working in TI settings is not in keeping with the current cost of living. Additionally, staffs are not given increments commensurate with their experience and performance. There is no flexibility in TI budget to meet the varied needs of the IDUs in different settings.
- Overdose prevention and management, as well as prevention, treatment and care for hepatitis is not provided for in TI settings

- The intervention for IDUs is currently focused on provision of services through TI model alone. Other needs of IDUs which cannot be provided through TI settings are not met, as a result.
- Research evidence from India shows that stigma and discrimination not only for HIV but more importantly for drug use is a major barrier for IDUs to access services at TI and other service agencies.
- A number of services/commodities provided for currently in IDU TI, have not been rationalized in terms of quantity/budgets.
- Opioid substitution therapy
 - There has been considerable delay in the scale up of OST programme. NACP III had set out a target of covering 20% of the IDUs on OST. However, currently, only 2 – 3 % of the IDUs are on OST.
 - There is a great disparity in the resources provided to NGO OST and Government OST facilities.
 - Clients require a menu of options to choose from. Medications such as Methadone should be explored for OST programme.
 - Accreditation systems must be applicable to both public health facilities and NGO settings. Additionally, accreditation systems need to be rationalized.
- The capacity building efforts have not kept pace with expansion of the IDU TIs. This includes capacity gaps across service providers, monitoring / mentoring officers as well as SACS and STRC
- Though linkages and networking exist peripherally, the central mechanisms for establishing linkages with other ministries/departments are weak at national and state level.
- The other needs of IDUs are not met in TI currently, provision of which is important for HIV prevention. This includes, for e.g., nutrition, homelessness, etc. For detoxification services, though IDUs are referred by the IDU TIs, they are not able to get admitted in the detoxification centre, as the centre charges money for food (stay and treatment are free of cost).
- It is not known how many IDUs are on ART. However, members from the group, especially those working in IDU TIs, felt that the number of IDUs registered with ART centres is too low. In addition, adherence to ART medications is also an issue.
- IDU services should be made gender responsive. The design of interventions should address the needs of female IDUs and female sex partners of IDUs. Research evidence shows that this subset of population may require separate and different interventions as compared to their male counterparts.

STRATEGIC APPROACHES FOR NACP IV

KEY CONSIDERATIONS FOR NACP IV STRATEGY

- Despite a threefold increase in the number of interventions in the last four years, people who inject drugs have emerged as the population with the highest prevalence of HIV. The National HIV Programme should recognize that during the next phase of implementation, IDU-HIV epidemic should be the key focus of Targeted Intervention activities. It should also recognize that the needs of IDU population are different and to be effective, any response should be tailored in accordingly.
- It is increasingly recognised and scientifically proven that drug dependence, is a medical condition and needs to be treated as such. The treatment strategy requires multiple approaches – medical, psychological and social approaches. A single approach alone will not be 100% effective and acceptable to the drug using client.
- A number of services, required for the IDU, are being provided/expected to be provided to drug using population by other departments and ministries in the country. The HIV prevention strategy for IDUs should encompass various services, both direct and indirect, for preventing new infections. While some of the services can be provided through the National AIDS Programme, other services, especially social services, can be leveraged through the other ministries (such as Ministry of Social Justice & Empowerment, Ministry of Women & Child Development, Ministry of Urban Development & Poverty Alleviation etc.).
- Strategies under the National AIDS Programme for IDUs should not only focus on service provision through targeted intervention, but also through other strategies, such as IEC, mechanisms of formal linkages (e.g., with drug treatment and rehabilitation services) and addressing stigma and discrimination among IDUs. Additionally, strategies to cover the IDUs situated in rural pockets need to be developed.

GUIDING PRINCIPLES

- A. **Nothing for us without us:** community to be involved at all levels of programme – planning and designing, implementation and monitoring/evaluation.
- B. **Flexibility:** the programme needs to be flexible considering that the interventions are spread across vast geography and in different terrains. ‘One size fits all’ model would not work in practical terms.
- C. **Inclusive:** The programme should be inclusive of all groups, population and services.
- D. **Comprehensive package of interventions:** single interventions for IDUs are not successful. Comprehensive package of interventions alone achieve the desired results of HIV prevention.
- E. **Need based services:** Strategies to incorporate the needs of IDU in the current programme will ensure success.

