

Injecting Drug Use

Strategy Report for NACP IV planning

BACKGROUND

Injecting Drug Use (IDU) has emerged as an important route 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 2008-2009 shows declining HIV infections among female sex workers but Injecting Drug Users (IDUs) and Men who have Sex with Men (MSM) are more vulnerable to HIV with increasing trends in many states (NACO, 2010). Of the nine districts reporting > 15% HIV prevalence among IDUs in the country seven districts are in the three high prevalence states of Manipur (3), Punjab (3), and Tamil Nadu (1) [NACO, 2008]¹.

The burden of HIV among IDUs is expanding and blood-borne infections, such as HIV, hepatitis B (HBV) and hepatitis C (HCV) are spread among IDUs primarily through 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. An 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 interventions². The prevention package includes the following nine components: 1) Needle syringe exchange programme (NSP); 2) Opioid substitution therapy (OST); 3) Voluntary Counselling and Testing (VCT); 4) Anti-Retroviral Therapy (ART); 5) Sexually Transmitted Infections (STI) prevention; 6) Condom programming for IDUs and partners; 7) Targeted Information, Education and Communication (IEC) for IDUs and their sexual partners; 8) Hepatitis diagnosis, treatment (Hepatitis A, B and C) and vaccination (Hepatitis A and B); and, 9) Tuberculosis (TB) prevention, diagnosis and treatment. There is strong evidence that these interventions, implemented in a variety of settings (including a range of closed settings) are effective in reducing risk behaviours, preventing HIV infections, and accessing essential care and treatment services for IDUs. Additionally, the comprehensive package will have the strongest impact, when delivered together rather than as separate interventions³.

India through its National AIDS Control Program (NACP) stands committed to Millennium Development Goal (MDG) of reversing the spread of HIV/ AIDS by 2015. The National AIDS

¹ HIV sentinel surveillance and HIV estimation 2007 – a technical brief. National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India, 2008.

² WHO, UNODC, UNAIDS. Technical guide for target setting for HIV prevention, treatment and care for injecting drug users. Geneva, WHO, 2009

³ Degenhardt L, Mathers B, Vickerman P, Rhodes T, Latkin C, Hickman M. Prevention of HIV infection for people who inject drugs: why individual, structural and combined approaches are needed. *Lancet* 2010;376(9737):285-301

Control Organisation (NACO) has adopted the harm reduction (HR) strategy in NACP - III to prevent HIV amongst the IDUs through targeted interventions (TI) by non government organizations (NGOs). The current IDU program in the country is reaching out and delivering low threshold harm reduction services such as outreach and needle-syringe distribution to a significant proportion of estimated IDU population. The NACP-III has laid the foundation for constructing an efficient, effective, evidence based and comprehensive response for halting and reversing the HIV epidemic among IDUs.

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 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.

NACP IV WORKING GROUP ON INJECTING DRUG USE

A total of 33 individuals were nominated in the working group on IDU. Each working group had to choose a chairperson and a rapporteur for guiding the deliberations and document the same. The names of the individuals who attended the first planning exercise were as follows:

Chairperson: Dr. Suresh Kumar

Co-Chairperson: Luke Samson

Rapporteur: Dr. Ravindra Rao

Co-Rapporteur: RK Raju

Members present during the discussion:

- Mr. PK Jha, PD Manipur SACS
- Dr. Alok Agrawal, NACO
- Aditya Singh, NACO
- Sophia Khumukcham, NACO
- Charanjit Sharma, NACO-NERO
- Bernice Djuvechu, Nagaland
- Gary Reid, WHO SEARO
- Srikar Panyam, NACO NTSU
- Rajesh Kumar, SPYM
- Richard Kipgen, NERO PO
- Keitho, NERO PO
- Sabina Bindra Barnes, DFID
- Francis Joseph, DFID TAST
- Nandini Kapoor Dhingra, UNAIDS
- Taoufiq Bakkali, UNAIDS
- Dr. Atul Ambekar, AIIMS
- Manish Kumar, SPYM TSU Punjab
- Dr. Ranbir Rana, Psychiatrist Civil Hospital, Tarn Taran, Punjab
- Ms. Nini Pakhama, VHAM, Meghalaya
- Tito Thomas, CSRD
- Dr. Langkham, EHA
- Mahesh Nathen, West Bengal
- Umesh Sharma, Manipur

