1 Introduction

The number of people living with HIV worldwide continued to grow, reaching an estimated 33.4 million [31.1 million–35.8 million]. The total number of people living with the virus in 2008 was more than 20% higher than the number in 2000, and the prevalence was roughly threefold higher than in 1990. In 2008, 4.7 million [3.8 million 5.5 million] people in Asia were living with HIV, including 350 000 [270 000–410 000] who became newly infected last year. Asia's epidemic peaked in the mid-1990s, and annual HIV incidence has subsequently declined by more than half. Regionally, the epidemic has remained somewhat stable since 2000.[1]

The spread of HIV/AIDS in India has come to represent a grave danger to the country's future economic development and social stability. India had an estimated 1.8 – 2.9 million HIV positive persons in 2007, with an estimated adult HIV prevalence of 0.34% (0.25%–0.43%). As the HIV Prevalence among the high risk groups (HRG) is very high compared to that among the general population, India continues to be in the category of concentrated epidemic.

The sexual mode continues to be the major mode of transmission, though transmission through injecting drug use and Men having Sex with Men are on the rise in many new pockets.[2] Injecting drug users have some of the highest HIV prevalence of any population in Asia. Regionally, 16% of injecting drug users is believed to be HIV infected.[3]

The overall HIV prevalence among different population groups continues to portray the concentrated epidemic in India, with a very high prevalence among High Risk Groups – , MSM (7.4%), IDU (7.2%), FSW (5.1%) & STD (3.6%) and low prevalence among ANC clinic attendees.[4]

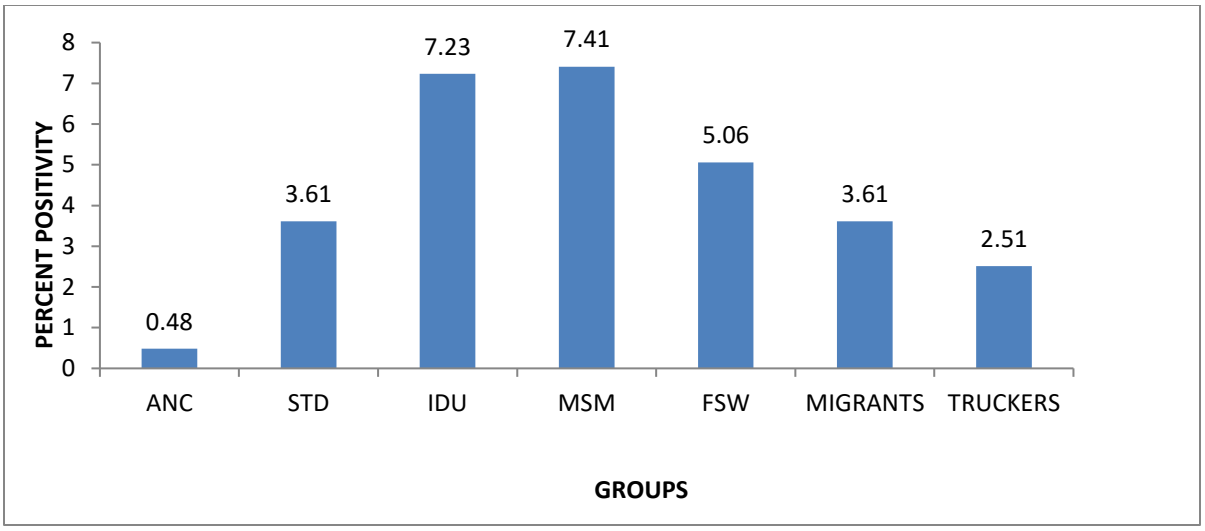


Figure 1: Graph showing the percent positivity amongst high risk groups, INDIA. (NACO, 2007)

Injecting drug use is an important cause in the continuing epidemics of HIV. IDUs become infected with HIV in two ways:

(a) Through high risk drug use (the sharing of contaminated injection equipment)
(b) Through high risk sex (unprotected sex, sex with many partners, failure to treat STIs).

One of the nine priority areas of UNAIDS Outcome Framework 2009–2011 is protecting drug users from becoming infected with HIV. There is good evidence that HIV epidemics among IDUs can be prevented, slowed and even reversed through the implementation of specific strategies. Prevailing problems related to injecting drug use and the transmission of blood-borne infections are negative attitudes towards IDUs, lack of basic knowledge of addiction as a treatable disease, limited funds for prevention and harsh laws and regulations. Effective harm reduction efforts are needed to help IDUs reduce transmission among their drug using partners, their sex partners, and their children and ultimately among the general population. Harm reduction targeting the IDU sub-population are more effective and economically feasible if begun before HIV prevalence among the target IDUs exceeds 5 per cent (UNAIDS/WHO, 2004). In Manipur, India, HIV prevalence among injecting drug users and reported needle sharing at last injection fell by more than two thirds during the seven years after implementation of harm reduction programmes.[5]

However, it is also important to mention that the messages on HIV prevention need to be disseminated to substance users and their partners, even before the incidence of HIV are reported in the area. In 2004, UNODC and the Ministry of Social Justice and Empowerment, jointly release the National Survey on the Extent, Pattern and Trends of Drug Abuse in India which had multiple components.

There are also cases among metro cities of India where HIV prevalence among IDUs are increasing. Among such one is Delhi. Study on IDUs' behavioral pattern reveals that injecting drug practice is a recent phenomenon in Delhi. High needle sharing practices, sex with commercial sex partner and low condom usage has been found among IDUs.[6]

Table 1 HIV Prevalence among IDUs in Delhi (NACO, 2007)

HIV PREVALENCE AMONG IDUs IN DELHI	
Year	**Mean Prevalence IDUs**
2003	14.40
2004	17.60
2005	22.80
2006	10.00
2007	10.10

Annual report of NACO 2008-09 revealed that there us an increase in HIV prevalence among IDUs in Delhi. Thus, this study will focus on the developments regarding harm reduction specific for IDUs in Delhi.

In many cities with concentrated populations of IDUs, the HIV prevalence is above the critical level of 5%, causing great public health concerns. Available data also indicates that HIV infection is spreading from high-risk groups to low-risk groups in the population. Of

serious immediate concern is the original role of IDU in the 'feminization' of the epidemic, where HIV is sexually transmitted from injecting drug users to their non drug-using wives and partners. In this way, the indirect impact of IDU on the spread of the HIV epidemic is considerable. Intervention strategies are required urgently.

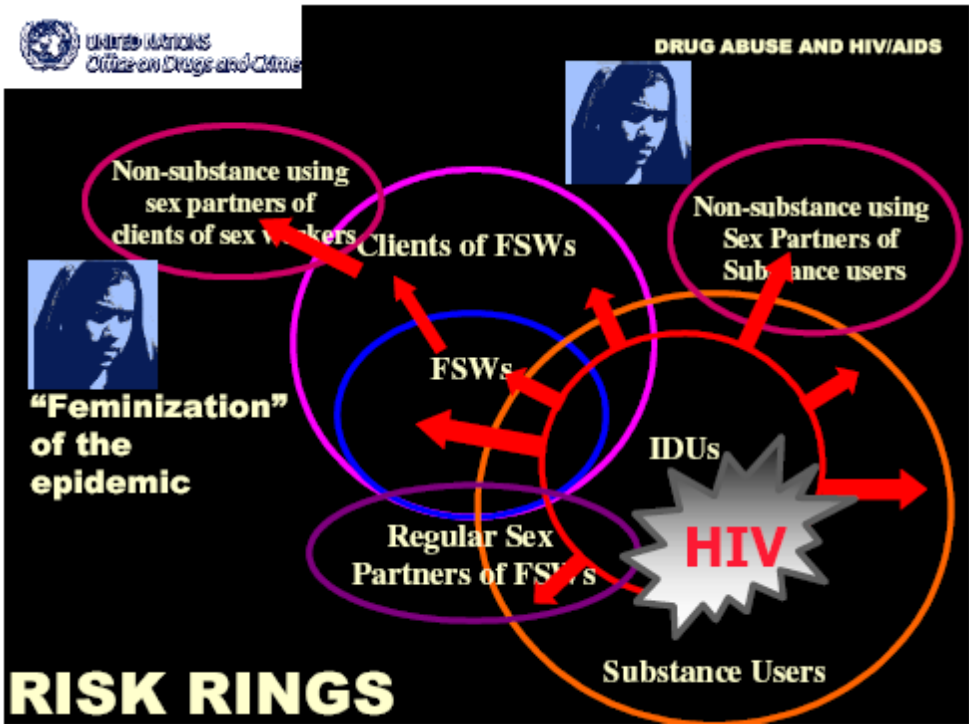


Figure 2: Risk Rings-UNODC

Extent of the problem

The data revealed that about 0.1 per cent of adult males from the general population reported having injected drugs for non-medical reasons at least once in their lifetime. Among drug users seeking treatment, about 14 per cent were injecting drug users (IDUs). In the survey component conducted among identified drug users recruited from the streets, about 43 per cent had injected drugs at some point in time. A small proportion of women drug users and prisoners injected drugs. Injecting drug use was also reported from users in the border areas (Indo-Myanmar, Indo-Nepal, Indo-Bangladesh, Indo-Pak and Indo-Sri Lanka). Injecting drug use was well established in the Northeastern states of India. But it was also observed to be prevalent in the major metropolitan cities and towns of India. The relationship between sex

work and drug injecting was noted in the study on women and drug abuse. Among those in treatment centres across the country, IDUs were reported, in particular, from urban areas and north eastern states like Mizoram, Manipur and Nagaland. Current information shows that HIV infections among injecting drug users in some states and major cities in India are also generally high as follows: Delhi (14.4%); Karnataka (2.8%); Mumbai (24.8%); Mizoram (6.4%); West Bengal (2.7%), Imphal (18%), Churachandpur (32.8%), Bishnupur (22.4%), Dimapur (10%), Kohima (6.8%), Tuensang (24.9%) and Chennai (63.8%)[7]

