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Access to comprehensive package of services for injecting drug users and their female sex partners

Identification and ranking of barriers in Northeast India

A MIXED METHODS STUDY

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Preface

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 that of the nine districts reporting > 15% HIV prevalence among IDUs in the country three districts are in the northeast alone (NACO, 2008).

Further, in keeping with its trend Northeast India has HIV epidemics which are concentrated mostly among people who inject drugs. Currently, in most states of Northeast India, people who inject drugs have poor access to harm reduction services. Even though harm reduction interventions have been implemented in Northeast India for over two decades now, barriers to implementation are yet to be overcome. Some of these key challenges include improvement in the quality of services, expansion of services to reach individuals at a larger scale, services for hepatitis C, tuberculosis and other health consequences of unsafe injecting drug use.

Moreover focus towards ensuring that services are equitable, accessible, affordable, comprehensive and sustainable is critical for universal access goals. This therefore requires sound understanding of the context in which injecting drug use occurs and services for IDUs are delivered. It also involves identifying structural, societal and other factors that may impede the successful delivery of these interventions and working towards creating a more supportive environment.

In the context of Northeast India it is also pertinent to note that people who inject drugs are often marginalized and are subject to stigma, discrimination and due to the misperceptions sometimes linked with illegality of drug use; IDUs may sometimes also be victims to legal sanctions. Structural factors such as changes in drug supply or injection practices can have an impact upon HIV transmission. Legal and law enforcement conditions can act as barriers to the delivery and scaling up of HIV prevention services. Means by which such barriers might be addressed include ensuring that policing policy and practice does not impede the delivery of services.

This study is an effort by UNODC as part of the joint UN HIV/AIDS response in Northeast India to assess, identify and prioritize critical barriers for IDUs in Northeast India that impede their access to comprehensive package of services. It further aims to provide necessary information to the National AIDS Control Programme and related development partners regarding critical barriers in order of their priority and therefore for their removal within the existing framework of the National AIDS Control Programme.

The study was conducted using the mixed methods methodology and also involved significant deliberations nationally and regionally with line ministries and departments from the government, civil society organisations and members of the drug using communities who have all contributed actively towards the development of this document. Conscious efforts have also been made to ensure that this study helps in understanding the varying context of barriers that impede the access of IDUs and their sex partners to comprehensive package of services.

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

Acknowledgement

The UN office on Drugs and Crime, Regional Office for South Asia (UNODC ROSA), is implementing a joint UN HIV/AIDS programme in Northeast India. As part of this initiative UNODC's component forms one part of a programme which has been formulated involving three UNAIDS co-sponsors in India (UNICEF, UNDP and UNODC) under a joint UN system response. This programme of assistance was developed in collaboration with the Government of India and the donor AusAID.

UNODC's role in this context is to contribute to the national response in reducing the risk and impact of HIV/AIDS particularly in the four states of Northeast India, namely Nagaland, Manipur, Mizoram and Meghalaya. In doing so, UNODC's efforts will involve amongst other things to evolve state-specific innovative interventions to augment the response to the drug-use-related aspect of the HIV epidemic.

This study was commissioned by UNODC as part of the joint UN HIV/AIDS programme in Northeast India. This study would have not been possible without the collective efforts of a number of partners, stakeholders and individuals who have worked tirelessly through the various stages of the development of this document. They need a special mention acknowledgement.

To begin with we would like to thank Dr Venkatesan Chakrapani for authoring this document. We would also like to sincerely thank the following agencies and staff members for their unstinting help in data collection:

a) From Bethesda Youth Welfare Centre

b) Society for Community Care in Mizoram

c) Nirvana Foundation

d) Manipur Network of Positive People

e) Social Awareness Service Organisation (SASO)

f) Indian AIDS Consortium

g) VOLCOMH

h) Samaritan Society of Mizoram

i) SHALOM

j) Grace Inn

k) Living Hope Ministry

l) Civil Hospital (Aizawl)

m) Presbyterian Hospital

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Abbreviations & Acronyms

AIDS	Acquired Immuno-deficiency Syndrome
ART	Antiretroviral Treatment
CBO	Community-based Organization
CCC	Community Care Centres
DIC	Drop-In Centres
DOTS	Directly Observed Treatment Strategy [Tuberculosis]
FGD	Focus Group Discussion
FSW	Female Sex Workers
HBsAg	Hepatitis-B Surface Antigen
HCP	Health Care Provider
HCV	Hepatitis C Virus
HBV	Hepatitis B Virus
HIV	Human Immuno-deficiency Virus
ICTC	Integrated Counselling and Testing Centres
IDUs	Injecting Drug Users
KII	Key Informant Interview
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non-Governmental Organization
NSP	Needle and Syringe Program
OST	Opioid (or Oral) Substitution Treatment
PLHIV	People Living with HIV
RNTCP	Revised National Tuberculosis Control Programme
SACS	State AIDS Control Society
TB	Tuberculosis
TI	Targeted Intervention
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Table of Contents

Tables

Boxes

Diagrams

EXECUTIVE SUMMARY

A. Background and Purpose

The **WHO, UNODC and UNAIDS** recommend the following comprehensive package of interventions for IDUs:

1) Needle and syringe programs
2) Opioid substitution treatment and other drug dependence treatment
3) HIV testing and counselling
4) Antiretroviral therapy
5) Prevention and treatment of sexually transmitted infections
6) Condom programs for IDUs and their sexual partners
7) Targeted information, education and communication for IDUs and their sex partners
8) Vaccination, diagnosis and treatment of viral Hepatitis
9) Prevention, diagnosis and treatment of tuberculosis. It is important to ensure that these comprehensive services are available, accessible and affordable for the majority of IDUs

The **overall purpose** of the study is to provide necessary information to NACO and its Northeast Regional office to prioritize the removal of critical barriers for IDUs to access the comprehensive package of services, and to inform development of appropriate responses/ strategies (within the existing framework of the National AIDS Control Programme-III) to overcome those barriers.

B. Methodology

This **concurrent triangulation mixed methods study** included a quantitative survey and qualitative in-depth key informant interviews. Three study sites were chosen in Northeast India in the states of Manipur, Mizoram and Nagaland.

A survey (n=388) was conducted among current IDUs as well as people on OST. A structured survey questionnaire was used to identify and rank barriers. A total of 388 people (men: 300; women: 88) participated. The age range was between 18 and 55 years. Of the people surveyed, 233 were current IDUs accessing services from agencies that implement needle syringe programs; 81 were on OST; and 74 were current IDUs who had not been enrolled in targeted intervention (TI).

Key informant interviews (n=21) were conducted to understand the views and perspectives of key stakeholders on barriers to accessing services for IDUs and their regular sexpartners and to get informants' suggestions for overcoming those barriers. Qualitative data thus complemented the survey findings.

Quantitative data were analysed using SPSS-17 and qualitative data were analysed using techniques derived from grounded theory to identify categories and themes.

C. Key Findings

This study has shown that a majority of IDUs and people on OST face specific barriers to accessing services, both while getting into the services for the first time as well as in continuing to use those services. The top

three reported barriers for each of the key services are listed and discussed in detail in the report.

The fear of being identified by others as a drug user and fear of police harassment – both related to structural barriers (societal stigma and drug-related criminal laws) – came within the top three barriers to accessing most of the services. 'Travel costs' came within the top three barriers in continuing to access ART and OST services. Financial barriers included the inability to afford the costs of drug and alcohol de-addiction treatment services, HBV/HCV diagnostic screening tests and treatment for Hepatitis C.

Lack of adequate number of clean syringes – due to the ceiling on the number of syringes provided per day to IDUs (which is typically four) – was cited by high frequency users as a key reason for sharing needles. Lack of adequate number of 'slots' was mentioned as a top barrier for not getting into OST program; thus, many IDUs were in the 'waiting list' for OST.

Specific populations such as female IDUs, spouses of male IDUs and prisoners face even greater and sometimes unique barriers in accessing services that are summarized below:

***Female IDUs*:** Since the TI projects are separate for female sex workers and IDUs, female IDUs – a significant proportion of whom also engage in sex work – face difficulty in accessing services from two different places. Also, in general, female IDUs find it difficult to access services provided through TI for IDUs since the drop-in centre (DIC) or OST centre (within the TI implementing agencies) are primarily occupied by males. Openly visiting a centre for drug users was a top barrier listed by female IDUs (including those in sex work) for fear of their drug use behaviour being disclosed by others and fear of possible police harassment. Need to take care of children and/or others in the family was among the other top barriers.

Female sex partners of male IDUs: Consistency of condom use with regular partners of both male and female IDUs was considerably lower than among casual or commercial partners. Several challenges exist in reaching out directly and indirectly to female spouses of male IDUs to provide health education and to promote early diagnosis and treatment. Apparently, some proportion of male IDUs does not want to disclose their HIV or STI status to their wife. And some male IDUs might have already been separated or divorced from their wives. Some male IDUs do not prefer bringing their wives to DICs for IDUs, as they are predominantly occupied by male IDUs.

Prisoners: Virtually none of the participants (n=77/388) who had been to prison in the past two years had access to either condoms or OST and free syringes/needles. Also, HIV-positive IDUs in prisons face difficulties in accessing ART.

D. Recommendations

The following steps are suggested for overcoming service barriers and to improve HIV prevention and treatment outcomes for IDUs and their partners.

1. Address structural barriers to accessing services

- Develop and implement comprehensive stigma reduction plan to **increase support from family and society** through education (mass media) and counselling (one-to-one or group counselling for family members) to provide accurate information about drug use and HIV.
- Sensitize **police** (at all levels) and anti-drug agencies on drug dependency and need for NSP and OST.
- Implement stigma reduction measures in the **health care settings** and sensitize health care providers on the health and human rights issues of IDUs and people living with HIV.

2. Address financial barriers to accessing services

- Provide financial support for **travel costs** related to accessing services such as ART and OST (which requires daily travel) at least to needy IDUs. This financial support can be in the form of providing travel allowance for appointment-related trips.
- Provide **free or affordable drug and alcohol de-addiction** treatment for IDUs and IDUs living with HIV.
- Ensure **free laboratory screening** of all IDUs, especially of those living with HIV, for Hepatitis B and C viruses (**HBV and HCV)**. Consider providing free field-based rapid tests for HIV, HBV and HCV for IDUs to encourage uptake of testing and for early diagnosis and referral.
- Develop mechanisms to **support treatment for HCV and HBV** infections among IDUs, regardless of their HIV status.