- F. **Gender responsive services:** The interventions and services provided should be responsive to the needs of women including female drug users as well as female sex partners of IDUs.
- G. **Services for special populations:** this includes services for adolescents, MSM-IDU, FSW-IDU, Migrant and Trucker-IDU, etc.
- H. **Improved quality of services:** emphasis should be on improving the quality of services, as quantity without quality will not enable HIV prevention among IDUs.
- I. **Appropriate models of service delivery for an integrated care:** use the strengths of other existing programmes for drug users, including IDUs and provide integrated care and support.
- J. **Enabling environment:** it is seen that without an enabling environment, IDUs will not be able to access services. Emphasis should be placed on creating an enabling environment both in TI as well as public healthcare settings to ensure that IDUs are able to access these services without fear and prejudice.
- K. **Address drug use and HIV related stigma and discrimination:** Campaigns for stigma and discrimination should not address HIV alone, but drug use issues also, as IDUs face greater stigma due to drug use rather than HIV.
- L. **Enhanced capacity:** there is urgent need to build the capacity of IDU interventions across all levels – service providers, monitoring/mentoring officers as well as SACS, STRC and TSUs.

PRIORITIES

Geographical priorities

IDU and HIV among IDUs is now well established problem in various parts of the country. The previous assumption of IDU and IDU-HIV epidemic being restricted to north eastern region alone is now no longer true. Indeed there is no state, where IDU pockets have not been identified.

- Apart from the 3 states (Manipur, Mizoram and Nagaland) where IDU and HIV among IDUs was an established problem in the northeast region, the other states where IDU and IDU among HIV is a major concern include: Punjab, Orissa, Delhi, Maharashtra (Mumbai), Kerala, West Bengal and parts of Bihar.
- Additionally, the following states where estimates show that IDUs are in large numbers: Haryana, Madhya Pradesh, Uttar Pradesh, Andhra Pradesh, and Chattisgarh.

Programmatic priorities

The Targeted Intervention strategy, expanded under NACP III, continues to be an important strategy for HIV prevention among IDUs. However, the following areas needs to be strengthened for effective HIV prevention programme among IDUs:

- Emphasis should be given on a combination of interventions, rather than single intervention such as NSP. The combination package should include, at the minimum: NSP, OST, HIV testing and ART provision, Condom and STI.

- OST, initiated under NACP III, should now be expanded to all districts with significant IDU population (more than 250). Districts with either an existing high IDU-HIV epidemic or a high vulnerable population (IDU > 500) should be priority for scale-up of OST.
- Apart from targeted intervention strategies, strong emphasis should be placed on establishing formal linkages and mechanisms for leveraging and optimising resources from other schemes/programmes available under other agencies/departments of the Government of India (such as Ministry of Social Justice & Empowerment, Ministry of Women & Child Development, Ministry of Urban Development & Poverty Alleviation etc.).
- Female IDUs and female sex partners (including spouses) of IDUs should be intervened with HIV prevention services.

EMERGING ISSUES

- Newer pockets of IDUs being identified in many states and regions of India
- Presence of co-infections such as Hepatitis C among IDUs, which leads to challenges in ART, OST administration as well as high rates of deaths among IDUs
- Emergence of IDU among female and adolescent population

STRATEGY

A. IDU definition, coverage and numbers

- The definition of IDU will be considered at two levels. For intervention purpose and to maintain the thrust of the programme towards the most-at-risk IDUs, the definition for providing intervention through Targeted intervention programmes for IDUs will continue to be *'those IDUs who have used psychoactive substances through injection route at least once in the **last 3 months**'*. However, for the purpose of conducting other interventions such as IEC, mapping and other operational research, the definition of IDUs will be broadened to *'those IDUs who have used psychoactive substances through injection route at least once in the **last 12 months**'*. This will help the programme in ensuring availability of data on number, vulnerability of such IDUs who inject over the last 12 months, but not so recently, and finally such IDUs will not be denied services if they reach a targeted intervention site. In such cases, IDUs will be provided services through IEC, referrals and counselling.
- The current emphasis on measuring coverage through NSP alone should be changed to coverage with minimal package of comprehensive services for IDUs (e.g. NSP, OST, condoms, HIV testing and ART provision). The target for IDU programme of NACP IV should be UNIVERSAL ACCESS to the comprehensive package of services as mentioned above.