Drugs injected

The Rapid Assessment Survey indicated that the following drugs are injected in the 14 cities studied

1. Heroin
2. Propoxyphene (Spasmoproxyvon, Dextropropoxyphene plus Dicyclomine)
3. Buprenorphine alone or in combination with antihistamines (Avil) and / or sedatives like diazepam (Calmpose)
4. Injectable opiates (pharmaceutical drugs) like Morphine, Pethidine and Pentazocine (Fortwin) Diazepam (Calmpose) Promethazine (Phenargan) Chlorpheniramine (Avil)

Switch from Non-injecting to Injecting in Delhi

Abstract from UNODC-India Report[8]

According to those interviewed, there had been a notable shift towards injecting drugs, particularly pharmaceutical drugs, in Delhi. Two categories of injectors were discerned from the field data: current injectors and occasional injectors. Together, they constituted about 50 per cent of the total respondents. Current injectors make up 27 per cent of the total respondents, while occasional injectors, including those who have ever injected for recreational purposes, account for another 23 per cent of the sample. Overwhelmingly, injectors used pharmaceutical preparations such as buprenorphine, usually in combination with otherdrugs. The most commonly witnessed combination was that of buprenorphine (Tidigesic), Avil and Phenargan. There were no instances of heroin injecting in the sample. Ethnographic data supports this finding, as heroin injecting is very rarely reported in the nation's capital.

Harm Reductions for IDUs

Harm reduction refers to policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs. Harm reduction began to be discussed frequently after the threat of HIV spreading among and from injecting drug users was first recognized. However, similar approaches have long been used in many other contexts for a wide range of drugs.

Harm reduction complements approaches that seek to prevent or reduce the overall level of drug consumption. It is based on the recognition that many people throughout the world continue to use psychoactive drugs despite even the strongest efforts to prevent the initiation or continued use of drugs. Harm reduction accepts that many people who use drugs are

unable or unwilling to stop using drugs at any given time. Access to good treatment is important for people with drug problems, but many people with drug problems are unable or unwilling to get treatment. Furthermore, the majority of people who use drugs do not need treatment. There is a need to provide people who use drugs with options that help to minimize risks from continuing to use drugs, and of harming themselves or others. It is therefore essential that harm reduction information, services and other interventions exist to help keep people healthy and safe.

Definition

'Harm Reduction' refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community.[9]

Principles

The harm reduction approach to drugs is based on a strong commitment to public health and human rights.

Harm reduction is a targeted approach that focuses on specific risks and harms. Politicians, policymakers, communities, researchers, frontline workers and people who use drugs should ascertain:

- What are the specific risks and harms associated with the use of specific psychoactive drugs?
- What causes those risks and harms?
- What can be done to reduce these risks and harms?

Evidence based and cost effective

Harm reduction approaches are practical, feasible, effective, safe and cost-effective. Harm reduction has a commitment to basing policy and practice on the strongest evidence available. Most harm reduction approaches are inexpensive, easy to implement and have a high impact on individual and community health. In a world where there will never be sufficient resources, benefit is maximized when low-cost/high-impact interventions are preferred over high-cost/low impact interventions.

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Thus, Harm reduction targets the causes of risks and harms. The identification of specific harms, their causes, and decisions about appropriate interventions requires proper assessment of the problem and the actions needed. The tailoring of harm reduction interventions to address the specific risks and harms must also take into account factors which may render people who use drugs particularly vulnerable, such as age, gender and incarceration.

Incremental Importance

Harm reduction practitioners acknowledge the significance of any positive change that individuals make in their lives. Harm reduction interventions are facilitative rather than coercive, and are grounded in the needs of individuals. As such, harm reduction services are designed to meet people's needs where they currently are in their lives. Small gains for many people have more benefit for a community than heroic gains achieved for a select few. People are much more likely to take multiple tiny steps rather than one or two huge steps. The objective of harm reduction in a specific context can often be arranged in a hierarchy with the more feasible options at one end (eg measures to keep people healthy) and less feasible but desirable options at the other end. Abstinence can be considered a difficult to achieve but desirable option for harm reduction in such a hierarchy. Keeping people who use drugs alive and preventing irreparable damage is regarded as the most urgent priority.

Outline of the report

As background of the study is discussed in the introduction, further report is outlined as follows from chapter 2 to 5.

Chapter 2 Research Methodology

Chapter 3 Results and Findings

Chapter 4 Conclusions

Chapter 5 Limitations of the Study

Chapter 6 References

2 Research Methodology

A qualitative methodology was adopted to seek objectives. Desk research was being done to find out the available harm reduction programs/intervention/agencies/facilities. Among these in depth interviews with concern officials was carried out and some facilities were observed. Findings are documented and presented to understand extent and trends of harm reduction developments in the specified geographic area.

Output from the collected information was generated in descriptive form. Developments in the concern areas was documented and analyzed to understand accessibility and availability of such initiatives.

Proposed respondents of this study are mentioned in table shown below. As study would showcase overall perspective of developmental initiatives, different stakeholders are identified.

Table 2: Respondents for the Study

STAKEHOLDERS	TENTATIVE RESPONDENTS (in numbers)
UN Agency	1
International Agency	4
Government Agency	3
NGOs/CBOs/Implementing Agency	4
Target HRG individuals	5
	Total = 17

Report is developed considering the following objectives:

As scope of the study is pertaining to IDUs in Delhi, objectives for the study were;

- To identify the available harm reduction interventions
- To understand the role and extent of various agencies for such developments
- To propose strategies and recommendations for harm reduction interventions

The guideline for in-depth interview and discussion was developed (Annexure 1). As per the guidelines, one on one discussions were done physically and else on telephonic interview.

It was observed from literatures and discussions that, some of the roles of the different organization are not concentrated to Delhi. Thus organizations those are directly-indirectly involved in harm reduction activities were included in the study. Some of the information from the organizations was collected through desk research and compiling their documents with prior permission from the officials else which are open to access were considered.

3 Results and Findings

This chapter comprise of findings based on the field research, desk research and certain publications which are open to access. This chapter is followed by first introduction and role of organizations involved in Harm Reductions overall in Asia, India and then scrutinized to focus of the study, Delhi. Different issues discussed during the discussions are divided under subheadings as Issues and Problems.

Role of different organization is compiled below to understand Harm Reduction initiatives and interventions. These organizations are mentioned as per hierarchy in Harm Reduction initiatives.

A. Role of Organizations

1. UNODC (United Nations Office for Drug & Crime)

UNODC is a global leader in the fight against illicit drugs and international crime. Established in 1997 through a merger between the United Nations Drug Control Programme and the Centre for International Crime Prevention, UNODC operates in all regions of the world through an extensive network of field offices. UNODC relies on voluntary contributions, mainly from Governments, for 90 per cent of its budget.

UNODC is mandated to assist Member States in their struggle against illicit drugs, crime and terrorism. In the Millennium Declaration, Member States also resolved to intensify efforts to fight transnational crime in all its dimensions, to redouble the efforts to implement the commitment to counter the world drug problem and to take concerted action against international terrorism.