3. Address barriers to accessing services for specific populations

a. Service delivery for female IDUs

- Take steps to strengthen linkages between agencies serving female sex workers (FSWs) and IDUs, since majority of female IDUs engage in sex work or FSWs also inject drugs. Alternatively or in addition, consider introducing IDU-specific components within the sex worker TIs if a critical number of FSWs also inject drugs.
- Provide housing support and night shelter for homeless/needy female IDUs.
- Employ female outreach workers and peer educators to reach out to female IDUs.

b. Service delivery for female sex partners of male IDUs

- Female sex partners (especially spouses) of male IDUs can be indirectly reached through male IDUs by encouraging them to disclose their HIV or STI status to their spouses and ask them to visit the nearby government hospital or agency serving women for HIV and STI screening and treatment.
- Where possible, male IDUs can be encouraged to bring their spouses during a particular time slot to the DIC where couple counselling and referral services can be provided.
- With male IDUs' consent, female outreach workers can talk to their female sex partners, provide them prevention education and refer them to HIV/STI screening and treatment services.

c. Prisoners

- Introduce harm reduction services (condoms, needles/syringes and OST) and ensure treatment, including ART for prisoners.
- Develop mechanisms to ensure continuity in care for IDUs on OST and ART even after their release from the prison.

4. Meet the gaps in the demand for existing services

- Develop fool-proof mechanisms to ensure that adequate needles/syringes are available for IDUs because the current ceiling of about four needles/syringes per day is not sufficient for high frequency users, resulting in needle-sharing.
- Rapidly scale-up OST program to ensure adequate coverage of all IDUs who are wait-listed for this service and who require this service. Ensure adequate 'slots' for female IDUs. Where female IDUs are large in number, consider having a separate OST centre for females or have separate timings for females in the OST centre accessed by both males and females.
- Scale up the availability of free drug and alcohol de-addiction services (increase the capacity of existing centres and increase the number of centres) and ensure that they offer high quality and non-discriminatory treatment.

5. Prepare tools for identifying and removing barriers to accessing services

- Prepare a simple set of tools for identification of individual, systemic/institutional, and structural level barriers faced by IDUs so that a tailored plan for each IDU to overcome the barriers is developed. These tools can be used by both NGOs and government health care providers for identifying barriers and following-up with IDUs to ensure that barriers no longer exist.
- Prepare a referral checklist tool that can be used by government centres and NGOs to ensure relevant and timely referral services for IDUs and their partners.

1

INTRODUCTION

Injecting drug users (IDUs) are one of the 'core groups' identified by the National AIDS Control Organisation (NACO) for targeted HIV prevention and care interventions[1]. In 2007, an estimated 2.31 million people were living with HIV in India. The HIV epidemic in India is concentrated with a high HIV prevalence among marginalized groups such as IDUs, men who have sex with men (MSM) and female sex workers (FSWs)[2]. According to the NACO expert group on size estimation, there are approximately 96,463 to 1,89,729 male IDUs and 10,055 to 33,392 female IDUs in India; Northeast India alone has about 55,000 IDUs[3]. Among IDUs, an average HIV prevalence of 9.19% has been documented as per 2008 HIV sero surveillance data of the NACO[4].

The WHO, UNODC and UNAIDS recommend the following comprehensive package of interventions for IDUs[5]:

1) Needle and syringe programs (NSPs)
2) Opioid substitution treatment (OST) and other drug dependence treatment
3) HIV testing and counselling (T&C)
4) Antiretroviral therapy (ART)
5) Prevention and treatment of sexually transmitted infections (STIs)
6) Condom programs for IDUs and their sexual partners
7) Targeted information, education and communication (IEC) for IDUs and their sex partners
8) Vaccination, diagnosis and treatment of viral Hepatitis
9) Prevention, diagnosis and treatment of tuberculosis (TB). It is important to ensure that these comprehensive services are available, accessible and affordable for majority of IDUs

The National AIDS Control Programme (Phase III) is implementing a large-scale HIV prevention program targeting 80% coverage of the estimated IDUs and their sex partners with evidence-informed prevention and care interventions. The prevention services delivered through the IDU TIs[6] include NSP, OST, condom programming, treatment for STI infections, targeted IEC, and primary health care including abscess management.

From IDU TIs, IDUs are referred to government ART and TB Directly Observed Treatment Strategy (DOTS) centres for treatment and care related to HIV and TB and to Integrated Counselling and Testing centres (ICTCs) of the government for HIV testing. The NACP-III midterm evaluation report (September 2009) notes that at the end of April 2008 there were about 133 exclusive TIs for IDUs with an estimated coverage of 73 percent.

Availability of free services does not automatically mean that people for whom those services were intended will have no problems with access and use. Programmatic experiences from Northeast India have shown that in spite of the free services available for IDUs through non-governmental organizations as well as government hospitals, some proportion of IDUs face barriers in accessing and using services. Barriers may exist even for IDUs who are currently using those services, which may prevent them from continuing to use those services as well as using all the

necessary services. Given that the government is committed to make the services available to all those who need them, it is important to identify barriers faced by IDUs in accessing and using services.

1.1 Purpose

The *overall purpose* of the study is to provide necessary information to NACO and its Northeast regional office:

- To prioritize removal of the critical barriers[7] for IDUs to access the comprehensive package of services
- To inform development of appropriate responses/strategies (within the existing framework of the National AIDS Control Programme III) to overcome those barriers

1.2 Study Objectives

The study employed mixed methods approach to achieve the objectives.

Quantitative research component
(Primary focus of the study)

The quantitative research component was employed:

- To identify and rank perceived individual level, health-system level and structural barriers to accessing key services for IDUs and their regular sex partners
- To determine the extent to which perceived barriers are similar or unique to different types of services and how they differ between men and women

Qualitative research component
(Secondary focus of the study)

There was also a secondary focus through the *qualitative research component* to capture the perspectives and insights of key stakeholders (such as IDU/People living with HIV (PLHIV) leaders and project staff of NGOs working with IDUs) on overcoming the topmost barriers faced by IDUs, especially barriers faced by female IDUs and female sex partners (especially spouses) of male IDUs[8].

2

METHODOLOGY

2.1 Study Design

This mixed methods study included a quantitative survey and qualitative in-depth key informant interviews. Quantitative and qualitative data collection proceeded simultaneously, i.e., concurrent triangulation mixed methods study (*see* Diagram 1).

The survey was conducted among current IDUs as well as people on OST (more details are provided later in this section). Key informant interviews were conducted to understand the views and perspectives of key stakeholders on barriers to services for IDUs and their sex partners, and to get their suggestions for removing those barriers. Qualitative data thus complemented the survey findings.

2.2 Study Sites

Three study sites were chosen in Northeast India in the States of Manipur, Mizoram and Nagaland. These study sites have diverse characteristics (*see* Table 1) in terms of the nature of the site (urban, semi-urban and rural) and HIV prevalence among IDUs and general population. However, all the study sites have interventions for IDUs that provide NSP and OST services. This was basically because the main purpose of this study is to understand the barriers faced by the IDUs in accessing *existing* free services.

2.3 Training for Field Research Team

A two-day training program was conducted for the field research team. The research staff was trained on the content of the survey instrument and qualitative in-depth interview guides, conducting survey and qualitative interviews, recruitment plan preparation, and on ethics and informed consent.

2.4 Methods

A. Quantitative component

A survey instrument was developed to identify and rank barriers and was administered by trained interviewers in local languages. The questionnaire contained the following sections: socio-demographic characteristics, alcohol and drug use behaviour, NSP, OST, drug rehabilitation/de-addiction services, alcohol de-addiction services, access to services within prisons, sex and relationships, HIV and ART, Hepatitis C Virus (HCV) and Hepatitis B Virus (HBV), tuberculosis, sexually transmitted infections, and family support.

Participants and sampling methods

Participants were recruited through three NGOs implementing TIs for IDUs in these states. Other agencies working with IDUs were also approached by these agencies to recruit potential participants.

Participants were chosen primarily from three *stratified sampling* categories:

- *NSP clients:* Those IDUs who are currently receiving needles/syringes services from TIs
- *OST clients:* Those people who are currently on OST
- *'Non-NSP' IDUs:* Those IDUs who are not getting needles/syringes directly from NGOs[9]

Data collection was conducted between May and July 2010. The details of the number and

categories of the participants are provided in Chapter 3, Table 4.

Wherever possible, eligible persons were selected consecutively (consecutive sampling) for each of the three strata (NSP, OST, non-NSP). In addition to this, convenience sampling of eligible participants was done until the required sample size was achieved.

Procedure

Potential participants were screened by research staff for eligibility (≥18 years) and ability to participate and provide informed consent (that is, mentally fit to provide informed consent). After informed consent was obtained, the participants were interviewed either in a private room in the office of an NGO or at their home.

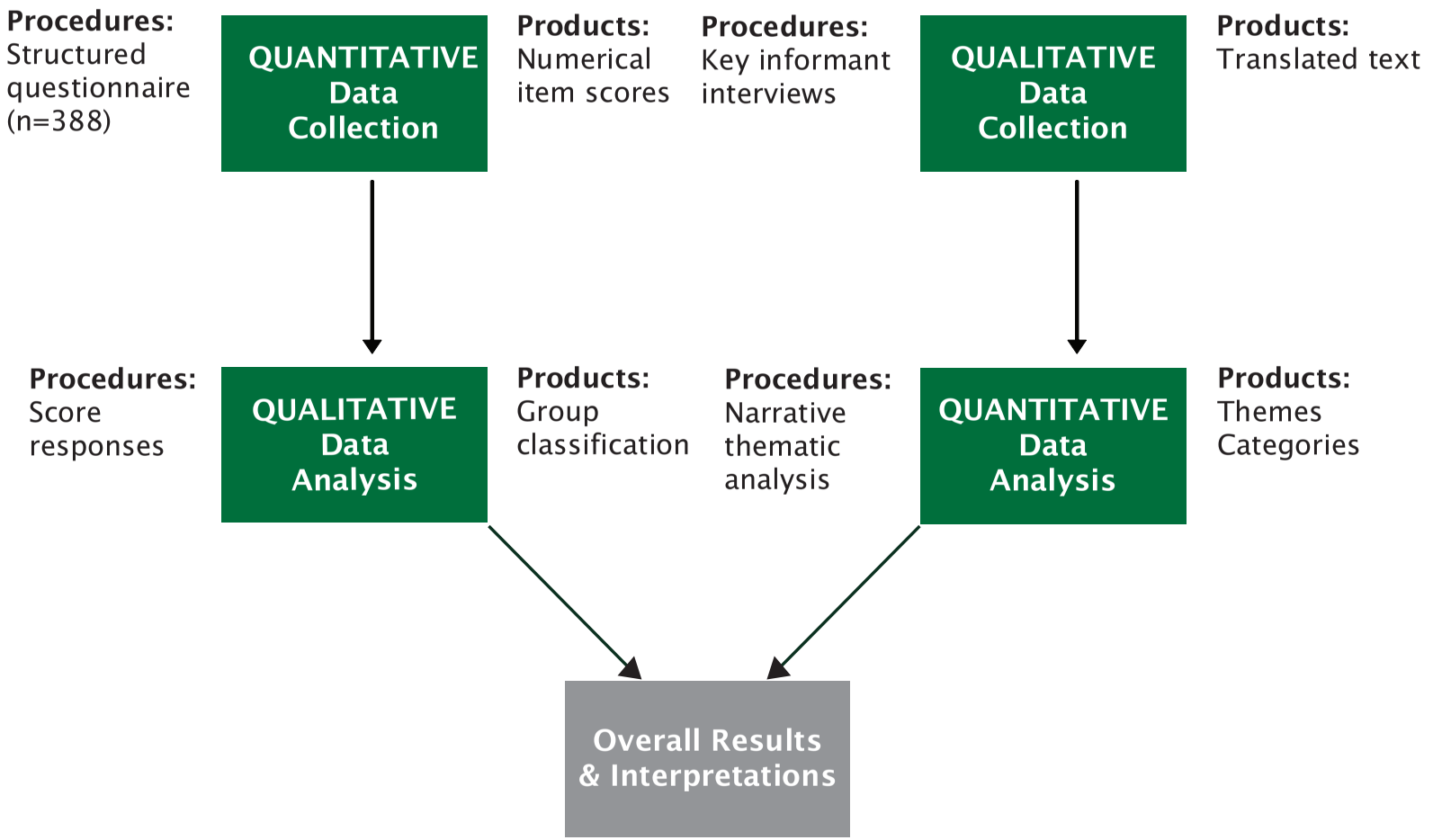
Table 1: Characteristics of the Study Sites and Study Partner Agencies