B. TI programme

- For defining the population to be covered under a particular IDU TI, while the minimum may be fixed at 150, the upper limit should be based on existing

mapping data available at the local level. However, the upper limit should not exceed beyond 600 – 650, as otherwise, it would be difficult to manage such a population. For smaller population size, strategies such as composite interventions, outreach centres, and sub-DIC should be followed.

- The outreach strategy needs to be modified – outreach workers (irrespective of their drug using status) should be the staff who will be responsible for ensuring availability of services at field level. The bulk of the documentation will be done by the outreach workers, while the peer educators would need to fill a simple documentation form (e.g. field based diary). Peer educators should be from the current injecting drug use background and should serve as a link between the IDU clients and the outreach staff. They should be responsible for bringing IDU clients into the fold of the TI, provide commodities and for basic behaviour change communication.
- Taking into consideration the fact that IDU clients have to be reached out on almost daily basis, the ratio of peer educator and outreach worker should be rationalised. The PE to client ratio should be 1:25, while the ORW to PE ratio should be 1:4.
- Additional to the existing staff, a post of monitoring and evaluation officer/data manager should be provided for in the TI. Additionally, a peer counsellor should be employed to provide BCC and other counselling services for IDUs. The salaries of the staff of IDU TIs should be rationalised and should also take into account – number of years of working at TI, performance of the staff, and existing salary norms in other Government programmes.
- Emphasis should be placed on counselling services for IDUs, and there should be a separate post of a staff managing the counselling services on Harm reduction as well as HIV related services, apart from the position of ANM who will take care of the abscess management, STI care and general medical care.
- The package of services being offered in IDU TI should be broadened and should include –
 - Hepatitis c prevention materials, awareness and BCC on Hepatitis C, and referrals for Hepatitis C testing on a voluntary basis
 - Appropriate allocation for waste disposal,
 - Hepatitis B vaccination, etc.
 - Prevention and management of overdose should be emphasized. Naloxone should be provided through National AIDS programme/NRHM both in TI and in the concerned district hospital/PHC/CHC.
- For HIV testing, possibilities for collection of blood samples at TI-DIC should be explored through DBS method. The counsellor at IDU TI should be trained on pre and post test counselling, ART adherence, and positive prevention. Alternatively, the lab technician and the counsellor of ICTC can have field visits to the TI DIC and collect the samples in the DIC itself. Further, mobile ICTCs should be increasingly used for covering TIs, which are situated far off. In the absence of TI-DIC based testing, appropriate financial provision should be made in the budget for the accompanied referral particularly in the areas where ICTC is located at a distance from hotspots.

- For detoxification, multiple options should be provided with resources allotted for the same. The options include – detoxification at detoxification centres, home based detoxification as well as camp based detoxification services.

C. Opioid Substitution Therapy

- The target for OST currently set in terms of number of IDUs reached through OST to 20% of IDUs on OST, should be modified. The modified target should take into consideration, local context and population of IDU in the particular geography. Apart from the target in terms of minimum number of IDUs reached through OST, targets should be set to have an OST centre in every district with high number of IDUs (population of more than 250) and/or with high HIV prevalence among IDUs.
- OST, initiated under NACP III, should now be expanded to all districts with significant IDU population (more than 250). Districts with either an existing high IDU-HIV epidemic or a high vulnerable population (IDU > 500) should be priority for scale-up of OST.
- OST should be provided for in both NGO based TI settings as well as through public health care settings, such as Government medical college hospitals, district hospitals, and CHCs. The staffing pattern and emoluments to the staff in both these settings should be at par with each other. Options for operating sub-OST centres for smaller population size, female IDUs should be provided for.
- For OST through public healthcare settings, the National AIDS Programme should leverage resources (especially human and infrastructure) through NRHM and Drug De-addiction Programme of Ministry of Health and Family Welfare. While provision of OST medicines, training and quality assurance mechanisms can be provided through the National AIDS Programme, other resources can be leveraged through Health departments/NRHM.
- A range of medicines should be available for OST and should include – methadone, and buprenorphine-naloxone combination, in addition to buprenorphine.
- The existing operational guidelines, practice guidelines and Standard Operating Procedures should be relooked into by a focused technical group on OST, and provisions for including adolescents, pregnant women and occasional injectors in OST programme, provisions for take-home doses should be looked into.