The three pillars of the UNODC work programme are:

- Field-based technical cooperation projects to enhance the capacity of Member States to counteract illicit drugs, crime and terrorism
- Research and analytical work to increase knowledge and understanding of drugs and crime issues and expand the evidence base for policy and operational decisions

- Normative work to assist States in the ratification and implementation of the relevant international treaties, the development of domestic legislation on drugs, crime and terrorism, and the provision of secretariat and substantive services to the treaty-based and governing bodies

In pursuing its objectives, UNODC makes every effort to integrate and mainstream the gender perspective, particularly in its projects for the provision of alternative livelihoods, as well as those against human trafficking

Issue: Access to drug dependence treatment

People with drug abuse problems have different social backgrounds and life experiences. Treatment services must therefore offer a range of approaches tailored to each patient's needs. The quality of treatment is highly dependent on the knowledge and experience of staff. UNODC thus emphasizes staff training and support.

Action:

UNODC facilitates access to the latest evidence-based information on treatment of specific population groups (women, young people and offenders). It provides direct support to governments in the development of accessible treatment services that are an integral part of the main health system; training, community-based services and programmes for drug abusers in prison; and opportunities for networking with experienced professionals.

To fulfill the objectives globally, UNODC has strategized this issue under result areas. Relevant areas are mentioned below: [10]

Result area 3.3. HIV/AIDS prevention and care (as related to injecting drug users, prison settings and trafficking in human beings)

3.3.1. Expand Member States' capacity to reduce the spread of HIV/AIDS among injecting drug users, in conformity with relevant international conventions and the established mandates of UNODC

3.3.2. Expand Member States' capacity to reduce the spread of HIV/AIDS in prison settings

3.3.3. Expanding, in consultation with the Member States concerned, the capacity of relevant entities of civil society to respond to HIV/AIDS among injecting drug users and in prison settings, in accordance with relevant international conventions and the established mandates of UNODC

Result area 3.5. Treatment and rehabilitation of drug-dependent persons

3.5.1. Increased Member States' capacity to provide treatment and support services to drug-dependent persons

3.5.2. Enhanced knowledge of treatment and rehabilitation for abusers of new and emerging types of drugs and expanded Member States' capacity to respond to the abuse of such drugs

3.5.3. Improved well-being, rehabilitation and reintegration into society of people undergoing treatment for drug dependence

3.5.4. Increased partnerships with relevant civil society entities that advance Member States' capacities to provide treatment and rehabilitation that are in accordance with the relevant international conventions

Result area 3.6. Prison reform

3.6.1. Wide application of international standards and norms on the treatment of prisoners

3.6.2. Increased capacity to apply international standards on the professional management/operation of prisons

3.6.3. Increased capacity to apply international standards and norms on diversions, restorative justice and non-custodial sanctions, where appropriate

3.6.4. Increased partnerships with relevant civil society entities that advance Member States' capacities to apply international standards and norms that are in accordance with the relevant international conventions and within the established mandates of UNODC.

The United Nations Office on Drugs and Crime (UNODC) is leading the international campaign to raise awareness about the major challenge that illicit drugs represent to society as a whole, and especially to the young.

The goal of the campaign is to mobilize support and to inspire people to act against drug abuse and trafficking. The campaign encourages young people to put their health first and not to take drugs.

The international campaign **"Do drugs control your life? Your life. Your community. No place for drugs"** communicates that the destructive effects of illicit drugs concern us all. Their use harms individuals, families and society at large. Drugs control the body and mind of individual consumers, the drug crop and drug cartels control farmers, trafficking and crime control communities.

Teenagers and young adults are particularly vulnerable to using illicit drugs. The prevalence of drug use among young people is more than twice as high as that among the general population. Peer pressure to experiment with illicit drugs can be strong and self-esteem is often low. Also, those who take illicit drugs tend to be either misinformed or insufficiently aware of the health risks involved.



Figure 3: Campaingn Logo of UNODC

UNODC and its campaign only focus on drugs under international control, as specified in the three multilateral treaties that form the backbone of the international drug control system. These illicit drugs include amphetamine-type stimulants, coca/cocaine, cannabis, hallucinogens, opiates and sedative hypnotics.

2. The Global Fund and India-CCM

The Global Fund is a unique global public/private partnership dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, Tuberculosis and Malaria. This partnership between governments, civil society, the private sector and affected communities represents a new approach to international health financing. The Global Fund works in close collaboration with other bilateral and multilateral organizations to supplement existing national efforts dealing with the three diseases.

Since its creation in 2002, the Global Fund has become the main source of finance for programs to fight AIDS, Tuberculosis and Malaria with approved funding of US$ 18.7 billion for more than 572 programs in 140 countries. It provides a quarter of all international financing for AIDS globally, two-thirds for tuberculosis and three quarters for malaria.

Global Fund financing is enabling countries to strengthen health systems by, for example making improvements to infrastructure and providing training to those who deliver services. The Global Fund remains committed to working in partnership to scale up the fight against the disease and to realize its vision – a world free of the burden of AIDS, TB and Malaria.

The India CCM – The India Country Coordinating Mechanism is established in response to requirements and recommendations of the Global Fund. At the country level, the Country Coordinating Mechanism is a partnership composed of all key stakeholders in a country's response to the three diseases. The CCM does not handle Global Fund financing itself, but is responsible for submitting country proposals to the Global Fund, nominating the entities accountable for administering the funding, and overseeing grant implementation. The CCM should preferably be an already existing body, but a country can instead decide to create a new entity to serve as CCM.

The India CCM has been in existence since December 2002 and has been successful in obtaining grants from the Global Fund. The CCM has been playing the role of an in-country board that facilitates and oversees the Global Fund grants on AIDS, TB and Malaria.

Country Coordinating Mechanisms are central to the Global Fund's commitment to local ownership and participatory decision making. These country level partnerships develop and submit grant proposals to the Global Fund based on priority needs at the national level. After grant approval they oversee the progress during implementation.

Currently the India portfolio of the Global Fund grants is approximately USD 956 million with USD 417 million disbursed so far.

Under Round 9 of the GFATM, Ministry of Health & Family Welfare and NACO put proposal under the HIV component stating objectives which are;

Strengthen the harm reduction programme in the country by improving individual and institutional capacities.

- Implementing quality assurance systems for harm reduction
- Improving access to services for Female Injecting Drug Users and sexual partners of IDUs
- Introducing (on trial basis) re-integration and after care services for IDUs

Proposed framework under Round 9 is given below;

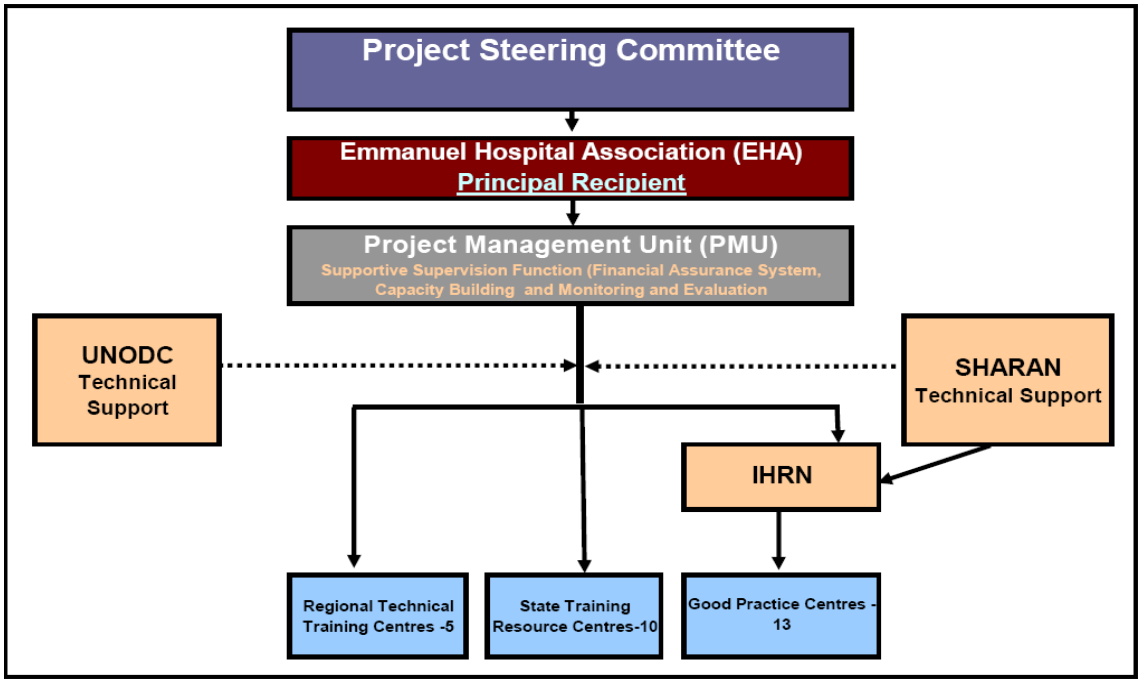


Figure 4: Proposed framework under Round 9-India CCM-GFATM

Key processes and Service Delivery Areas are:

- Strengthening of civil society and institutional capacity building
- Quality Assurance Systems for Harm reduction
- Reintegration and after care Services for IDUs

Proposed key role and responsibilities are mentioned as follows;

Table 3: Role Matrix for India CCM-GFATM

Agency Role	Role	Description
Advisory Body	Advisory	• Review the project once in a quarter and provide advisory inputs to strengthen the quality of delivery of the project. • Close review and addressing coordination issues between National AIDS Control Organization and Good practice centre on training
National AIDS Control Organization (NACO)	Programme Partnership	• Project advisory role • Contracting, financial and monitoring of Targeted Interventions' in Harm Reduction Setting up Systems of accreditation, procurement and quality control • Financial support for the trainees who attend the Programme envisaged in this Project (budget for training already provided under National AIDS Control Programme) • Building Opioid Substitution Therapy sites and the Targeted Interventions sites as per schedule
Emmanuel Hospital Association	Principal Recipient	• Overall responsibility for the project • Financial Management • Setting up of the Project Management Unit (PMU) • Reporting to Global Fund and ICCM • Setting up Project Management Unit (PMU) • Setting up the Project Advisory Body
Project Management Unit (PMU)	Supportive Supervision	• Performance Management of the deliverables under • this Project • Technical and managerial support to the entire programme • Fund disbursement to Sub recipients • Monitoring and Evaluation • Reporting to PR • Management of Capacity Building System
United Nations Office on Drug And Crime (UNODC)	Technical Partner	• Operation Research • Quality assurance SOPs and trainings • Capacity Building material development • Training of Master Trainers • Other Technical support
SHARAN	Technical Partner	• Support and strengthen Good Practice Centres • support and strengthen Indian Harm Reduction Network

These initiatives will help to strengthen the Harm Reduction initiatives in India.

3. Ministry of Social Justice and Empowerment (MoSJE)

India also has an international obligation to, inter alia, curb drug abuse. The United Nations General Assembly, in its 20th Special Session in 1998, has accepted demand reduction as an indispensable pillar of drug control strategies. The demand reduction strategy consists of education, treatment, rehabilitation and social integration of drug addicts for prevention of drug abuse.

For the purpose of drug demand reduction, the Ministry of Social Justice & Empowerment has been implementing the Scheme of Prevention of Alcoholism and Substance (Drug) Abuse since 1985-86. The Scheme was revised twice in 1994 and 1999, and at present provides financial support to NGOs and employers mainly for the following items:

i. Awareness and Preventive Education

ii. Drug Awareness and Counselling Centres (CC)

iii. Treatment- Cum- Rehabilitation Centres (TC)

iv. Workplace Prevention Programme (WPP)

v. De-addiction Camps (ACDC)

vi. NGO forum for Drug Abuse Prevention

vii. Innovative Interventions to strengthen community based rehabilitation

viii. Technical Exchange and Manpower development programme

ix. Surveys, Studies, Evaluation and Research on the subjects covered under the scheme.

The Ministry takes up awareness generation programme every year disseminating information, education and communication (IEC) materials, organizing programs in schools and community, holding exhibitions and publishing newsletters and journals.

Presently about 41 CCs and 401 TCs are functioning with the support of the ministry in the country. De-addiction camps are organized regularly to reach out to uncovered areas. The

Ministry has set up a National Centre for Drug Abuse Prevention (NCDAP) in the National Institute of Social Defence (NISD) for capacity building and training of NGOs running CCs and TCs. The Ministry is also supporting eight NGOs working in the field of drug abuse prevention to function as Regional Resource and Training Centres (RRTCs) for imparting training in local cultural setting to the service providers working in various TCs and for undertaking advocacy, research and monitoring of drug abuse programmes. The NISD also maintains an electronic database hosted on the World Wide Web called Drug Abuse Management System (DAMS) for collection of data on the addicts receiving treatment in the TCs supported by the Ministry.

Pursuant to the above the Central Government has approved the revised scheme (Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse, 2008) the main components of which are as follows;

i) Integrated Rehabilitation Centre for Addicts (IRCA)

ii) Programme for Prevention of Alcoholism and Drug Abuse at Workplace (WPP)

iii) Regional Resource and Training Centers (RRTC)

iv) Awareness-cum-De addiction Camps (ACDC)

v) Technical Exchange and Personal Development Programme

vi) Preventive Education and Awareness Generation through Media Publicity

vii) NGO Forum for Drug Abuse Prevention

viii) Innovative Intervention to Strengthen Community Based Rehabilitation

ix) Survey, Studies, Evaluation and Research on the subjects covered under the Scheme

4. National AIDS Control Organisation

National AIDS Control Organisation is a division of the Ministry of Health and Family Welfare that provides leadership to HIV/AIDS control programme in India through 35 HIV/AIDS Prevention and Control Societies.

In 1986, following the detection of the first AIDS case in the country, the National AIDS Committee was constituted in the Ministry of Health and Family Welfare.

As the epidemic spread, need was felt for a nationwide programme and an organisation to steer the programme. In 1992 India's first National AIDS Control Programme (1992-1999) was launched, and National AIDS Control Organisation (NACO) was constituted to implement the programme and currently National AIDS Control Programme-NACP III is implemented.

NACP-III is based on the experiences and lessons drawn from NACP-I and II, and is built upon their strengths. Its priorities and thrust areas are drawn up accordingly and include the following:

- Considering that more than 99 percent of the population in the country is free from infection, NACP-III places the highest priority on preventive efforts while, at the same time, seeks to integrate prevention with care, support and treatment.
- Sub-populations that have the highest risk of exposure to HIV will receive the highest priority in the intervention programmes. These would include sex workers, men-who-have-sex-with-men and injecting drug users. Second high priority in the intervention programmes is accorded to long-distance truckers, prisoners, migrants (including refugees) and street children.
- NACP-III ensures that all persons who need treatment would have access to prophylaxis and management of opportunistic infections. People who need access to ART will also be assured first line ARV drugs.
- Prevention needs of children are addressed through universal provision of PPTCT services. Children who are infected are assured access to paediatric ART.

- NACP-III also plans to invest in community care centres to provide psycho-social support, outreach services, referrals and palliative care.

- Socio-economic determinants that make a person vulnerable also increase the risk of exposure to HIV. NACP-III will work with other agencies involved in vulnerability reduction such as women's groups, youth groups, trade unions etc. to integrate HIV prevention into their activities.

Mainstreaming and partnerships are the key approaches to facilitate multi-sectoral response engaging a wide range of stakeholders. Private sector, civil society organisations, networks of people living with HIV/AIDS and government departments all have a crucial role in prevention, care, support, treatment and service delivery. Technical and financial resources of the development partners are leveraged to achieve the objectives of the programme.

The overall goals of NACP-III is to halt and reverse the epidemic in India over the next five years by integrating programmes for prevention, care and support and treatment. This will be achieved through a four-pronged strategy

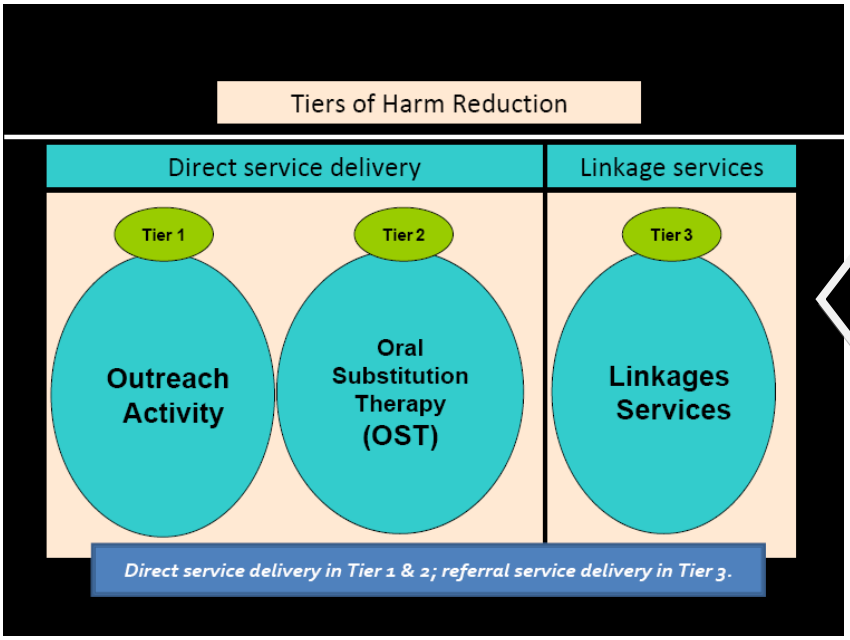
- Prevent infections through saturation of coverage of high-risk groups with targeted interventions (TIs) and scaled up interventions in the general population.
- Provide greater care, support and treatment to larger number of PLHA.
- Strengthen the infrastructure, systems and human resources in prevention, care, support and treatment programmes at district, state and national levels.
- Strengthen the nationwide Strategic Information Management System.