Item	Manipur	Mizoram	Nagaland
Name of the agency that implemented the study	Nirvana Foundation	Society for Community Care	Bethesda Youth Welfare Centre
Number of IDU TIs implemented by the agency in the state	1	1	4
Nature of the study site	Rural (Khundrakpam Constituency)	Urban (Aizawl City)	Urban and Rural (Areas: Duncan Basti; Nagaland Gate; Chumukedima; & Bhandari/Sanis)
Estimated total number of IDUs in the project area(s)	1,158	500	3,000
Current number of IDUs reached out or registered in the project area(s)	1,023	348	2,362
Estimated number of female IDUs (including those in sex work) in the project area(s)	350	30	100
Availability of OST in the study city/town	Yes (Not by the study implementing agency)	Yes	Yes

Table 2: Key Features of the Study States

Item	Manipur	Mizoram	Nagaland
Population size[10]	23.8 lakh	891,058	19.9 lakh
Main languages	Meteilon/Manipuri	Mizo	Nagamese
HIV prevalence among general population[11]	1.39%	0.94%	1.36%
HIV prevalence among IDUs[12]	19.8%	3.05%	2.39%
Estimated IDU population[13]	10,324	15,200	*16,398
Estimated number of female IDUs	Not known	700 to 800	200
Number of TIs for IDUs	42	34	33
Number of agencies that implement TIs for IDUs	41	31	22 plus
Estimated number of people on OST	920 + 100 (through MACS and Project ORCHID)	280	380
Number of IDUs (current/former) on ART	Data not available	Data not available	Data not available

Diagram 1: Visual Diagram of the Procedure in this Mixed Methods Study



(Based on the suggestions for visual presentation of the mixed methods study in the book Creswell JW & Plano Clark VL. *Designing and Conducting mixed methods research*. Sage publications. 2007.)

Table 3: Sampling Details of Key Informant Interviews

Category of the key informant	Manipur	Mizoram	Nagaland
SACS official	1	1	1
Project manager of an NGO implementing TI for IDUs	1	1	-
Project manager of an NGO providing OST	1	1	-
Head of an NGO that provides services to female IDUs (including those who sell sex)	1	1	1
PLHIV network leader	1	1	-
Health care provider who treats IDUs and IDUs living with HIV	1	1	1
Outreach worker of an NGO implementing TI for IDUs	1	1	1
Peer educator of an NGO providing OST	1	1	1
Total = 21 key informants	**8**	**8**	**5**

If a home visit was made, prior permission to visit was first obtained through the agency staff and then by calling the participant. Survey questionnaires were administered by the interviewers.

B. Qualitative component
(Key informant interviews)

Key informant interviews (n=21) were conducted to get stakeholder perspectives about the barriers to accessing services for IDUs and to document their suggestions on best practices, if any, to overcome the barriers. In the key informant interviews, a semi-structured interview guide was used. The categories of the key informants are given in Table 3.

C. Review of documents

Relevant key documents were reviewed and analysed. Government documents and web-sites that provide background information related to IDUs in the northeast; published studies and reports (technical and evaluation reports) on barriers to accessing services for IDUs; and reports that documented best practices in relation to services for IDUs and their sex partners. The inferences from the review were integrated into the introduction and discussion sections of this report.

2.5 Data Analysis

Analyses of quantitative and qualitative data were conducted separately (as explained) and later compared and contrasted. The following questions were examined when comparing the quantitative and qualitative findings: To what extent do the quantitative and qualitative data converge? How and why? To what extent do the themes identified in the qualitative approach support the survey results? What similarities and differences exist across the levels of analysis? (Creswell, 2007). In the individual discussion sections on quantitative and qualitative findings, similarities and differences, if any, between quantitative and qualitative findings were presented.

Quantitative data analysis
(Measurement and ranking of barriers)

Data were analysed using SPSS-17 for Windows. For relevant survey items, descriptive statistics such as frequencies, percents, mean, standard deviation and range were computed.

Items modified from standard questionnaires that had been used to assess perceived barriers were used. The types of barriers listed in the questions were primarily based on the previous qualitative studies[14] that assessed barriers to

accessing various services (ART, HIV testing, TB, NSP, OST, etc.) for IDUs in Chennai and Manipur. The participants' perceived barriers leading to difficulty with, delay in or lack of receipt of services were assessed. Some of the barriers that were assessed included those related to money and finances, transportation and distance, time constraints, provider and institutional constraints, alliance and rapport with service providers and staff, and individual factors.

For each of the services, the participant was asked: "For you, what are the top three barriers in getting access to [service]?" The barriers were listed below those questions. The list of potential barriers was read out and the participant then chose from that list and ranked the first, second and third barrier. There was also an option of naming any other barrier that was not listed (i.e., open-ended).

The common barriers that were listed for ranking the top three barriers included: Don't know where to get services; need to travel a long distance to the agency that supplies clean needles and syringes; services cost too much for one to afford; somebody might find out about one's drug use behaviour if one goes there; somebody might find out about one's HIV status if one goes there; one would have to wait too long to get services; fear of being harassed or arrested by police; no outreach workers to deliver needle and syringes at the areas where IDUs frequently inject; one has to take care of other people at home; one doesn't know what to do with children when one visits the DIC. The top three barriers were compared between males and females for each of the services using frequency of people choosing the barriers.

Qualitative data analysis

Detailed notes were taken during the key informant interviews (KIIs), including writing important quotes in verbatim. And these notes were expanded soon after the KIIs were completed. The themes and patterns identified from the KIIs were subsequently summarized.

Key informant interview data were explored using framework analysis (Ritchie & Spencer, 1994)[15] to identify categories and derive themes. In accordance with framework analysis, we developed a hierarchical thematic framework and used the framework to classify and organize data according to key themes, concepts and emergent categories. Framework analysis is particularly appropriate for applied qualitative research when a study is oriented towards policy outcomes (Green, 2005)[16]. An adapted version of Aday and Andersen's[17] (1974) framework of access to health services was used for analysis.

2.6 Inference Quality ('Validity') and Inference Transferability ('Generalizability')

Quantitative component

Limitations of the study restrict generalizability of results. First, our measures of service access and use were based on self-report. Sampling bias is possible since a significant proportion of participants were self-selected into the study. Validity and accuracy of self-report must also be considered. Second, we assumed participants answered honestly. Nevertheless, persons may over- or under-report certain perceptual information (Polit & Beck, 2004)[18]. Third, the data is cross-sectional. Thus, we were unable to establish causal inferences from this analysis.

Qualitative component

'Member checking' was conducted with key informants to increase credibility of the findings (Lincoln & Guba, 1985)[19]. 'Peer debriefing' (Lincoln & Guba, 1985) was undertaken with IDU community leaders and health-care researchers to increase trustworthiness of the findings. The findings correspond to the emergent categories/themes; all quotations are drawn from the interviews and focus groups.

3

KEY FINDINGS

3.1 Socio-demographic Characteristics of Survey Participants

(See Table 4)

A total of 388 people (Men: 300; Women: 88) participated in the survey. The age range was between 18 and 55 years (Mean: 30.23; Median: 29.00). Of the people surveyed, 233 were current IDUs accessing services from agencies that implement needle syringe programs; 81 were on OST at the time of recruitment; and 74 were current injecting drug users who had not been enrolled in any targeted intervention (NSP or OST).

Men (n=300)

The age range was from 19 to 55 years (mean=30.29). More than one-third (37%; n=112/300) had completed 11th grade. About half (53%; n=157/300) were unemployed. Among those who were employed (48%; n=143/300), 40% had a monthly income of less than INR 2,000 and one-third (33%) had a monthly income between INR 2,000 and 5,000. Almost half (48%; n=145/300) were unmarried and one-third (36%; n=107/300) were currently married.

Of the 229 participants who reported being tested for HIV, 19% (n=43/229) reported having tested positive. Self-reported HIV-positive cases were high among current IDUs on NSP and those who are currently on OST (51%; n=22/43 and 47%; n=20/43 respectively).

Women (n=88)

The age range was from 18 to 49 years (mean=30.05). Only one-fifth (20%; n=18/88) had completed 11th grade. One-third (35%; n=31/88) reported sex work as their main occupation. Forty-one percent (n=36/88) of the participants were either separated or divorced and 24% (n=21/88) were currently married.

Of the 70 participants who reported being tested for HIV, 51% (n=36/70) reported being HIV positive. Within the subgroups, self-reported HIV-positive cases were more than two times higher among women (51%) than among men (19%). About half (n=16/36) of the women who reported being HIV-positive also reported sex work as their main occupation.