Processes followed

The group adopted the following procedures to discuss and deliberate for the first meeting:

1. Stock taking on NACP III implementation status as well as gaps by requesting some of the members to present their analysis and findings.
 - Current status of IDU implementation under the NACP III – Dr. Alok Agrawal
 - Recommendations from the Mid-term review and Joint implementation review mission on NACO IDU programme – Nandini Kapoor Dhingra
 - Presentation on the harm reduction situation analysis report funded by DFID TAST – Dr. Suresh Kumar
 - Presentation on the IHRN recommendations – Luke Samson
2. Discussions on the issues raised during stock taking exercise
3. Identifying various themes from the presentations and discussions
4. Sub-group work on how to address the issues in NACP IV on each of the theme/issue identified
5. Discussions among the IDU work group on the presentations made by each sub-group
6. Consensus building after discussions for formulating recommendations

OUTCOME AND RECOMMENDATIONS

The discussions and deliberations were on three broad fronts: current status of IDU programme under NACP III, gaps in the response so far and recommendations for NACP IV planning.

A. CURRENT STATUS OF IDU PROGRAMME

The primary objective of NACP-III is to halt and reverse the spread of HIV epidemic by 2012 and it is aimed 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. Harm reduction is recommended as the key strategy for intervention among IDUs and their sexual partners, to reduce the risk of acquiring and transmitting HIV. NSP and OST are two critical components in the harm reduction strategy. The services provided by the TIs are in three tiers: the tier 1 services are outreach based interventions and NSP constituting the backbone of the harm reduction strategy. The tier 2 is primarily OST 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, the estimate of IDU was carried out by using the available TI data and population size estimation method. Further, it was decided to carry out the detailed field mapping of High risk groups in 20 states during the initial period of the project. The target of TIs for the states is set based on the revised

mapping estimate AS. The revised estimates for IDU population against the NACP III estimates are given in table 1 below.

- IDUs have been defined as an individual who injects at least once in the last three months. Though a broad range of the estimates of IDUs in the country was used for NACP III planning, through mapping exercise and subsequent revalidation through existing TIs and monitoring mechanisms, the number of IDUs as defined in NACP III stands at 1,77,000.
- The sentinel surveillance sites for determining HIV prevalence among IDUs has substantially increased and about 63 sites were chosen in the last conducted sentinel surveillance. HIV prevalence among IDUs has increased as compared to previous years. Currently, the HIV prevalence among IDUs is 9.2%, which is the highest for any population group. Newer pockets of IDU – HIV have emerged in the country. These include states such as Punjab, Haryana, Madhya Pradesh, Orissa, and Bihar. Sadly, some of these states/sites in these states also record high HIV prevalence among IDUs (e.g. Punjab, Orissa, Bihar).
- Considerable progress has been made in the last four years of NACP III. Some of the notable achievements include:
 - Three fold increase in the number of exclusive IDU TIs in the country, with currently 263 TIs providing services to the IDUs.
 - Increase in the number of IDUs registered in the TIs - 76% IDUs reached out at least once (one time coverage)
 - 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.
 - Production of capacity building materials such as guidelines for waste disposal management, training module on harm reduction, counselling module, Standard Operating Procedure (SOP) for OST, practice guidelines for OST, Manual for working with partners of IDUs, etc.
- 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. OST using sublingual buprenorphine is provided in 52 OST TI centres covering 4810 clients. 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 450 clients are targeted to be covered under this initiative.

In summary, there has been considerable progress made in NACP III with regards to IDU intervention.

B. GAPS IN RESPONSE

The intervention and intervention models currently used in NACP III was discussed extensively and feedback from implementing agencies and monitoring officers were especially considered along with community representatives. The following were identified as major gaps in response:

- There were major gaps in terms of regular coverage of IDUs. While one time coverage of about 80% was achieved, there was no accurate information on the regular coverage, and was generally perceived to be low currently.