The specific objective is to reduce the rate of incidence by 60 per cent in the first year of the programme in high prevalence states to obtain the reversal of the epidemic, and by 40 percent in the vulnerable states to stabilise the epidemic.

In the recent years, Injecting Drug Users have emerged as a major group with a high prevalence of Human Immunodeficiency Virus (HIV). As per the HIV Sentinel Surveillance in 2007, the prevalence rate amongst Injecting Drug users (IDUs) was 7.23%. In addition, HIV is also transmitted from Injecting drug users (IDUs) to their spouses and general population. To address this growing threat, about 220 Targeted Interventions (TI) have been implemented in various geographical locations of the country. The Needle Syringe Exchange

Programme (NSEP) forms a major component of the TI intervention. NSEP involves distributing a new needle/syringe to the IDU client and taking back the used needle/syringe from the client.

NACO has proposed the following model of harm reduction for IDUs. NACO guide and give funding to the State AIDS Control Societies for the same. Monitoring is done with monthly report and yearly progress. NACO has published the guidelines in the various components as publications. Among those one is operational guidelines for Targeted Interventions for High Risk Groups (HRGs).



NACO follows this model for Harm Reductions among

NACO summarizes that, the HIV transmission dynamics in India are such that unless effective targeted HIV prevention saturates the most at-risk HRGs of FSWs, MSM/TGs and IDUs, the epidemic will not be controlled. But the positive implication of this is that if HIV prevention is successful in these HRGs, the epidemic will be substantially curtailed.

NACO has implemented through SACS protocols to map such high risk groups and providing interventions of harm reductions. NACO has implement quality control strategies under which high risk groups interventions are measured. CBOs and NGOs working for the IDUs are screened and monitored to have continuous care as TIs.

5. Delhi State AIDS Control Society

National AIDS Control Organisation provides leadership to HIV/AIDS Control Programme in India, implementing one National Plan within one monitoring system. State AIDS Prevention and Control Societies (SACS) implement NACO programme at state level, but have functional independence to upscale and innovate.

SACS Structure

SACS are autonomous and decentralized. Each State AIDS Prevention and Control Society has a governing body, its highest policy-making structure, headed either by the minister in charge of health or the chief secretary. It has on board representatives from key government departments, the civil society, trade and industry, private health sector and PLHA networks, who meet twice a year. It approves new policy initiatives, annual plan and budget, appoints statutory auditors and accepts the annual audit report.

Functions of SACS are:

- Medical and public health services;
- Communication and social sector services; and
- Administration, planning, coordination, monitoring and evaluation, finance and procurement.

With the setting up of District AIDS Prevention and Control Unit under NACP-III, there will be increased emphasis on improving coordination functions at state level in supporting the programme implementation at the district level.

Currently DSACS is working for Harm Reductions for IDUs at 8 sites and 1 site is yet to ne launch soon. DSACS follows the same framework for Harm Reductions interventions like Oral Substitution Therapy and Needle Exchange Programme. They are involved in disseminating IEC materials to the target groups with the help of NGOs in local language for awareness and as part of BCC strategy also. DSACS has identified pockets where IDUs are located and incorporated NGOs and CBOs to work at TIs. With co ordination of NACO, DSACS monitor and evaluate activities implemented by them.

6. State Training Resource Centre

State Training and Resource Centre (STRC) has been setup by NACO at Delhi School of Social Work, University of Delhi. The centre which came into being in August, 2008, is a part of NACO's strategy to develop sustainable systems for the capacity building of NGOs/ Civil Societies implementing Targeted Intervention projects for High Risk Groups (HRG) with Delhi State AIDS Control Society under NACP III.

The centre is responsible for designing the structure of training course/module; develop case studies; design teaching aids; organize field visits; develop evaluation and assessment tools and undertake any other activity required to make the training knowledge as well as skill based.

The centre has also set up A Resource cum Documentation Centre at STRC.TI partner organizations/civil society organizations and anyone who is interested can access the documents and other material pertaining to HIV/AIDS, Health and other development areas

STRC Delhi has conducted over 40 training programs till March, 2009 covering 1371 personnel of various categories working in TI.

7. Society for Promotion of Youth & Masses

SPYM is a national organisation with a countrywide network working in the area of community mobilization, health care and socio-economic development since last 23 years. SPYM's mission is to provide quality services within available resources which enable people to maximize their potential, increase their abilities, preserve and enhance human dignity/worth, prevent or reduce the need for services by empowering the community to sustain the program activities on their own for their overall long term development. SPYM has been active at the state, national, international levels and it works in the domains of:

- Community mobilization for Development including micro finance
- Health care (STIs, HIV/AIDS, Drug Use/Injection Drug Use etc.,)
- Field Survey , Research, education and documentation

SPYM has played a pioneering role as a bridge between NGO sector and Govt. of India in area of policy analysis, advocacy and communication. It has been member of various advisory committees of NACO, Ministry of Health, Ministry of Social Justice & Empowerment, Ministry of Youth Affairs and Sports, Ministry of Women and Child Development etc. since last 23 years. It has advocated and sensitized government regarding the health and socio-economic needs and concerns of the community and civil society organizations.

Furthermore, SPYM is the member of:

- Country Coordination Mechanism (CCM-India) for Global Fund
- Technical Resource Groups (TRGs) of National AIDS Control Organisation
- Grant Approval Committee of Ministry of Social Justice & Empowerment, Govt. of India.
- Steering committee Project H-13, UNODC for the SAARC countries
- Central advisory committee of the Ministry of Women and Child Development, Govt. of India on Anti Human Trafficking etc.

SPYM's experience and expertise in the health sector is reflected in the fact that the Ministry of Social Justice & Empowerment as well as NACO, Ministry of Health, Govt. of India and United Nations Office on Drugs & Crime (UNODC) has designated SPYM as the Regional Resource and Training Centre for Northern part of India (RRTC-North) and the responsibilities are as follows:

- Training of service providers based on the assessment of the training needs.
- Documentation of programmes / results at the regional level.
- Advocacy, research and monitoring on regional issues.
- Technical support to NGOs/CBOs/Enterprises in strengthening their programmes.

• Strengthening the rehabilitation of the addicts by networking and convergence dof resources in Punjab, Haryana, Chandigarh, Madhya Pradesh, Delhi, Bihar, U.P and other states of Northern India. SPYM has capacitated for quality service delivery more than 500 NGOs across the country SPYM in partnership with NACO as RRTC and Technical support Unit (TSU) to capacitate State AIDS Control Societies has organized capacity building training programs for the staff of Targeted Interventions (TIs) of various SACS i.e. Punjab, Haryana, Chandigarh, Himachal Pradesh ,U.P, Rajasthan, Delhi, Uttarakhand, Bihar, etc. It has trained more than NGO staff of Northern India on issues related to HIV/AIDS/STIs, sex & sexuality, drug demand reduction including harm reduction approach etc.

Publications of SPYM:

- A set of 21 exhibition panels on HIV/AIDS and Harm Reduction related issues,
- Flip charts/pamphlets on HIV/AIDS,
- Guide book on peer education and communication,
- Resource book on harm reduction for HIV/AIDS prevention among IDUs
- Books on HIV/AIDS & preventive options, and HIV/AIDS & sexual health issues
- Training modules for the capacity building of TIs and non HIV NGOs/CBOs
- Management and accounting module for the NGOs
- Web portal on Knowledge Management on IDU and HIV related issues
- Short films on Harm reduction issues

8. SHARAN

Sharan has continued to be a leading NGO in up scaling the use of OST as an intervention for prevention of HIV by Injecting Drug Users. Its harm reduction strategy and continuum of care models are acclaimed at national as well as international levels. Sharan continued its endeavour to help the marginalized communities living in extremely poor resources by way of providing services in terms of general health care, counseling/treatment/follow up of clients addicted to drugs through its various existing projects/programs supported by both Government and non-government/international bodies.