Table 4: Socio-demographic Characteristics of Survey Participants

Characteristics	Overall sample (n=388)				Manipur				Nagaland				Mizoram			
	Men		Women		Men		Women		Men		Women		Men		Women	
	n (300)	%	n (88)	%	n (104)	%	n (25)	%	n (93)	%	n (37)	%	n (103)	%	n (26)	%
CATEGORY																
IDUs on NSP (NSP clients)	173	58	60	68	55	53	20	80	49	53	26	70	69	67	14	54
People on OST (OST clients)	64	21	17	19	25	24	5	20	20	22	3	8	19	18	9	35
IDUs not directly getting syringes/ needles from NGOs	63	21	11	13	24	23			24	26	8	22	15	15	3	11
AGE (YEARS)																
18 – 22	38	13	12	14	4	4			4	4	4	11	30	29	8	31
23 – 27	65	22	18	21	16	15	2	8	15	16	10	27	34	33	6	23
28 – 32	101	34	30	34	24	23	5	20	55	59	15	41	22	21	10	39
33 & above	96	32	28	31	60	58	18	72	19	20	8	22	17	17	2	8
Mean	**30.29**		**30.05**		**33.5**		**36.08**		**30.17**		**28.57**		**27.12**		**26.35**	
Range	**19-55**		**18-49**		**21-48**		**27-49**		**19-45**		**19-38**		**19-55**		**18-43**	
GENDER																
Man	300	100			104	100			93	100			103	100		
Woman			88	100			25	100			37	100			26	100
EDUCATION																
Illiterate	12	4	5	6	1	1	4	16	11	12	1	2				
No formal education but can read/write	4	1	7	8	2	2	5	20					2	2	2	8
1st to 5th grade	44	15	25	28	6	6	4	16	21	23	14	38	17	17	7	27
6th to 10th grade	124	41	33	38	40	39	5	20	42	45	16	43	42	41	12	46
11th & 12th grade	76	25	12	14	33	32	2	8	15	16	5	14	28	27	5	19

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Characteristics	Overall sample (n=388)				Manipur				Nagaland				Mizoram			
	Men		Women		Men		Women		Men		Women		Men		Women	
	n (300)	%	n (88)	%	n (104)	%	n (25)	%	n (93)	%	n (37)	%	n (103)	%	n (26)	%
Completed under-graduate course	28	9	3	3	17	16	2	8	3	3	1	2	8	8		
Completed post-graduate course	8	3	3	3	5	5	3	12	1	1			2	2		
Completed diploma	1	0.3											1	1		
No response	3	1											3	3		
EMPLOYMENT																
Unemployed	157	52	33	38	44	42	7	28	34	37	3	8	79	77	23	89
Student	4	1	1	1	1	1			1	1	1	3	2	2		
Daily-wage labourer	45	15	2	2	17	16			23	25	2	5	5	5		
Government staff	8	3	1	1.1	2	2			4	4	1	3	2	2		
Private company staff	12	4	3	3	2	2			3	3	3	8	7	7		
Voluntary organization staff	19	6	7	8	7	7	3	12	11	12	2	5	1	1	2	8
Sex work	2	0.7	31	35			14	56	2	2	17	46				
Self-employed	51	17	10	11	31	30	1	4	13	14	8	22	7	7	1	4
Other	2	0.7							2	2						
MONTHLY HOUSE-HOLD INCOME (INR)	**n= 143**		**n= 55**		**n= 60**		**n= 18**		**n= 59**		**n= 34**		**n= 24**		**n= 3**	
< 2000	57	40	13	24	25	42	6	33	30	51	5	15	2	8	2	67
2001- 5000	47	33	29	52	22	37	6	33	17	29	22	65	8	33	1	33
5001 – 10000	20	14	7	13	10	17	3	17	5	8	4	12	5	21		
10001 & above	3	2	2	4	1	2	2	11					2	8		
Don't want to share	3	2							3	5						
No response	13	9	4	7	2	3	1	6	4	7	3	9				

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Characteristics	Overall sample (n=388)				Manipur				Nagaland				Mizoram			
	Men		Women		Men		Women		Men		Women		Men		Women	
	n (300)	%	n (88)	%	n (104)	%	n (25)	%	n (93)	%	n (37)	%	n (103)	%	n (26)	%
MARITAL STATUS																
Never married	145	48	22	25	53	51	6	24	39	42	11	30	53	52	5	19
Currently married	107	36	21	24	42	40	5	20	44	47	8	22	21	20	8	31
Separated/Divorced	47	16	36	41	8	8	6	24	10	11	18	49	29	28	12	46
Widowed	1	0.3	9	10	1	1	8	32							1	4
ALCOHOL USE																
None	137	46	29	33	66	64	7	28	29	31	7	19	42	41	15	58
Current use (past month)	163	54	59	67	38	37	18	72	64	69	30	81	61	59	11	42
DRUG USE																
Non-injectable drugs																
None	85	28	33	38	45	43	21	84	18	19	4	11	22	21	8	31
Last 3 months	215	72	55	63	59	57	4	16	75	81	33	89	81	79	18	69
Injectable drugs																
None	58	19	13	15	25	24	5	20	18	19	2	5	15	15	6	23
Last 3 months	242	81	75	85	79	76	20	80	75	81	35	95	88	85	20	77
HIV STATUS	**n= 229**		**n= 70**		**n= 77**		**n= 25**		**n= 69**		**n= 23**		**n= 83**		**n= 22**	
Do not know the result/No response	24	10	6	9	13	17	5	20	9	13			2	2	1	5
Negative	162	71	28	40	36	35	4	16	53	77	14	61	73	88	10	45
Positive	43	19	36	51	28	27	16	64	7	10	9	39	8	10	11	50

3.2 Injectable and Non-injectable Drug Use and Alcohol use

Injectable drug use

More than four-fifth of the participants (men=81%; n=243/300 and women=85%; n=75/88) reported injecting drugs in the past three months. Heroin and Spasmoproxyvon were the commonly used injectable drugs among both men and women (61% and 61%; 28% and 23% respectively).

Non-injectable drug use

Compared with women (63%; n=55/88), a higher proportion of men (72%; n=215/300) reported using non-injectable drugs in the past three months. Among men, Spasmoproxyvon (Dextropropoxyphene), Nitrosun (Nitrazepam), Hasish/Ganja and Cocaine (40%, 36%, 29% and 7% respectively) were the most commonly used non-injectable drugs. Among women, they were Spasmoproxyvon, Hasish/Ganja, Cocaine and Nitrosun (33%, 31%, 16% and 16% respectively).

Alcohol use

Alcohol use in the past month was reported higher among women (67%; n=59/88) than among men (54%; n=163/300). Forty-two percent (n=25/59) of women consumed alcohol daily. Among those women who consumed alcohol daily, 60% (n=15/25) reported sex work as main occupation. Only a small proportion of men (19%; n=31/163) reported consuming alcohol daily.

3.3 Needle and Syringe Program

Current users who are enrolled in NSP

A total of 233 participants (men=173; women=60) were recruited under the category of people who are currently on NSP.

Sources of information about NSP

NGO outreach workers, drug-using partners and friends were the three major sources of information about NSP (43%, 30% and 25% respectively). Minor differences were noted in the major sources of information for men and women. For men, NGO outreach workers and drug-using partners (36% and 35% respectively) were the two major sources; whereas for women, they were NGO outreach workers and friends (62% and 15% respectively).

Travel distance and travel costs

About one-third (30%; n=71/233) reported travelling more than 3 km each time they visited the agency that provided needles/syringes. Among those who travelled more than 3 km, 66% (n=47/71) visited the agency thrice a week. And among those who reported visiting the agency daily, 13% (n=8/62) reported spending more than INR 50 each time they visited the agency. (*Note:* People who reported visiting the agency might have visited for getting services besides needles/syringes.)

Charge for needles/syringes

All the participants reported receiving needles/syringes free-of-charge because they were enrolled in the targeted intervention projects supported by SACS/NACO.

Number and types of syringes provided through NSP

One-third of the participants reported receiving as many needles/syringes as they needed both from the NGO outreach workers (35%; n=81/233) and DICs (36%; n=83/233). Among the 233 participants who were currently on NSP, 52% (n=120/233) used 1 ml syringe to inject drugs, 36% (n=84/233) used 2 ml syringe and 12% (n=29/233) used both 1 ml and 2 ml syringes.

Of 233 participants who were on NSP and who reported injecting drugs in the past three months, 63% (n=146) injected Heroin, 25% (n=59) injected Spasmoproxyvon and four participants injected both Heroin and Spasmoproxyvon. Among the Heroin users, 117 (80%) used only 1ml syringes, 10% used either 2ml or both 1ml and 2ml syringes. Among those who reported injecting Spasmoproxyvon, 81% (n=48) used only 2ml syringe and 17% (n=10) used both 1ml and 2ml syringes.

Other services available in the agencies that implement NSP

A range of other services were reported to be offered by the agencies that implement NSP. The percentages of the participants who reported the availability of other services and the respective services are given below:

- Drop-in centre (73%)
- Information about safer sex and safer injection drug use (82%)
- Free condoms (79%)
- Information about STI/HIV screening and treatment (85%)
- Information about OST (58%)
- Information about drug de-addiction (57%)
- Information about HBV/HCV (45%)
- Information about TB (50%)
- Information about ART (43%)

Referral services

When asked about referral services, a majority of the participants (83%; n=193/233) reported having been referred to government hospitals for STI/HIV testing and treatment; one-third (34%) had been referred for TB testing and treatment. Referrals to other services such as alcohol de-addiction, ART, OST and drug de-addiction were relatively low (3%, 10%, 21% and 24% respectively).

Drug-using pattern

About half (52%; n=121/233) of the participants reported injecting drugs daily in the past month; 24% injected (n=56/233) a few days a week; 19% (43/233) injected most days of the week and less than five percent injected drugs either once a week or a few days a month (4% and 1% respectively). About two-third (65%; n=151/233) used the same needle/syringe to inject drugs more than once and 15% (n=34/233) reported sharing needles/syringes. About one-fifth (18%) mentioned that they could not get needles/syringes whenever they needed one.

Among the 126 participants (n=126/233) who reported that they could not get as many needles as needed (from NGO outreach worker and NGO run drop-in centre), a relatively higher proportion (75%; n=95/126) reported reusing needles/syringes more than once. Even among those who could get needles/syringes as much as needed, more than half (52%; n=56/107) reported reusing needles/syringes more than once. However, no significant difference was found in needle sharing between those who reported getting as many needles as needed and those who did not. Only 15% in each of these two categories (n=19/126 and n=15/107 respectively) reported sharing of needles/syringes with others.

Of the 121 participants (n=121/233) who injected drugs daily, 59% (n=71/121) reported that they could not get as many needles/syringes as needed. Similarly, among those participants (n=71/233) who travelled more than 3km for procuring needles/syringes, a higher proportion (62%; n=44/71) reported reusing needles/syringes.

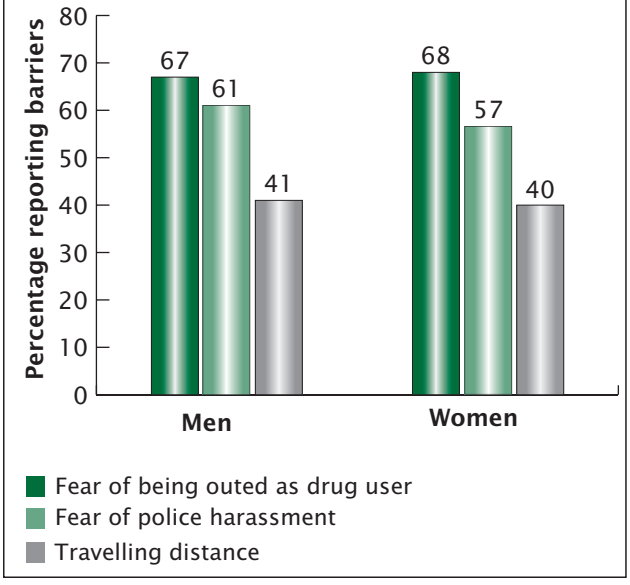
Almost equal proportion of women (57%; n=34/60) and men (50%; n=87/173) reported injecting drugs daily. Similarly, almost equal proportion of men and women (66% and 62% respectively) reported injecting drugs with

the same needle/syringe more than once. Women (22%; n=13/60) reported sharing of needles two times higher than the men (12%; n=21/173). Similarly, compared with men (15%; n=26/173), a higher proportion of women (28%; n=17/60) reported that they could not get needles/syringes whenever they needed one.