D. Linkages and mainstreaming

- Linkage should form an important pillar of NACP IV IDU strategy. Mechanisms for establishing and operationalising linkages currently exists only at peripheral units at TI level alone. In NACP IV, the linkages should be strongly reflected in district, state and central level activities. The National AIDS Programme should make use of existing Convergence Committees constituted at district, state and national levels.
- A number of linkages which can be established and institutionalised include:
 - Social security:

- Shelter: Linkage with local municipal corporations for access to shelter homes as well as with urban shelter improvement boards for urban based IDU population
- Tie-up with 'Rashtriya Swasthya Bima Yojana (RSBY)' for access to Government insurance scheme
- Access and coverage under schemes implemented/operated by Women and Child Department (WCD)
- Registration of IDUs in the Unique Identity Card (UID) scheme
- Legal issues: Linkage with National Legal Service Authority (NALSA), State legal service authority (SALSA), Juvenile Justice Board (for adolescent / children), Child welfare committee, etc. should be established
- Skill Building/Livelihood options: Linkage with National Rural Livelihoods Mission (NRLM), National Rural Employment Guarantee Act (NREGA), skill building mission through Urban poverty alleviation schemes should be established.
- Treatment and Rehabilitation: formal linkage with Ministry of Social Justice and Empowerment (MoSJE) for OST and drug rehabilitation, and Government De-addiction centres for detoxification
- Linkage with Prison authorities for HIV prevention services to IDUs in prisons, including access to OST, STI treatment, HIV testing and ART provision.
- Linkages with law enforcement authorities, both at state level and centrally should be established. These include Narcotics Control Board under the Ministry of Home Affairs, Department of Revenue under the Ministry of Finance, State level Police departments and prison officials. Mechanisms for regular exchange of information combined with mechanisms for capacity building and sensitization should be established.

E. Special population groups: Female IDUs, Female sex partners of IDUs and Children / Adolescents

- Female IDUs
 - A mapping should be undertaken to determine the size of Female IDUs in the country
 - Specific intervention and programmes for female DUs/IDUs should be developed taking into consideration the existing intervention models and pilots.
 - Separate Interventions for Female IDUs should be provided for in the NACP IV programme, with provision of female staff for reaching out to the Female IDUs. The outreach component should have a strong 'home based' outreach. The intervention modality and the package of services should take into account the specific and unique needs of the female IDUs.

- Focus should also be given to building capacity of service providers on issues related to FIDUs through training modules/materials and operational guidelines
- The minimum population required for setting up intervention should be relaxed for such interventions.
- Focus should also be given to psychosocial support, general healthcare and RCH services, child care through DIC/linkages and provision of female condoms.
- Separate indicators should be developed for capturing the information related to reach and the effectiveness of the interventions for FIDUs.
- Female Sex partners/Female spouses of male IDUs
 - About 40% of male IDUs are married and live with their spouses. Studies have also shown high HIV positivity among IDUs. Hence addressing this vulnerable population should be emphasised upon in NACP IV.
 - Multiple models should be used for reaching out to this population group, including stand alone as well as within the existing TIs/DIC.
 - Focus should also be given to psychosocial support, general healthcare and RCH services, child care through DIC/linkages and provision of female condoms.
- Adolescent IDUs
 - should be included in the programme and youth friendly services should be provided.
 - OST should be expanded to reach out to adolescent IDUs
 - Strong linkages with Juvenile justice boards/homes should be established to reach out to this population group.

F. Capacity building

- The capacity building needs to be strengthened. Leverages should be obtained from the ongoing Global Fund Round 9 IDU activities, which may continue till the year 2015.
- Specific modules for each of the staff working in IDU TIs should be developed.
- The modules developed should be adopted by state to reflect state level issues and priorities.
- The capacity building should also focus on skill development. Specific sessions devoted to skill building of the service providers should be developed. Training curriculum should include hands on training and field visit to the best practice sites.
- There is a need to systematically assess pre and post training knowledge and skill development and develop mechanisms for periodic refresher trainings at all levels.
- The capacity building should also focus on training the monitoring / mentoring officers along with SACS and STRC.