SHARAN is involved in the field of drug treatment & HIV/AIDS in respect to counseling, crisis care, awareness & prevention, detoxification of drug users. It is committed to be of service to urban poverty, in a Christian spirit of love and compassion. SHARAN aims to raise the health status of the poor through curative, preventive and proactive programs, i.e. through diagnosing illnesses, prescribing & dispensing of medication and through health education and training to the leaders and women of the community. It also works towards creating a community consciousness among the poor, where they would be involved in sharing their resources with one another, assisting each other when in need and to break down caste, creed and religious barriers in the process so that people can co-exist in harmony. This is achieved through the provision of:

- Effective models of service
- Support and capacity building of these communities
- Advocacy and empowerment leading to overall community development

SHARAN has extensive experience of working in the IDU / harm reduction sector and has run several field interventions, been part of several consultancy assignments, training and other events. At the national level SHARAN managed and implemented - Project Network supported by DFID Challenge Fund PMO - A National scale up of IDU interventions across nine states during 2006 in India which aimed to establish comprehensive HIV interventions through a Continuum of Treatment approach for IDUs and their partners that could be sustained through partnership between Governmental and Non-Governmental Organizations. The project scaled-up (under DFID support to SHARAN for Opioid Substitution Therapy) established, and strengthened interventions for injecting drug users, and is currently sustained through the mechanisms of the National AIDS Control Programme Phase III. To ensure universal standards of service are followed and practiced by partners across the states, guidelines for protocols on Needle Syringe Exchange Programme (NSEP), Opioid Substitution Therapy, wound management, general health and M&E have been disseminated to all partners for implementation through the Technical Support Unit, a pool of resource consultants, each an expert in the above mentioned areas to provide support to partners, established and managed by SHARAN. SHARAN has provided support on advocacy and

technical areas in launching drug substitution treatment in Nepal and developing Harm Reduction programs in Pakistan. SHARAN is a member of the Technical Resource Group (TRG) set up by National AIDS Control Programme.

9. The Indian Harm Reduction Network (IHRN)

IHRN is a consortium of established organizations/networks and professionals working on drug treatment; and HIV prevention, treatment and care. It was established in February 2007. Its mission is to secure access to quality health services for drug users within a rights framework; and to support the participation of drug users/primary stakeholders in service delivery and in policy development. This would be achieved through capacity building, networking, information sharing, research, policy advocacy and collective action.

Members of the network include key grassroots organizations like Sahara, Indian Network of Positive people and technical support organizations like India HIV/AIDS Alliance, Emmanuel Health Association and others who will be partnered by the IHRN to provide the necessary training policy or structural interventions.

IHRN will play a major role as discussed under GFATM.

10. Emmanuel Hospital Association (EHA)

Emmanuel Hospital Association (EHA) is a large faith based non-government organization providing health care in India, having a network of 20 hospitals (some 200 bedded and the lowest with 30 beds) and 30 community-based health and development projects spread across 14 states across the North east, East, North and Central India as well as the Andaman and Nicobar Islands in the south. EHA is a registered Indian non-profit charitable society, registered under the Societies Registration Act 1860 on May 1970. The mission of EHA is to fill the gaps of comprehensive health care for the poor and the marginalized in rural India.

EHA today is one of the important players of HIV/AIDS response in India. EHA provides HIV prevention interventions to a variety of people engaged in practices that put them at risk

for HIV/AIDS. EHA works across 25 districts in 10 states through the hospitals and projects, other non-government organizations (NGOs) and community based organizations (CBOs).

During the year 2008-09, 18,000 injecting drug users, 4500 sex workers, 1500 MSMs, 1800 IDUs on drug substitution, and 3000 people living with HIVAIDS, benefited from HIV/AIDS care & prevention interventions. EHA will be the principle recipient of funding under round 9 as discussed under role of GFATM.

11. Resource Centre for Sexual Health and HIV/AIDS (RCSHA)

In 2002, when the second phase of India's National AIDS Programme1, was in the early stages of implementation, a resource centre for HIV/AIDS and sexual health programming was established in New Delhi with support of the Department for International Development (DFID) and managed by AC Nielsen ORG-MARG Centre of Social Research (ORGCSR). Initially known as the Sexual Health Resource Centre (SHRC), the Centre's primary mandate was to work with the National AIDS Control Organization (NACO) and selected State AIDS Control Societies (SACS) to strengthen the existing capacity of the National Programme. Recognizing that there was a great deal of potential and capacity within India, the Resource Centre's main role was to find this capacity, work with it, put it in touch with the areas where it was needed, and provide overall direction to this process.

Providing Technical Assistance, Measuring Impact, Creating an Intellectual Resource for the Future

Preventing infection in high-risk groups controls the spread of HIV in the general population in the long run. Therefore, well timed interventions and prevention services for high-risk populations is crucial to the overall control of the epidemic. The Resource Centre assisted TI evaluations, enhanced the capacity of individuals working in TIs, and most importantly, carried out DFID's objective of determining the impact of these interventions.

Role of RCSHA is an important in a way to combining all the effort to establish resource and capacity building.

12. Role of Other Organizations

There are several other NGOs like Krupa Foundation, Salam Balak Trust etc working at grass root level under the guidance of DSACS and other agencies which were not covered as scope of the study was limited in concern with the time. Prime focuses of such organizations are to implement the interventions among affected population and promoting community participation. Role of **DFID Technical Assistance Support Team for India's National AIDS Control Organisation in Support of the National AIDS Control Programme III,** Futures Group is leading a support team that is providing technical assistance (TA) and management support to the National AIDS Control Organisation (NACO) and State AIDS Prevention and Control Societies (SACS) in India. The TA focuses on strengthening capacity of NACO and SACSs, facilitating policy formulation, and guiding implementation in three core areas: harm reduction and Opioid Substitution Therapy (OST) for injecting drug users (IDUs); males who have sex with males and transgender interventions; and research capacity. This support is enabling an effective decentralized response to HIV and AIDS that is focused on vulnerable groups and context-specific needs.

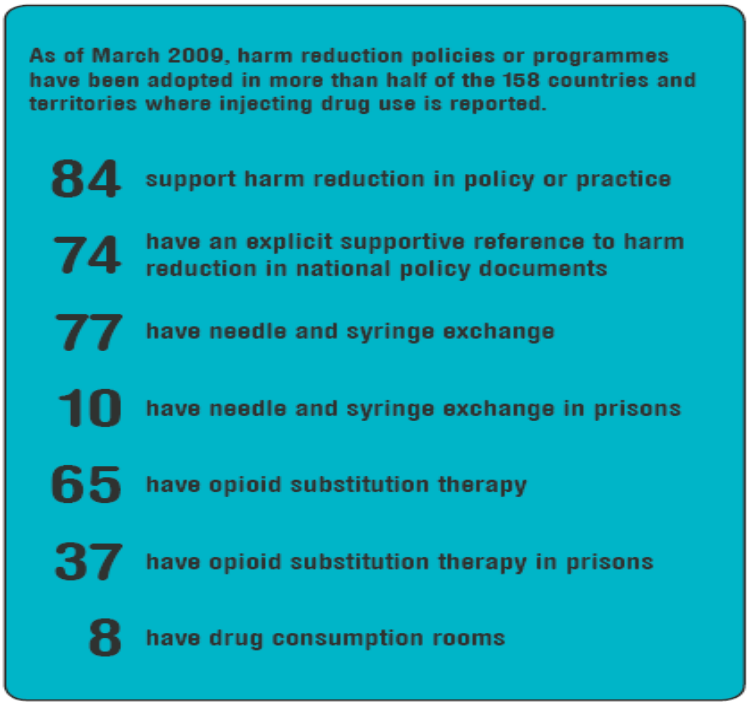
B. Harm Reduction Approaches

There are various ways suggested for Harm Reduction for IDUs. These are briefly compiled in **Table**. Globally these ways are followed and results are satisfactory.

Table: 4 Ways of Harm Reduction[11]

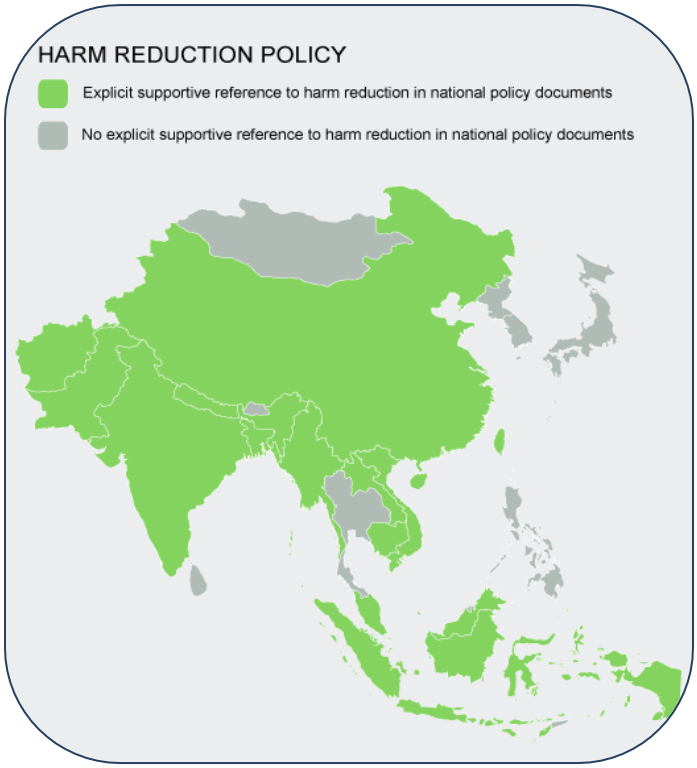
Reducing Harm through Services
Needle exchange, methadone and buprenorphine, overdose prevention, and legal support
Reducing Harm through Technical Assistance
New models of treatment for HIV and drug dependence
Reducing Harm through Advocacy
Policies based on evidence rather than ideology
Reducing Harm through Community Mobilization
Working with people who use drugs and people living with HIV