Top three reported barriers
(See Table 5)

All the participants currently on needles/ syringes program responded to the question that asked them to rank the top three barriers in accessing free needles/syringes. Fear of his/her drug use behaviour being disclosed by others (67%; n=157), fear of being arrested by police (60%; n=140), and travelling distance (41%; n=95) were reported as the top three barriers. Men and women did not differ much in their rankings (*See Diagram 2*).

Diagram 2. Top three reported barriers for accessing needles/syringes
(Overall sample of current IDUs)



Current drug users who are not formally accessing NSP
(i.e., are not registered with an NGO that implements NSP)

A total of 74 participants (n=63 men; n=11 women) were recruited under the category of people who were current injecting drug users but not on NSP.

A little more than one-third (41%; n=30/74) reported injecting drugs daily in the past month. Three-fourth (73%; n=54) reported using the same needle/syringe more than once. Fifteen percent (n=11) shared needles with others. About one-third (34%; n=25) reported that they were not able to get needle/ syringe whenever they needed one.

Top three reported barriers

All the participants responded to the question that was intended to find out the top three barriers in accessing NSP services. Fear of drug use behaviour being disclosed by others (45%; n=33), travelling distance (39%; n=29), and fear of being arrested by police (31%; n=23) were reported as the top three barriers.

Men and women differed in their ranking of barriers. Men ranked fear of their drug use behaviour being disclosed by others (43%; n=27/63), travelling distance (41%; n=26), and fear of being harassed by police (29%; n=18) as the top three barriers, whereas women ranked fear of their drug use behaviour being disclosed by others and lack of knowledge about where to get clean needles/syringes (55%; n=6/11), fear of being harassed by police (46%; n=5) and travelling distance (27%; n=3) as the top three barriers.

3.4 Opioid Substitution Treatment

A total of 81 people (n=64 men; n=17 women) were recruited under the category of people who are currently on OST. Among the current

Table 5: Top Three Reported Barriers for Key Services for IDUs

Service		N	Don't know where to get services	Travelling distance	Services cost too much to afford	Somebody might find your drug/alcohol use if you go there	Somebody might find out your HIV status if you go there	Long waiting time to get access to services	Can't stay as an inpatient for long duration	Fear of being harassed or arrested by police	No outreach workers to deliver needles/syringes at the areas where you inject	Need to take care of other people at home	Don't know where to leave your children
NSP	Overall	233	6% (n=15)	41% (n=95)	5% (n=11)	67% (n=157)	15% (n=35)	5% (n=12)		60% (n=140)	9% (n=21)	12% (n=28)	9% (n=21)
	Men	173	5% (n=9)	41% (n=71)	5% (n=9)	67% (n=116)	11% (n=19)	6% (n=10)		61% (n=106)	9% (n=15)	12% (n=21)	7% (n=12)
	Women	60	10% (n=6)	40% (n=24)	3% (n=2)	68% (n=41)	27% (n=16)	3% (n=2)		57% (n=34)	10% (n=6)	12% (n=7)	15% (n=9)
OST	Overall	388		31% (n=122)	4% (n=15)	31% (n=122)	6% (n=23)	12% (n=48)		15% (n=58)		13% (n=51)	5% (n=21)
	Men	388		33% (n=98)	4% (n=13)	32% (n=95)	5% (n=14)	11% (n=34)		15% (n=44)		13% (n=39)	4% (n=13)
	Women	88		27% (n=24)	2.3% (n=2)	31% (n=27)	10% (n=9)	16% (n=14)		16% (n=14)		14% (n=12)	9% (n=8)
Drug De-addiction	Overall	388		36% (n=140)	52% (n=202)	33% (n=126)	8% (n=31)		46% (n=180)	8% (n=30)		25% (n=96)	9% (n=34)
	Men	300		39% (n=118)	53% (n=159)	30% (n=91)	4% (n=12)		47% (n=142)	7% (n=20)		25% (n=74)	6% (n=19)
	Women	88		25% (n=22)	49% (n=43)	40% (n=35)	22% (n=19)		43% (n=38)	11% (n=10)		25% (n=22)	17% (n=15)
Alcohol De-addiction	Overall	22		32% (n=7)	32% (n=7)	27% (n=6)	18% (n=4)		46% (n=10)	5% (n=1)		9% (n=2)	18% (n=4)
	Men	15		20% (n=3)	27% (n=4)	33% (n=5)	20% (n=3)		40% (n=6)	7% (n=1)			20% (n=3)
	Women	7		57% (n=4)	43% (n=3)	14i% (n=1)	14% (n=1)		57% (n=4)			29% (n=2)	14% (n=1)

Topmost barrier Second barrier Third barrier

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Service		N	Don't know where to get services	Travelling distance	Services cost too much to afford	Somebody might find your drug/alcohol use if you go there	Somebody might find out your HIV status if you go there	Long waiting time to get access to services	Can't stay as an inpatient for long duration	Fear of being harassed or arrested by police	No outreach workers to deliver needles/syringes at the areas where you inject	Need to take care of other people at home	Don't know where to leave your children
ART	Overall	19		79% (n=15)	42% (n=8)	16% (n=3)	26% (n=5)		16% (n=3)	5% (n=1)		53% (n=10)	11% (n=2)
	Men	10		80% (n=8)	20% (n=2)	20% (n=2)	50% (n=5)		30% (n=3)	10% (n=1)		40% (n=4)	20% (n=2)
	Women	9		78% (n=7)	67% (n=6)	11% (n=1)						67% (n=6)	
TB Treatment	Overall	13		62% (n=8)	15% (n=2)	15% (n=2)	15% (n=2)		39% (n=5)	15% (n=2)		8% (n=1)	23% (n=3)
	Men	10		50% (n=5)	10% (n=1)	20% (n=2)	10% (n=1)		30% (n=3)	10% (n=1)		10% (n=1)	20% (n=2)
	Women	3		100% (n=3)	33% (n=1)		33% (n=1)		67% (n=2)	33% (n=1)			33% (n=1)

Topmost barrier Second barrier Third barrier

IDUs, 58% (n=177/307) reported having heard about OST, including 61% (n=141/233) of IDUs on NSP and 49% (n=36/74) of those not on NSP.

Sources of information about OST

Friends, NGO outreach workers and drug-using partners were the three major sources of information about OST services (41%, 26% and 20% respectively). Men and women differed in relation to the major source of information about OST. For men, friends and NGO outreach workers (48% and 20% respectively) were the two major sources; whereas for women, they were NGO outreach workers and drug-using partners (47% and 29% respectively).

Travel distance and travel expenses

Forty-one percent of the participants (n=33/81) travelled more than 5 km each time they visited the agency that provided OST services. Among those who travelled more than 5 km, almost all (n=32/33) visited the agency daily. And among those who reported visiting the agency daily, 19% (n=15/79) reported spending more than INR 50 each time.

Charge for OST service

All the participants accessing OST services reported that the services were provided to them free of charge because they are supported by the SACS/NACO.

Other services available in the agencies that offer OST

A range of other services were reported to be offered by the agencies that provide OST. The percentage of the participants who reported the availability of other services and the respective services are given below:

- Drop-in centre (74%)
- Information about safer sex and safer injection drug use (85%)
- Free condoms (88%)
- Information about STI/HIV screening and treatment (78%)
- Information about drug de-addiction/ rehabilitation/treatment (64%)
- Information about HBV/HCV (61%)
- Information about TB (59%)
- Information about ART (52%)

Adherence to OST

Compared with women (18%; n=3/17), a higher proportion of men (33%; n=21/64) reported having missed OST doses in the past month.

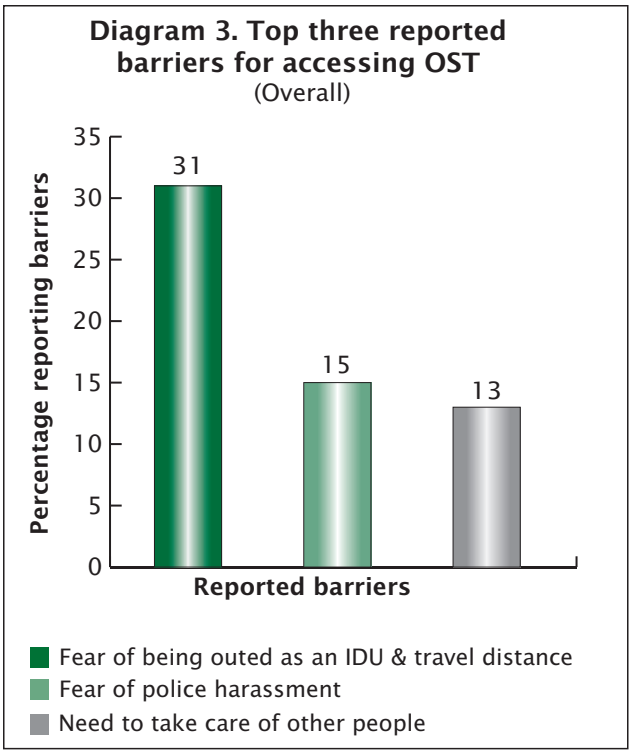
Referral services

When asked about referral services, a majority of the participants (74%; n=60/81) reported having been referred to government hospitals for STI/HIV testing and treatment; while one-third (35%) were referred for TB and HBV/HCV testing and treatment. Other than these, referrals to other services such as alcohol de-addiction, ART and drug de-addiction were very low (3%, 6% and 12% respectively).

Top three reported barriers

All the participants responded to the question that was intended to find out the top three barriers in accessing OST services. Fear of drug use behaviour being disclosed by others and travelling distance (31%; n=122) followed by fear of being arrested by police (15%; n=58) and the need to take care of other people at home (13%; n=51) were reported as the top three barriers. (*See* Diagram 3).

Men and women differed in their ranking of barriers. Men ranked travelling distance (33%; n=98/300), fear of being identified by others as a drug user (32%; n=95), and fear of being harassed by police (15%; n=44) as the top three barriers; whereas women ranked fear of being identified by others as a drug user (31%; n=27/88), travelling distance (27%; n=24) and



long waiting time to get the services, and fear of being harassed by police (16%; n=14) as the top three barriers.

3.5 Drug De-addiction Services

Forty-four percent (n=169/388; 133 men and 36 women) of the participants reported having ever been enrolled in a residential drug rehabilitation/de-addiction centre. Among those who had been enrolled, 66% (n=112/169) had been enrolled more than once.