- Existing networks such as IHRN, IDUF, State level networks should be used for on-field handholding of the newer IDU TIs. The networks should be enabled to identify and develop local resources for on-field handholding and skill development at local level.
- Convergence with MSJE should also be explored in capacity building efforts for IDU services through RRTCs established across the country. Additionally, it should be ensured that IDU-HIV issues are included in the training curriculum of RRTCs should be ensured.

G. Addressing stigma and discrimination

In case of IDUs, it is seen and established through research studies that stigma and discrimination from drug use itself. Thus, IDUs face triple stigma and discrimination – drug use, injecting and HIV. Stigma and discrimination in case of IDUs is seen to act as a crucial barrier for IDUs to take up services offered, as well as their entry into mainstream services, including Government based healthcare settings.

- Focus should be on reducing stigma and discrimination resulting from drug use along with HIV related stigma and discrimination.
- IEC campaigns and specific IEC messages on reducing drug related stigma should be carried out
- Law enforcement authorities should be sensitized on drug and HIV related issues to reduce harassment. The message ‘drug use is a health related issue’ should be emphasized.
- Mechanisms for formal engagement with professional bodies such as Indian Medical Association, Indian Psychiatric Association should be developed to reduce stigma and discrimination by physicians. Sensitization and training programmes for healthcare professionals should be carried out.

H. Community mobilisation

Existing networks such as Indian Harm Reduction Network (IHRN), Indian Drug Users Forum (IDUF), North East India Harm Reduction Network (NEIHRN) are being strengthened through Global Fund Round 9 activities and programmes. This strengthening should be utilised to bring about an acceptable and co-ordinated response for HIV prevention among IDUs.

- Local level networks and forums of IDUs should be built to assist in field based skill building for IDU TIs, as well as in advocacy measures.
- State level networks should be enabled to form state harm reduction working group, which can then assist the state and NACO to
 - Identify new/emerging pockets of IDU in the country
 - Provide feedback to the state and NACO on the status of interventions in their state
 - Act as focal points for recommending any changes/flexibility in the interventions being carried out

- Liaise with other networks / agencies to leverage resources for IDU programme in the state.

Such networks should be assisted to hold regular meetings, conferences and state-level advocacy meets to address the issue of IDU-HIV at state level.

- The community should find increased representation in the TI staff (and where required, the norms may be relaxed to accommodate the community members), academic committees constituted for capacity building, advocacy groups and state level workings.

KEY CHALLENGES

For a successful HIV prevention programme among IDUs, there are certain key challenges that have to be borne in mind for the National AIDS Programme

- HIV among IDU spreads at a faster rate than any other population group. Whereas the National AIDS Control Programme has made significant accomplishments in halting and reversing the HIV epidemic among HRGs such as FSWs, HIV infection among IDUs is emerging in certain areas and explosive in some other areas. As a result, HIV prevention programme has to gear towards providing a rapid response to contain HIV that consists of scaling up evidence based combination of interventions for IDUs and innovative approaches.
- Once HIV prevalence among IDUs increases beyond a certain level (>5%), it is difficult to contain and reverse the spread of HIV only through prevention strategies. It is essential to ensure that apart from comprehensive HIV prevention efforts, all HIV positive IDUs requiring HIV treatment are provided ART.
- OST is a key intervention as it is both HIV prevention and drug dependence treatment strategy for opioid injectors; in addition OST improves adherence to ART. Hence the National Programme's key priority is to scale-up OST for IDUs.
- Sexual transmission of HIV among and from IDUs and their regular sexual partners needs special consideration. Women IDUs require specialised services and outreach strategy needs to be strengthened to reach out to Women IDUs and spouses of male IDUs. Women controlled safer devices such as female condoms are important. As recent evidence points out to the importance of early ART to prevent HIV transmission among sero-discordant couples, all efforts should be taken to provide HIV treatment for HIV+ IDUs.
- IDUs have multiple needs which are key to and determine the uptake of services, continuity of services received and the overall acceptability of services among IDUs. These multiple needs cannot be fulfilled through a typical HIV prevention programme alone. As a result of the above, strong emphasis needs to be put on establishing linkage mechanisms and leveraging resources through other agencies, departments and ministries. Built-in mechanisms for co-ordination of different ministries overseeing/providing drug treatment, social welfare and health schemes at all levels is key to successful HIV prevention among IDUs.