However, it is also important to mention that the messages on HIV prevention need to be disseminated to substance users and their partners, even before the incidence of HIV are reported in the area. Global state of Harm Reduction[12] is as follows;



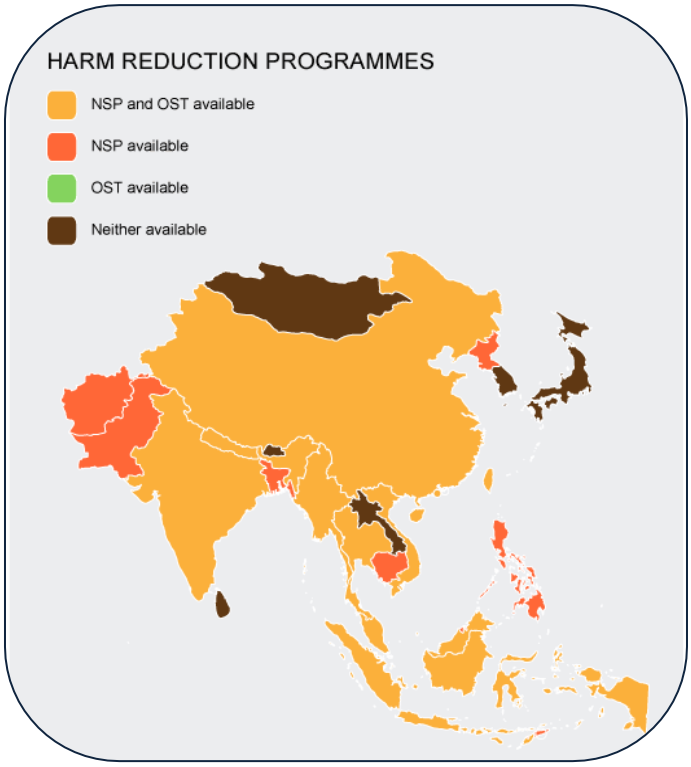
Global State of Harm Reduction

Overall in Asia efforts are done to minimize the spread of HIV/AIDS among IDUs. The responses targeted in Asia are shown below as per the report on Harm Reduction in Asia.[13]



Asian Support for Harm Reduction

Harm Reduction Programmes in Asia



C. Problems and Issues identified

Role of NACO and at the state level role of Delhi is discussed in previous section. As per the discussions with the providers of Harm Reduction services and per literatures reviewed, here is an effort to compile the issues considering the objective of the study. These are in context with general as well as specific IDUs of Delhi.

1. IDU Population

As this vulnerable population is difficult to identify, providers are incorporating strategy of involving community itself who are/were exposed to such habits. Extent of IDUs in the city is difficult and various data showing few variations as well. National AIDS Control Programme Phase III (2007-2012) (Estimation by Expert Committee on Vulnerable Groups-2006) has indicated other: IDU Male 100,000 to 200,000 and IDU female 10,000 to 35,000. Independent mapping by DSACS-2005 estimated 18,000 users in Delhi. Current interventions are covering around 4800 IDUs in Delhi.

The data used in this report on the extent of drug injecting in India has been obtained primarily from The Extent, Pattern and Trends of Drug Abuse in India2, National Survey, which had multiple components:

National Household Survey (NHS)

Drug Abuse Monitoring System (DAMS) – data obtained from major treatment centres (government and non-government) around the country[14]

Rapid Assessment Survey (RAS) [15]

Additionally, information on injecting drug use has also been collated from focused thematic studies.

Drug Abuse among Women[16]
Drug Abuse in Border Areas
Drug Abuse in Prison Population[17]

It should be pointed out, however, that it is risky to try to derive national estimates of injecting drug use using the national household survey as a basis. This is because household surveys; in general, tend not to fully access marginalized populations. Since IDUs are more likely to belong to such groups they are not necessarily captured through such a methodology. As a result, estimates of IDUs based on household surveys tend to produce an underestimation. Thus, while the National Household Survey (NHS) did suggest a lifetime prevalence of IDU among adult males at around 0.1 per cent, it would be inappropriate to use this figure to project an absolute number of IDUs for the country as a whole. Furthermore, the only data on HIV seropositivity among IDUs comes from sentinel surveillance and ethnographic studies and can also not be extrapolated to a national level.

2. Factors encouraging spread of IDUs

Non-availability and rising cost of heroin were the two most common reasons given for injecting drugs. Reports show that the poor quality of street heroin also led to injecting practices. Most reported that injecting was a cost-effective method of using drugs. Some (range: 7-27%) reported that they were using injections (of pharmaceutical drugs) to give up heroin. Structural factors are often important reasons for the transition from non-injecting to injecting. Opiate users have demonstrated considerable potential for switching to injecting. For this reason, preventing the transition to injecting is extremely critical. Given the fact that the majority of opiate users in India are still non-injectors, understanding the process of transition assumes great public health significance.[18]

3. Availability of Harm Reduction Programmes in Delhi

There are several harm reduction activities done in Delhi for IDUs. Still there is a gap in utilization and availability of resources for the same. DSACS is concentrating in pockets of Delhi where higher groups are identified indulging in injecting practices. NGOs working under the guidance of NACO and DSACS are sometimes in a situation where they identify the need gaps but unable to reach all. This is because of extent of coverage is limited. As discussed under GFATM-India CCM there is a clear understanding that need gaps can be

fulfilled by proposed network. Still OST and NSEP are quite satisfactorily incorporated among targeted population.

4. Co ordination

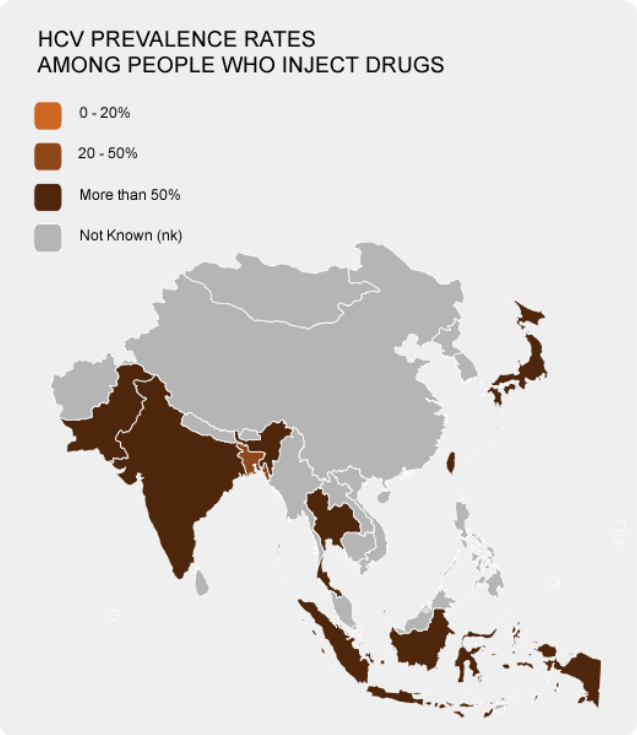
The issue of co ordination was also discussed. Currently NACO with efforts of DSACS is doing extensive monitoring of TIs which are being implemented by various NGOs and agencies. From various international platforms, UNODC drives the policy and advocacy for the country and uniform measures are considered for Delhi. Indian Harm Reduction Network can play a key role to co ordinate strategies at national levels and higher provenance zones can be targeted.