Charge for drug rehabilitation/de-addiction centre services

More than half (58%; n=98/169) of the participants paid fully for the treatment. One-third (34%; n=58/169) mentioned that the treatment was provided free of cost.

Other services available in the agencies that provide residential drug rehabilitation/ de-addiction services

A range of other services were reported to be offered by the agencies that provide drug rehabilitation/de-addiction services. The percentages of the participants who reported the availability of other services and the respective services are given below:

- Information about HIV/STI screening and treatment (83%; n=142/169)
- Information about safer sex and safer injection drug use (80%; n=135/169)
- Free condoms (68%; n=114/169)
- Information about ART (66%; n=112/169)
- Information about TB (46%; n=77/169)
- Information about HBV/HCV (42%; n=71/169)

Referral services

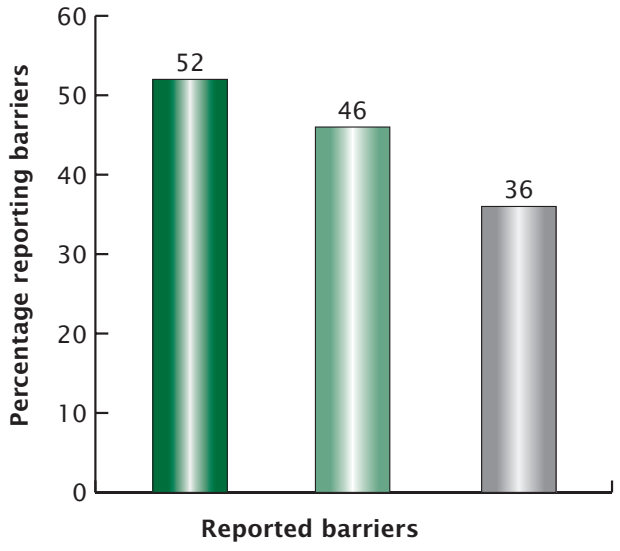
When asked about referral to other services, other than being referred to government hospitals for STI/HIV testing and treatment (45%; n=76/169), the participants informed that referrals to other services such as TB testing/ treatment (16%), HBV/HCV testing/treatment (12%) and ART (4%) were relatively low.

Top three reported barriers

All the participants responded to the question that asked them to rank the top three barriers in accessing drug rehabilitation/de-addiction services. Cost of the service (52%; n=202/388), not been able to stay as in-patient for a long time (46%; n=180/388), and travelling distance (36%; n=140/388) were the top three reported barriers (*See* Diagram 4).

Men and women differed in their ranking of barriers. For men, cost of the service (53%; n=159/300), duration of stay (47%; n=142/300), and travelling distance (39%; n=118/300) were the top three barriers; whereas women reported cost of the service (49%; n=43/88), duration of stay (43%; n=38/88) and fear of being identified by others as a drug user (40%; n=35/88) as the top three barriers.

Diagram 4. Top three reported barriers for accessing residential drug deaddiction treatment



3.6 Alcohol De-addiction Services

Only 6% of the total sample (n=22/388; 15 men and 7 women) had attended either outpatient or residential alcohol treatment service.

Charge for alcohol de-addiction centre services

Nearly two-third (68%; n=15/22) of the participants paid fully for the treatment.

Other services available in the agencies that offer alcohol de-addiction centre services

A range of other services were reported to be offered by the agencies that provide treatment for alcohol addiction. The percentages of the participants who reported the availability of other services and the respective services are given below:

- Information about HIV/STI screening and treatment (59%; n=13/22)
- Information about safer sex and safer injection drug use (55%; n=12/22)
- Free condoms (55%; n=12/22)
- Information about clean needles and syringes (41%; n=9/22)
- Information about OST (41%; n=9/22)
- Information about ART (32%; n=7/22)
- Information about HBV/HCV (27%; n=6/22)
- Information about TB (36%; n=8/22)

Referral services

When asked about referral services, nearly half of the participants (46%; n=10/22) reported having been referred to government hospitals for STI/HIV testing and treatment. Other than that, referrals to other services such as ART, TB testing/treatment and drug de-addiction were reported to be very low (9%, 18% and 23% respectively).

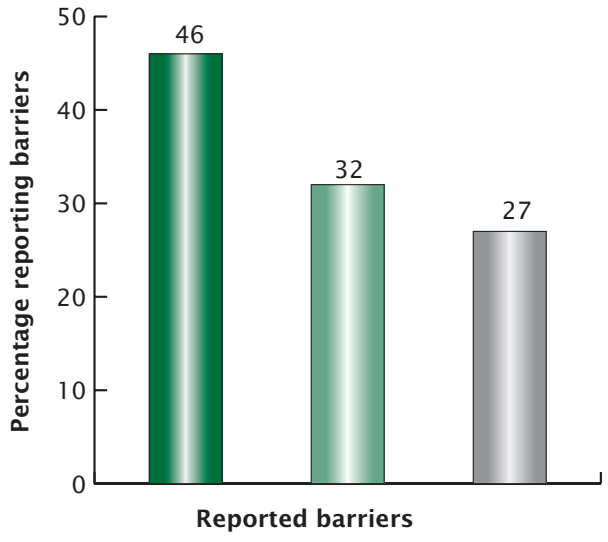
Top three reported barriers

All the participants responded to the question that asked them to rank the top three barriers in accessing alcohol de-addiction services. Duration of stay (46%; n=10/22), travelling distance and cost of service (32%; n=7/22) followed by fear of being identified by others as an alcohol user (27%; n=6/22) were reported as the top three barriers. Men and women differed in their ranking of barriers. For men, long duration of stay (40%; n=6/15), fear of being identified by others as an alcohol addict (33%; n=5/15) and cost of service (27%; n=4/15) were the top three barriers; whereas for women, duration of stay and travelling distance (57%; n=4/7) followed by cost of service (43%; n=3/7) and the need to take care of other people at home (29%; n=2/7) were the top three barriers (*See* Diagram 5).

3.7 Access to Services in Prison

One-third of the participants (36%; n=140/388) reported having been arrested/detained or held in the police custody in the past two years. One-fifth of the participants (20%; n=77/388;

Diagram 5. Top three reported barriers for accessing alcohol de-addiction treatment



58 men and 19 women) had been in prison in the past two years. Among those who had been in prisons, 43% (n=33/77) accessed HIV testing services within prison. Twenty-one percent (n=16/77) reported having accessed ART in prison. Less than 5% had access to OST, condoms and clean needles/syringes (4%, 4% and 1% respectively).

3.8 Condom Use with Female Sex Partners

Men

About half of the participants (51%; n=154/300) reported having had sex with a female partner in the past three months. Among those who reported having had sex with a female partner, 88% (n=135) had sex with a female regular partner and 30% (n=46/154) had sex with a female casual partner in the past three months.

Condom use

Frequency of condom use in the past three months was relatively low with female regular partner when compared with female casual partner. Nearly 50% (46%; n=62/135) never used condom for vaginal sex with their female regular partner; whereas with female casual partner, only 15% (n=7/46) never used condom for vaginal sex.

Among those who used condom, 19% (n=25/135) reported consistent condom use for vaginal sex with female regular partner and one-third (35%; n=16/46) reported consistent condom use with female casual partner. Similarly, when asked about condom use for vaginal sex with female partner the last time, a higher proportion of men (59%; n=79/135) hadn't used condom with female regular partner compared with female casual partner (41%; n=19/46).

Sex in exchange for money or drugs

Only a small proportion of men reported having had sex in exchange for money or drugs (8% and 11% respectively).

Source of condoms

NGOs, followed by shops and clinics/hospitals are the three places from where men obtained condoms (45%, 25% and 12% respectively). Among the 282 participants (n=282/300) who responded to whether condoms can be obtained whenever needed, 75% (n=212/282) answered in the affirmative.

Sex with males

None of the participants reported having had sex with men in the previous three months.

Women

Eighty-two percent (n=72/88) of the participants reported having had sex with a male partner in the previous three months. Among those who reported having had sex with a male partner, 74% (n=53/72) had sex with a male regular partner and 53% (n=47/88)

had sex with a male casual partner in the past three months.

Condom use

Frequency of condom use for vaginal sex in the past three months was low with male regular partner compared with male casual partner. Nearly twenty-five percent (23%; n=12/53) never used condom for vaginal sex with their male regular partner; whereas with male casual partner, only two out of 47 never used condoms. Among those who used condoms, about half (51%; n=24/47) reported consistent condom use for vaginal sex with male casual partners compared with male regular partners (19%; n=10/53).

Similarly, when asked about condom use for vaginal sex with a male partner the last time, a higher proportion of women (81%; n=38/47) had used condom for vaginal sex with male casual partners compared with male regular partners (45%; n=24/53).

Sex in exchange of money or drug

Compared with men, a relatively high proportion of women reported having had sex in exchange for money or drugs (65%; n=47/72 and 54%; n=39/72 respectively). About two-third (64%) of the participants who had sex in exchange for money or drugs reported sex work as their main occupation.

Source of condoms

NGOs and shops were the two places from where women obtained condoms (64% and 21% respectively). Three-fourth of the participants (76%; n=67/88) reported that they could obtain condoms whenever they needed one.

3.9 HIV

Knowledge About HIV/AIDS

A relatively high proportion of the participants had correct knowledge on the modes of HIV transmission and the ways of preventing it.

Modes of HIV transmission

- Unprotected vaginal sex (96%; n=371/388)
- Unprotected anal sex (80%; n=312/388)
- Unsterilized needles/syringes (97%; n=375/388)

Ways of preventing HIV

- Using condom during vaginal sex (92%; n=355/388)
- Using sterilized needles/syringes (93%; n=360/388)
- Using condom during anal sex (82%; n=317/388)
- Using blood (for transfusion) that has been tested for HIV (77%; n=297/388)

HIV Testing and HIV Status

More than three-fourth (77%; n=299/388; 229 men and 70 women) of the participants had ever been tested for HIV.

Place of HIV testing

Sixty-three percent (n=189/299) had undergone HIV testing at a government testing centre the last time and nearly one-third (29%; n=87/299) were tested through NGO clinic.

Counselling for HIV testing

More than three-fourth of the participants received both pre-and post-test HIV counselling (90% and 76% respectively) when they underwent HIV testing the last time. Eighty-six percent (n=258/299) of the participants had disclosed their drug using behaviour to counsellor or doctor the last time they underwent HIV testing.

HIV status

Among those who reported having ever been tested for HIV, 26% (n=79/299) tested positive for HIV. This included 43 men (54%; n=43/79) and 36 women (46%; n=36/79). Thus, a

higher proportion of men than women were HIV-positive. Among the 36 HIV-positive women, two-fifth (44%; n=16/36) reported sex work as their main occupation.

Antiretroviral Treatment

Among the 21 participants who reported having ever been on ART, 19 participants (10 men and 9 women) were currently on ART and all of them were taking first-line ARV drugs free of cost from the government-run ART centres.