- In the current strategy, a peer educator is expected to provide all the harm reduction services along with extensive data collection. It was felt that PE being an active drug user, it is often difficult for him/her to carry out the job demanded of him, especially considering the fact that he is not on regular pay-rolls of the TI programme.
- With the current definition for IDUs, a number of other IDUs who inject over and above 3 months, and non-IDUs are also vulnerable to HIV infection. In addition, interventions/strategies must also gear towards preventing DUs to become IDUs.
- Salary of the staff working in TI settings is not in keeping with the current cost of living. Additionally, staff are not given increments commensurate with their experience and performance.
- 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.
- Though linkages and networking exist peripherally, the central mechanisms for establishing linkages with other ministries/departments are weak.
- 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 number of IDUs are on ART. However, members from the group, especially those working in IDU TIs, felt that the numbers are too low. In addition, adherence to ART medications is also an issue.
- IDU TIs are not gender responsive. The needs of female IDUs and female sex partners of IDUs are not kept in mind during the design of intervention. Research evidence shows that this subset of population may require separate and different interventions as compared to their male counterparts.
- Opioid substitution therapy
 - There has been considerable delay in the implementation 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.
 - It is felt that emphasis on OST in public health settings alone will not achieve the desirable results. There is a great disparity in the resources provided to NGOs and the public OST facilities.
 - Only buprenorphine is provided for under the OST programme, while it is known that 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 needs 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. Existing resources in the country, including the strengths of existing networks such as IHRN have not been utilized in capacity building.

The members of the working group were also of the view that while the gaps are not insurmountable, there needs to be better implementation of the strategy formulated.

C. RECOMMENDATIONS FOR NACP IV

GUIDING PRINCIPLES

- Nothing for us without us:** community to be involved at all levels of programme – planning and designing, implementation and monitoring/evaluation.
- 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.
- Inclusive:** The programme should be inclusive of all groups, population and services.
- Comprehensive package of interventions:** single interventions for IDUs are not successful. Comprehensive package of interventions alone achieve the desired results of HIV prevention.
- Need based services:** the services provided to the IDU should be based on the needs of the IDU rather than what the programme thinks it best for him. For e.g. an IDU may feel the need to get his abscess treated as important, while the programme may feel that it is important to provided NSP alone. Strategies to incorporate the needs of IDU in the current programme will ensure success.
- 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.
- Services for special populations:** this includes services for adolescents, MSM-IDU, etc.
- Improved quality of services:** emphasis should be on provision on improving the quality of services, as quantity without quality will not enable HIV prevention among IDUs.
- 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.

STRATEGY

A. IDU definition, coverage and numbers

- The existing definition of IDU should be broadened from 3 months to ?12 months. This will enable to widen the scope of providing services to those people who inject occasionally but are nevertheless at risk of HIV. The cut-off can be decided based on examining existing literature as well as definition used in other successful IDU programmes.
- The current emphasis on measuring coverage through NSEP alone should be changed to provision of minimal package of comprehensive services for IDUs (e.g. NSP, OST, Condoms and testing/ART).
- Mechanisms for enabling early warning systems for identifying emerging IDU pockets in the country should be established.

B. TI programme

- Model of IDU intervention should go beyond the TI approach. The intervention model should be holistic and encompass both TI as well as linkages and mainstreaming with other departments/ministries.
- Coverage should focus not on NSP alone, but on a combination of services available to the IDU (e.g. NSP, Condoms and testing/ART)
- 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, and resources provided accordingly.
- Flexibility should be built in to address the local, geographical and social needs of the community
- The outreach strategy needs to be modified. Peer educators should be used as link between the IDUs and the outreach staff and for ensuring uptake of services regularly, facilitate the uptake of services by other IDUs, facilitate the BCC sessions, referrals and other services provided at outreach levels. In addition, they should be used as role models for other IDUs in terms of demonstrated safe behaviour and practices. The outreach workers (irrespective of their drug using status, and includes both IDUs and non IDUs) should be the basic unit of service provision at field level. Accordingly the outreach worker to IDU ratio should be rationalized. In addition, a

peer counsellor should be employed to provide BCC and other counselling services for IDUs.

- 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.
- The package of interventions being offered in IDU TI should be broadened and should include services such as hepatitis c prevention materials, appropriate allocation for waste disposal, and hepatitis B vaccination
- Prevention and management of overdose should be emphasized. Naloxone should be provided through National AIDS programme either in TI or in public health facilities.
- 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.
- For detoxification, multiple options should be provided with resources (including financial) allotted for the same. The options include – detoxification at detoxification centres, home based detoxification as well as camp based detoxification services.