5. Feminization

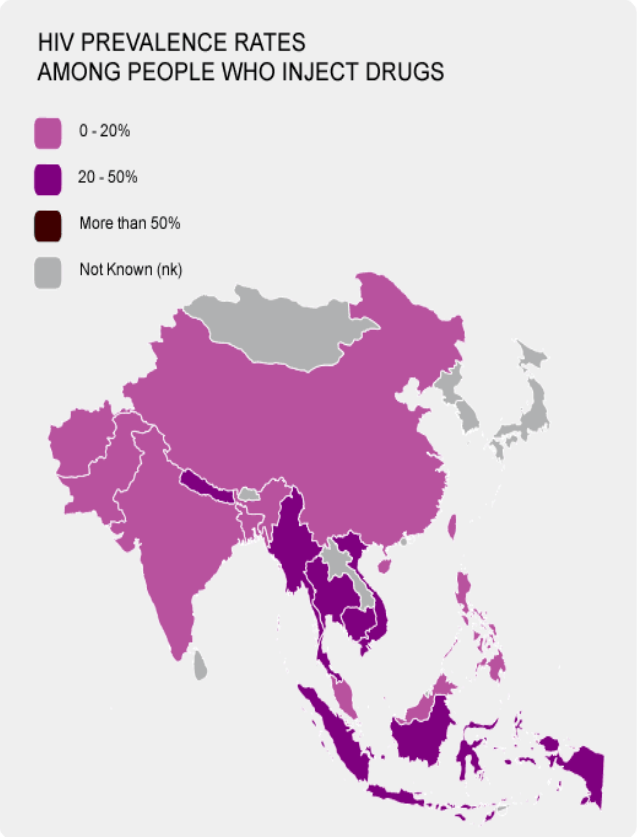
As discussed in the introduction of the report, clearly this vulnerable population is at a higher risk and this is acting as a feminization of the problem. Of serious immediate concern is the original role of IDU in the 'feminization' of the epidemic, where HIV is sexually transmitted from injecting drug users to their non drug-using wives and partners. In this way, the indirect impact of IDU on the spread of the HIV epidemic is considerable. Intervention strategies are required urgently.

6. Major Health Consequences

IDUs are also prone to other major health problems. Certain identified are HIV / AIDS, Tuberculosis, Hepatitis / Jaundice, STIs, Abscess and Drug Overdose. Certain issues are identified and, prevention and treatment programmes for the same are carried out. DSACS is having various centers where along with OST and NSEP, abscess treatment is also given. HIV and HCV prevalence are shown below for Asia region.[13]



HCV Prevalence



HIV Prevalence

7. Identification of marginalized group

As this vulnerable group is difficult to locate and time consuming to come to numbers, organizations working at grass root levels use peer education and peer leader approach with identification of Key Informant. There is an issue of identifying this group among high profile societies where locating them is difficulty and again involving them into such harm reduction activity would require unique approach, as objective of harm reduction is different than approach of de addiction.

8. Female IDUs

The issue discussed more commonly was identifying female IDUs. As this group is difficult to target, and some of them if involved in unsafe sexual practices, may lead to serious issue. There is a chance that there can be increased prevalence of HIV/AIDS.

4 Conclusion and approaches for way ahead

As discussed throughout the study, population under focus needs better identity. The pockets need to be located and interventions can be incorporated. Broadly summarizing the issue extent of Harm Reduction activities are on a pace as required, but there is a need for better co ordination.

The broadening of HIV epidemics formerly concentrated among IDUs underscores the importance of including sexual health education and condoms in harm reduction programs. It is also a reminder that failure to offer effective HIV prevention for IDUs has a grave impact not just on people who inject drugs, but also their partners and children. While IDU epidemics are generalizing, they remain concentrated in communities highly affected by drug use. It remains to be seen whether policymakers will use reports of generalizing HIV infections to turn away from the needs of such communities, or to reinvigorate programs serving IDUs and their social networks.

As reported by UNODC an urgent need for drug users—whether male or female, is the establishment of international drug treatment standards[18]. Too often drug users are subjected to ineffective, inhumane, and punitive forms of treatment consisting of little more than medicated withdrawal or prolonged incarceration in the name of health. Without substitution therapy or psychological support, they quickly relapse and are branded failures. Drug users should and must have access to treatment that is voluntary, affordable, high-quality, low-threshold, and gender-sensitive. For those faced with the threat of HIV, hepatitis, and other health issues, the stakes are high; the standards also should be. Multilateral institutions and national governments must offer greater guidance for human rights–friendly, effective treatment.

The ability to halt the epidemic requires a three part strategy: [18](i) preventing drug abuse, especially among young people; (ii) facilitating entry into drug abuse treatment; and (iii) establishing effective outreach to engage drug abusers in HIV prevention strategies that protect them and their partners and families from exposure to HIV, as well as encourage the uptake of treatment and medical care.

As reported by UNODC on Harm Reductions can be followed for Delhi and State agencies can incorporate the same to fight against prevalence of HIV/AIDS among IDUs.
Some of them are mentioned as follows;

- Community based approach
- Educate the drug user
- Encourage the drug dependence
- Establish a hierarchy of risk reduction strategies to prevent HIV among IDUs
- Strengthen peer-driven intervention
- Provide primary health care for drug injectors
- Voluntary HIV counseling and testing
- Reduce risky sexual behaviors among IDUs

There is also a need of Behavior Change Communication Strategies. Certain efforts are already being done by DSACS through different methods. Expanding awareness and prevention interventions to address secondary stakeholders such as law enforcement agencies, parents and policy makers are needed. Interventions targeting partners of IDUs, key stakeholders in HIV prevention, warrant consideration.

National AIDS Control Organization has developed and implemented Standard Operating Procedures (SOP) for providing Opioid Substitution Therapy. But for the comprehensive harm reduction programme, there are still standards that need to be developed and implementers trained on it. This will then need to be followed up with supportive supervision. The lack of a system for quality assurance, compounded with less than optimum capacity is major hindrances in reaching needed quality.

In addition to the above the IDU interventions have further gaps, which need to be addressed and take into account new knowledge relevant to the programme and targeted interventions. The most pressing gaps relate to lack of provision of services for Female Injecting Drug Users (FIDU) and partners of male injecting drug users and high relapse rates after the intervention. IDU are many times unemployed and face severe discrimination.

Without a meaningful livelihood, chances of relapse into Injecting Drug use are high. The current harm reduction services do not include reintegration – a combination of livelihood and social services which provide a safety net and supportive action. There is a need to experiment, learn and incorporate lessons within the national programme. While the National Programme seeks rapid scale up, this is unlikely to happen without addressing gaps related to capacities (individuals and institutions), quality assurance, supplementary services which are community friendly and reduces vulnerabilities. Careful facilitation of community institutions and NGOs to clearly focus and their respective core groups is essential for achieving both scale and quality.

As the twin epidemics of HIV and injecting drug use spread to every corner of an ever more connected world, the words of Martin Luther King, Jr., seem particularly appropriate:

"We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects me directly, affects all indirectly."

5 Limitations of the Study

There are certain limitations regarding this study. This can be taken up to highlight this issue in a better way. Identified limitations and suggestive actions are mentioned as follow;

1. Perspective of IDUs was not taken. It can be done to evaluate the services available.

2. Quality of Life model can be measured to suggest models for behavior modification

3. Quantitative analyses can be done to understand the depth and extent of interventions.

4. Some of the organizations were not covered due to scope of the study was limited with regard to time

6 References

1. UNAIDS, WHO, Report 2009
2. NACO, 2008-09
3. Mathers et al., 2008
4. NACO Estimates, 2007
5. Economic and Social Commission for Asia and the Pacific, 2008
6. Population Council, 2007
7. NACO, HIV Prevalence levels State wise: 1998 – 2003, accessed at http://www.nacoonline.org/factsnfigures/Statewisehiv. pdf
8. Abstract from UNODC-India Report
9. International Harm Reduction Network (IHRN), What is Harm Reduction? A position statement from the International Harm Reduction Association, International Harm Reduction Association, London, United Kingdom, September 2009.
10. UNODC Report,2008
11. IHRD, Harm Reductions Developments,2008
12. Accessed at http://www.ihra.net/Assets/1616/1/2009-04_GlobalState_HarmReduction2009.pdf
13. Accessed at http://www.ihra.net/Assets/1393/1/GSHRAsia1.pdf
14. UNODC and MSJE 2002a. UNDCP Regional Office for South Asia and Ministry of Social Justice and Empowerment, Government of India, (H. Y. Siddiqui), Drug Abuse Monitoring System: A Profile of Treatment Seekers, New Delhi, 2002.
15. UNODC and MSJE 2002b. UNDCP Regional Office for South Asia and Ministry of Social Justice and Empowerment, Government of India, (M. Suresh Kumar), Rapid Assessment Survey of Drug Abuse in India, New Delhi, 2002.
16. UNODC and MSJE 2002c. UNDCP Regional Office for South Asia and Ministry of Social Justice and Empowerment, Government of India, (Pratima Murthy), Women and Drug Abuse: The Problem in India, New Delhi, 2002.

17. UNODC and MSJE 2002d. UNDCP Regional Office for South Asia and Ministry of Social Justice and Empowerment, Government of India, (H.S. Sethi), Drug Abuse among Prison Population: A Case Study of Tihar Jail, New Delhi, 2002.
18. "Injecting Drug Use and HIV/AIDS in India"**,** UNODC-INDIA Report,2007