Source of information

Almost all (n=16/19) of the participants currently on ART reported that they came to know about ART centres through NGOs.

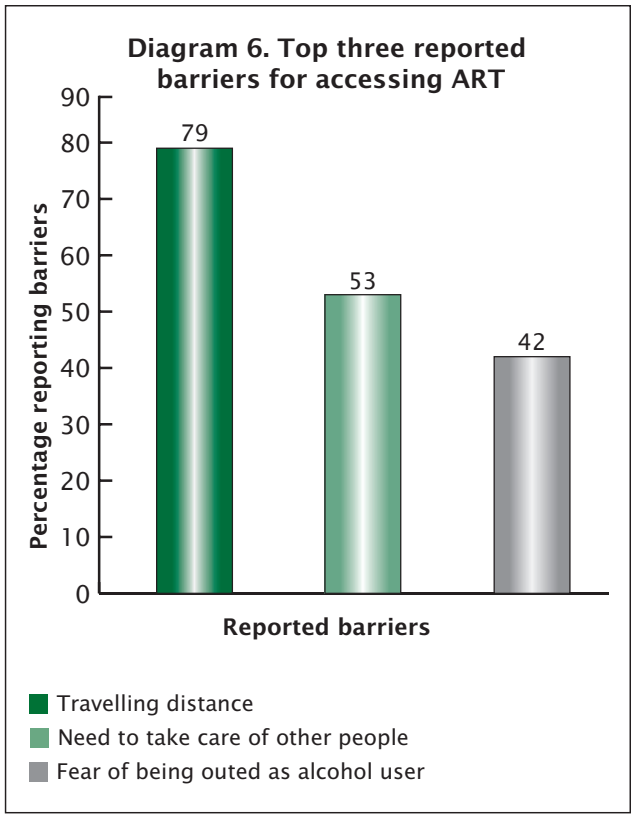
Travel distance and travel expenses

About half of the participants (53%; n=10/19) currently on ART reported having to travel more that 3 km each time they visited the ART centre. All the participants visited the ART centre once a month. Twenty-six percent (n=5/19) reported spending more than INR 40 each time they visited the centre.

Other services available in the government-run ART centres

Less than half of the participants currently on ART reported having access to the following services in government-run ART centres.

- Information about safer sex and safer injection drug use (47%; n=9)
- Information about STI screening and treatment (37%; n=7)
- Free condoms (37%; n=7)
- Information about OST (16%; n=3)
- Information about access to clean needles/ syringes (16%; n=3)
- Information about drug de-addiction/ rehabilitation and treatment (5.3%; n=1)



Top three reported barriers for ART

All the participants responded to the question that asked them to rank the top three barriers in accessing ART. Travelling distance (79%; n=15/19), need to take care of people at home (53%; n=10/19), and cost of the service (42%; n=8/19) were the top three reported barriers (See Diagram 6).

Men and women differed in their ranking of barriers. For men, travelling distance (n=8/10), fear of being identified by others as HIV-positive (n=5/10), and the need to take care of others at home (n=4/10) were the top three barriers; whereas for women, travelling distance (n=7/9), cost of service/need to take care of others at home (n=6/9), and fear of being identified by others as HIV-positive (n=1/9) were the top three barriers.

3.10 Diagnosis and Treatment of HBV and HCV

HBV testing

Only one-fourth (25%; n=97/388 - 58 men and 39 women) of the participants reported

having ever been tested for HBV. Among those who had been tested for HBV, one-fifth (21%; n=20/97; 12 men and 8 women) tested positive. Of the 20 participants who were tested positive for HBV, 11 (55%) were HIV-positive as well. Almost fifty percent (47%) were tested in the government hospitals and 41% were tested in private laboratories. Only 16% (n=11/69) of the participants who were tested negative for HBV had been vaccinated against HBV.And in the total sample, only 4% had been vaccinated against HBV.

Sources of information about HBV

The three major sources of information about HBV as reported by the participants were: NGOs that provide needles/syringes (43%; n=42/97), friends (16%; n=16/97) and NGOs that provide OST (15%; n=15/97).

HCV testing

Only 22% (n=87/388; 60 men and 27 women) reported having been ever tested for HCV. Among those who had been tested for HCV, 60% (n=52/87; 40 men and 12 women) tested positive. Of the 52 participants who were tested positive for HCV, 26 (50%) were HIV-positive as well. An equal proportion got tested in the government hospitals and private laboratories (46% and 44% respectively).

Sources of information about HCV

Similar to that for HBV, NGOs that provide needles/syringes (44%; n=38/87), friends (16%; n=14/87) and NGOs that provide OST (15%; n=13/87) were the three major sources of information about HCV.

HCV treatment

Among those who tested positive for HCV, 19 (37%; n=19/52) were asked by their doctors to initiate treatment for Hepatitis C. However, only 4 out 19 participants reported having been treated for Hepatitis C. Among the 15 who did not take treatment, nearly three-fourth (73%; n=11/15) stated that the treatment cost was too much for them to afford.

3.11 Diagnosis and Treatment for Tuberculosis

TB patients and treatment initiation

About one-fifth (22%; n=86/388) of the participants reported having been tested for TB in the past year. Among those who were tested for TB, only a small proportion (15%; n=13/86) were currently either taking TB treatment or were treated for TB in the past year. They (n=13) reported having taken TB treatment from government DOTS centres (n=7), other government hospitals (n=4) and NGO DOTS centres (n=2). NGO outreach workers (n=7/13) were reported to be the major source from where people with TB (n=7/13) got information about TB.

Travel distance and travel expenses

Nearly one-third of the participants with TB (n=4/13) reported having travelled to more than 5 km each time they visited TB treatment centres. About half of the participants (n=6/13) reported having spent between INR 50 and 3,000 each time they visited the treatment centre.

Other services available in the agencies that offer DOTS

A range of other services were reported to be offered by the agencies that provide DOTS, which include:

- Information about safer sex (n=5/13)
- Information about safer injection drug use (n=4/13)
- Information about sexually transmitted infections (n=4/13)
- Information about opioid substitution treatment (n=3/13)

- Information about drug de-addiction/ rehabilitation treatment (n=4/13)
- Referral for HIV/STI screening and treatment (n=6/13)
- Free condoms (n=3/13)

Thus, less than half of these former/ current injecting drug users with TB were provided with harm reduction information or necessary referral services (listed above) in TB treatment centres, which should have been ideally provided.

Top three reported barriers

All the participants responded to the question that asked them to rank the top three barriers in accessing TB services. Travelling distance (62%; n=8/13), could not stay as an in-patient for a long time (39%; n=5/13), and need to take care of children at home (23%; n=3/13) were reported as the top three barriers.

3.12 Diagnosis and Treatment for Sexually Transmitted Infections

Experience of STI-related symptoms

About 20% (n=77/388) reported having had an STI-related symptom in the past year; among these, 66% (n=51/77) experienced burning sensation while passing urine, 52% (n=40/77) had genital discharge and 16% (n=12/77) had genital sores.

Visit to treatment facility

Half (n=39/77) of the participants reported having visited a health care facility in the past year for treatment of their STI-related symptoms.

Place of treatment for STI-related symptoms

When asked about the place of STI treatment, voluntary organization clinic and private clinic followed by government hospitals (n=18, 14 and 8 respectively) were reported as the places that were accessed by participants who had STI-related symptoms in the past year.

Source of information

Only a small proportion (10%; n=39/388) visited any health care facility for STI-related symptoms in the past year. Among the participants who visited health care facility in the past year for any service, most opted for either an NGO clinic (46%; n=18/39) or private clinic (36%; n=14/39) while some used government hospitals (21%; n=8/39). Friends and NGOs that provide needles/syringes were reported as the major sources of information about STIs. About half of the participants (54%; n=21/39) who went to a health care facility got information from their friends and more than one-third (39%; n=15/39) got information from NGOs that provide needles/syringes.

Disclosure of STI symptoms to regular sex partners

Ten (3 men and 7 women) out of 39 participants had disclosed their STI symptoms to their regular sex partner; and five of their partners got treated for STIs.

3.13 Family Support

In general, family support (parents or spouse) to drug users or people on OST was quite low. Compared to women, a higher proportion of men received financial, emotional and both financial and emotional support from their families.

- Only financial support (14 men; 3 women)
- Only emotional support (78 men; 22 women)
- Both financial and emotional support (159 men; 17 women)
- No financial and emotional support (32 men; 29 women)

Box1: Barriers Faced by Female IDUs in Accessing Services

1. Discomfort among female IDUs in getting services from TIs 'serving male IDUs'

Targeted interventions serving IDUs are open for both males and females. However, key informants said that many female IDUs are not comfortable in using the DIC facility of IDU TIs because there are more male IDUs who use TI services than female IDUs.

> *"Many female IDUs also engage in sex work and most of them have no place to stay. They may want to change their dress or freshen up in the drop-in centre but they cannot do so because males are always present there."*
>
> *–NGO staff, IDU TI*

Most female IDUs also engage in sex work and hence mostly receive services from female sex worker TIs. However, female IDUs in sex work do come to the DIC of the IDU TI to pick up needles/syringes. They do so thrice weekly or once weekly, unlike many male IDUs who visit DICs much more frequently – some of the male IDUs visit the centres almost on a daily basis.

> *"It is like the chicken-and-egg story. Sometimes women become drug users and later get into sex work for survival and for getting money for drugs. Sometimes women who sell sex get into the habit of drugs. Therefore, both agencies implementing TI for sex workers and those who run TI for IDUs claim female IDUs to be their clients. It seems that there are more female IDUs in sex worker TIs. It could be so because these women are more comfortable with fellow women who come to those DICs. Often they use the DICs to wash their clothes and relax as many do not have a home."*
>
> *–SACS official*

2. Why female IDUs need a separate drop-in centre; Key informants' views

Many key informants stressed the need for separate DICs for female IDUs, regardless of whether they are enrolled in sex worker TI or in IDU TI.

No house

Female IDUs (whether they engage in sex work or not) often do not have a place to stay and their family members do not support them. Consequently, they rely on the place available in the DIC of sex worker TIs to clean themselves and wash their clothes.

contd...

As a key informant said,

"Female IDUs roam around and stay in abandoned places. They often use bathrooms in the FSW TI DICs and even wash their clothes there. They need to be provided at least some kind of temporary shelter."

–SACS official

Dynamics between female sex workers and female IDUs

Within the sex worker TI, a key informant reported that some female sex workers discriminate against female IDUs who engage in sex work.

"Sometimes we cannot call it 'discrimination'. Female IDUs sometimes steal from sex workers as they share the same DIC. Also, sometimes they borrow money from sex workers and do not return it. So it is natural that some sex workers don't like female IDUs."

–NGO Director, female sex worker TI

A SACS official said that she was told that female IDUs "dominate" the DICs, possibly because most of them do not have their own house; and hence, female sex workers sometimes do not want to visit the DIC when female IDUs are around.