C. Linkages and mainstreaming

- Formal linkages at state level as well as centrally should be established and operationalised with other ministries/departments mandated and dealing with drug use issues. These include – Ministry of Social Justice and Empowerment, Drug De-addiction Programme under the Ministry of Health. Regular co-ordination meetings should be held and mechanisms for referral – back referrals, drug use information systems, and OST should be established.
- 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.

D. Opioid Substitution Therapy

- The target for OST currently set (20% of IDUs on OST) should be modified. The modified target can take into consideration geographical and population of IDU in the particular geography.
- The choice of medicines available for OST should be broadened to include methadone, buprenorphine as well as buprenorphine-naloxone combination too.
- The existing operational guidelines on OST needs to be re-examined and issues such as inclusion and exclusion criteria, dosing, duration of treatment, special considerations for pregnancy needs to be revisited in the light of existing evidences and practices.
- The accreditation system for OST should be re-examined. The accreditation system may be extended to IDU TIs too.

E. Capacity building

- The capacity building needs to be strengthened. Leverages should be obtained from the ongoing Global Fund Round 9 IDU activities.

- Specific modules for each of the staff working in IDU TIs should be developed
- The capacity building should also focus on skill development. Specific sessions devoted to skill building of the service providers should be developed.
- The capacity building should also focus on training the monitoring / mentoring officers along with SACS and STRC.
- Existing networks such as IHRN, IDUF should be used for mentoring of the newer IDU TIs. In addition, the networks and local committees of IDUs/beneficiaries can be a vital part of feedback mechanisms on the implementation of the interventions.

F. Addressing stigma and discrimination

- 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.
- Advocacy by the IDUs (community led advocacy) at local level should be provided emphasis
- 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 Psychiatrist Association should be developed to reduce stigma and discrimination by physicians. Sensitization and training programmes for healthcare professionals should be carried out.

G. Special population groups

- Specific intervention and programmes for female DUs/IDUs should be developed. The existing intervention models and pilots should be studied to develop an appropriate model for providing gender responsive services.
- Specific intervention and programmes for female sex partners of IDUs should be developed after looking at the existing intervention models and pilots.
- Adolescent IDUs should be included in the programme and youth friendly services should be provided.
- Services should be provided to the non-IDU population through direct/linkage service provision. HIV prevention services and drug treatment should be provided to this population.
- Many IDUs are currently incarcerated and at risk of becoming HIV infected in closed settings. Current HIV prevention interventions are limited inside closed settings. There is a need for major expansion of HIV prevention information and education messages, provision of OST, access to a reliable supply of condoms, and access to broad ranging health services including HIV care, support and treatment.

The current status, gaps and recommendations have also been captured in the form a table, which is appended with this document (Appendix A).

Table 1: Current status, gaps and recommendations for IDU programme under NACP IV

Topic/issues/thematic clusters	Current status	Challenges	Proposal for NACP IV
A. Coverage and numbers			
Definition of IDU	Injecting at least once in 3 months	Not able to capture who have injected outside the 3 months, but are nevertheless at risk of HIV	Propose to define current IDU as one who has injected in the last 12 months at least once
Coverage	Current interventions reach out to 80% of IDUs as per current definition	Currently, major focus on NSEP and (hence) on daily injectors	Coverage should be measured on the basis of provision of comprehensive services out of which focus on NSEP should be on regular injectors whereas focus for irregular injectors should be on BCC, condoms, ICTC, STI and ART
B. TI programme			
No. of IDUs for initiating IDU TI programme	150 – 400	Excludes those TIs where geographical concentration of 500 – 1000 IDUs are available	Minimum number of IDUs remain at 150, but maximum number should be based on the mapping data
Outreach strategy	Currently PE is the backbone of the TI & is expected to deliver all the elements of services	PE being a current injector is not able to deliver the services expected of him	PE will be the facilitator of outreach services and the onus of service delivery should be on outreach worker; one outreach worker proposed for 80 – 100 IDUs and one PE for 25 IDUs; ORW to be a mix of ex/current and non-IDU
Staffing	ANM and counselor are combined	Counseling in IDU setting includes both HIV	ANM and counselor should be separately provided for

Topic/issues/thematic clusters	Current status	Challenges	Proposal for NACP IV
		prevention and drug related issues;	
	Salary	Salaries for staff to be optimized and incentive and experience based	
Services	Included some, but not all components of comprehensive package of services	Did not include prevention for hepatitis C, hepatitis B, OD treatment, waste disposal,	Including hepatitis c & hepatitis B prevention materials, nalaxone in TI/public health care settings, and adequate amounts for waste disposal system
DIC	Currently only one DIC is available in TI settings	Difficult to reach out to small pockets of IDUs	Sub DICs should be provided for IDU population of 50 minimum
ICTC	Referred to existing ICTC centres	Difficult for IDUs to avail testing facilities	Explore possibility of testing at DIC through DBS; pre and post test counseling by TI counselor
ART	Onus of ART adherence on IDU TI, with no provision of extra staff		Increased provision of ORW for ART adherence with building capacity of counselor for ART adherence and positive prevention
C. Linkage and Mainstreaming			
Linkages structures	Linkages with drug control agencies in peripheral units; central linkages are not strengthened	Drug control programmes are also mandates of MSJE and DDAP, MoHFW	Central formal linkages with MSJE and DDAP to be established – sharing of information on drug use, referral – back referrals, and OST
	Linkages with Law enforcement agencies not established centrally		Linkages with NCB, Police academies and sensitization, training to be strengthened
	Linkages with other		Linkages with

Topic/issues/thematic clusters	Current status	Challenges	Proposal for NACP IV
	support for IDUs not established		nutrition programmes, social protection schemes such as night shelters, antyodaya, adhaar and BPL cards
	Support for detoxification not available		Provision for detoxification should include support in detoxification centres, home based detoxification and detoxification camps
D. Capacity Building			
	Capacity building mechanisms currently fragmented for IDU programme	Capacities of SACS, STRC, TSU and TIs limited	Develop common resource pool Link with GF R 9 capacity building mechanisms Mechanisms for providing mentoring for TIs Skill building sessions should be built in the modules Separate modules for different IDU TI staff
E. OST			
	Currently target of 20% of IDUs on OST	Challenges in defining the 20% population	OST centre may be provided for a minimum number of IDU population and in a defined geography (e.g. atleast one OST centre in each district for 1000 IDU population)
	Emphasis on OST in public healthcare settings		OST centres should be available in both TI and public healthcare settings
	OST currently carried out in TI settings with minimal staff	Difficulty in providing optimal services of TI as well as OST	Staffing in OST TI setting should be optimized

Topic/issues/thematic clusters	Current status	Challenges	Proposal for NACP IV
	Accreditation system for OST exists	Accreditation system for OST currently not robust and provision are not in keeping with SOPs	Accreditation system should be independent of NACO and an independent mechanism and system should be established Accreditation system for IDU TIs should also be established
	OST medicine currently involves buprenorphine alone	Clients require a menu of options for OST	Include methadone, buprenorphine-naloxone combination in the OST programme
F. Addressing special population groups			
Female IDUs	Currently no provision for addressing FIDUs	FIDUs have greater vulnerabilities for HIV	Specific programmes, including interventions which have separate female staff, gender specific services should be initiated
Female sex partners of IDUs	Currently provision of one female ORW in IDU TI	This is not sufficient to address this group	Specific strategies for providing services to this population, including providing gender specific services including female condoms to be provided
Adolescent IDUs, including DUs	Current TI structures do not allow for addressing adolescent IDUs	Adolescent IDUs are equally vulnerable for HIV	Apart from providing access to existing IDU programmes, including OST, other adolescent specific services should be made available (education, youth friendly services, nutrition support, etc.)
G. Addressing stigma and discrimination			
	Current focus on HIV prevention	IDUs face stigma not only because of	Specific messaging and IEC campaigns to

Topic/issues/thematic clusters	Current status	Challenges	Proposal for NACP IV
	alone	HIV, but are discriminated more on account of drug use, which impedes access to HIV prevention services	reduce drug related stigma should be carried out
	Law enforcement authorities are not addressed for reducing drug related stigma	Drug users face harassment from law enforcement authorities	Sensitization programmes and formal engagement at central and state levels should be established Training programmes and curriculum on harm reduction for LEA should be carried out
	Health care providers are not addressed on drug related issues	Drug users face stigma from health care providers	Training programmes and curriculum on harm reduction for health care providers should be carried out