To avoid possible negative peer influence

A key informant strongly felt that some female sex workers are influenced by female IDUs to get into injecting drug use. She opined that different timings for female IDUs and FSWs (who are not drug users) to use the drop-in centre in the sex worker TI may not be a good idea.

3. Lack of dedicated staff for female IDUs (in TIs for sex workers and IDUs)

Lack of female outreach staff and counsellor for female IDUs was noted as another barrier to serve female IDUs in IDU TIs. In sex worker TIs, the counsellor's lack of adequate knowledge about drug dependency issues of IDUs was cited as a limitation in providing effective counselling to female IDUs who engage in sex work. The key informants stressed the need to create another counsellor's post in FSW TIs to deal with drug-dependency issues of FSWs.

Box 2: 'Reaching out' to Female Sex Partners (Spouses) of Male IDUs: Challenges and Opportunities

A key informant shared her thoughts about when to consider reaching out to spouses of male IDUs:

> *"Reaching out to the spouses of the male IDUs becomes important when the male IDU has HIV or STI. We want to make sure that the wife also gets screened and tested for HIV and STI. And if she tests positive or is found to have some infection, then she should be treated. Routinely reaching out to the spouses of all male IDUs may not be necessary or possible."*
>
> *–SACS official*

Key informants in all the three study states pointed out several challenges in reaching out to the spouses of male IDUs. A key informant pointed out the problems in directly reaching out to the spouses of male IDUs:

> *"We cannot compel the male IDUs to give the address of their spouses to us so that we can go and talk to them. Also, there are many male IDUs who are separated or divorced. Going to their spouses or ex-spouses and asking them to get tested for HIV may not be a good idea."*

A possible mechanism to screen spouses for HIV was suggested by a key informant:

> *"Most often HIV testing of male IDUs takes place in government-run ICTC. So if the counsellor knows that a particular male IDU has HIV, then they can ask him to bring his wife for HIV testing as well. The drug use status of the male IDU need not be revealed. Anyway, I think in most cases the family members know about the drug use of the person."*
>
> *–ART centre doctor*

Another possible way to link spouses of male IDUs with services was suggested by a key informant:

> *"We are thinking about the possibility of allocating separate timings for the male IDU and his wife to come to the drop-in centre. There they [female sex partners] can be counselled and the necessary information can be provided. They can be referred to other places such as ICTC [HIV testing] or STI clinic."*
>
> *–NGO staff*

contd...

However, another key informant thought that the above suggestion may not be feasible:

> *"The [male] IDUs will not agree [to bring their spouses] and their wives may not want to come. Many [IDUs] are not in a good [marital] relationship to be able to bring in their spouse to a drop-in centre of IDUs. They [male IDUs] themselves may not like that idea."*

Limited information is available on non-spouse female sex partners of male IDUs. The key informants agreed that male IDUs may have spouse, non-spouse female sex partners, casual partners and commercial partners. They thought that the focus can be primarily on spouse but agreed that more information is needed on whether and how to reach out to non-spouse female sex partners of male IDUs. Similarly, key informants noted the presence of non-spouse male sex partners of female IDUs who engage in sex work. Again, limited information is available on the various types of male sex partners of female IDUs and partner-specific risk behaviours, if any.

4

DISCUSSION

In this section, the top barriers for each of the key services for IDUs are summarized; barriers to service access for select populations (female IDUs, female sex partners of male IDUs and prisoners) are highlighted; and interconnections between structural barriers and individual level barriers are demonstrated. Recommendations for addressing some of the key barriers are noted in this section as well as separately summarized in the next section.

4.1 Top Barriers to Accessing and Using Key Services

Needles and Syringes

In spite of outreach workers reporting that they distribute adequate needles/syringes as per the needs of the clients, a significant proportion of IDUs (males and females) reported re-use and sharing of needles. Having a ceiling on the number of syringes per day (about four per day) that can be given to IDUs was cited as a reason for sharing. While one needs to be sensitive to the concern of project managers that providing more than adequate number of syringes may be "misused" (refers to selling 'excess' needles/syringes to others and use that money for buying drugs), that concern, should not prevent from providing adequate number of needles/syringes to high frequency injectors who genuinely require more than four syringes per day. Thus, there is a need to develop fool-proof mechanisms to ensure that adequate number of needles/syringes are available to all IDUs, especially high frequency injectors.

Fear of being identified by others as a drug user was the topmost barrier reported by IDUs who are currently not directly accessing needles/syringes from NGOs. As discussed later in this section, this points out the need to take steps to reduce both societal stigma and self-stigma to promote access to services for this group of IDUs.

Opioid Substitution Treatment

Absence of adequate number of 'slots' for OST means a lot of IDUs are registered for OST but are in the 'waiting list' (i.e., OST will be started once the 'slot' is available). Although well-intentioned, the stringent guideline that OST should be given only within the facility under supervision seems to cause practical difficulty, as people are required to travel to the centre on a daily basis and spend money on travel every day. Travelling distance and costs was one of the topmost three barriers listed by both males and females on OST. This could be the reason behind the high number of people (especially males) who reported missing doses of OST because they could not visit the OST centre on a daily basis. Women were reported to be embarrassed in visiting OST centres because of the presence of a predominantly male population; same reason also likely inhibits some women from getting enrolled in OST.

Drug de-addiction

Inability to afford the cost of the drug de-addiction treatment was reported as the topmost barrier by both men and women. Otherwise, some of them might have enrolled earlier or may want to enrol in the near future. The absence of adequate number of drug de-addiction centres that offer free and quality service is thus a key issue.

Two-fifth of the participants who are current IDUs and many people currently on OST had

been previously enrolled in drug de-addiction treatment services; some more than once. This indicates the high frequency of relapse among the IDUs;it may also mean that for some IDUs drug de-addiction treatment is not working. This raises the issue of what would be the appropriate referral pathway for people (who are current IDUs or on OST) who have previously used drug de-addiction service and for whom it is apparently ineffective.

Alcohol de-addiction

Both current injectors and people on OST reported using alcohol and non-injectable drugs. It could be because of lack of availability of Heroin or other injectable drugs, although sometimes alcohol and non-injectable drugs are used along with injecting drugs. Either way, alcohol and active drug use are likely to impede treatment adherence among current users; and hence there is a need to refer them to alcohol de-addiction treatment and OST or drug de-addiction treatment.

In the study sample, only a tiny proportion (about 1 in 20) had ever used an outpatient or residential alcohol de-addiction treatment facility even though about two-third reported currently consuming alcohol. Key informants reported that often alcohol use is not given much importance because alcohol use among drug users is taken for granted. However, given the combined negative effects of alcohol and Hepatitis C among drug users, it is prudent to focus on alcohol abuse prevention and refer them to alcohol de-addiction services. Alcohol de-addiction treatment referral should especially be a top priority for drug users with HCV and HIV and who are on ART because each of these three – alcohol, ART and HCV – can cause liver damage and jointly accelerate the damage. Outpatient treatment of alcohol dependency can be considered since both men and women reported long duration of stay as a top barrier in using alcohol de-addiction services. Alcohol de-addiction is usually available in the same centre that provides drug de-addiction treatment; hence, cost is a key barrier because most of these centres charge for their services.

Prevention and treatment of Hepatitis (HBV and HCV)

Until recently, HCV and HBV did not seem to be getting the attention of both drug users and health care providers. Over the last few years, however, the IDU groups have started to advocate for the need for treatment of HCV. High cost has been cited as the major reason by the Indian government for not taking any concrete steps to provide treatment for HCV, but it appears that many HIV-positive IDUs with HCV are dying of Hepatitis C rather than HIV. Thus, it is morally imperative for the government to provide free or affordable treatment for Hepatitis-C for needy people. Lack of diagnosis of HBV and HCV and late diagnosis are other issues. Even in the study sample, a significant proportion was not tested for HBV and HCV either because of lack of knowledge or because of the costs involved in getting tested for HBV/HCV; often the latter is the major reason. And even among a huge proportion of those who were tested negative for HBV, HBV vaccination had not been given. Steps need to be taken by the government to provide free HBV/HCV testing for all IDUs (former and current) and free HBV vaccination for HBV negative drug users.

4.2 Barriers to Access for Specific Populations

Female IDUs

A major issue seems to be at the program level. Traditionally sex worker TI and IDU TI are implemented separately, thus, female IDUs who engage in sex work are claimed to be the clients of both agencies implementing TI for sex workers and TI for IDUs. Ideally, if a female

sex worker needs needles/syringes she should able to get it from the centre where she is getting other services or commodities such as condoms, STI information and clinical services. However, because the TI projects are separate for FSWs and IDUs, female IDUs – a significant proportion of whom also engage in sex work – face difficulty in accessing services from two different places . Moreover, many female drug users find it difficult to access services at the drop-in centre of IDU TI because it is primarily occupied by males. Openly visiting a centre for drug users was another top barrier listed by female IDUs (including those in sex work) for fear of being identified by others as a drug user. Barriers to accessing drug and alcohol de-addiction services are similar to that of males, but other top barriers were the need to take care of children and others in the family.

Female sex partners of male IDUs

The survey findings showed that consistent use of condoms with regular partners of both male and female IDUs was about five times lower than among casual or commercial partners. Other studies in India have shown that some proportion of male IDUs do not want to disclose their HIV or STI status to their wives and may continue to engage in unprotected sex with them due to fear of rejection and discrimination.

Insights of the key informants and the available literature suggest that there could be both indirect and direct ways of 'reaching out' to female sex partners to prevent infections and link them with treatment services.

Indirectly reaching out to female sex partners can happen in two settings – in drop-in centres for IDUs and in government-run STI clinics and HIV testing centres. In the TI drop-in centres, individual counselling can be conducted with male IDUs (who have female sex partners) that might result in a tailored plan to have safer sex with their female partners (this may or may not involve disclosure of HIV status); and later asking them to refer their female sex partners for HIV/STI screening and treatment. Another possibility is asking male IDUs to bring their wives to the drop-in centres for male IDUs and then counselling their wives and providing referral services for HIV/STI screening and treatment. However, some IDUs do not seem to prefer bringing their wives to drop-in centres for IDUs, as these are predominantly occupied by male IDUs and often there is no female staff member. Another setting where female sex partners can be reached out indirectly is the government hospitals where male IDUs attend the HIV voluntary counselling and testing centres or STI clinics (often accompanied by the outreach staff). In these centres, male IDUs with female sex partners can be counselled about the need to screen their wives for HIV and STIs and the importance of early diagnosis and treatment of infections in their partners can be emphasized. This may also result in male IDUs bringing their spouses for HIV/STI screening and treatment.

Effective and sensitive ways of directly reaching out to the female sex partners of male IDUs are being discussed by the managers of IDU programs, and this year (2010) consultations have been held on this topic. Also, pilot projects to directly reach out to the female spouses of male IDUs (after obtaining the consent of male IDUs) through female outreach workers are being planned in select Northeast Indian states this year (2010). If the spouses of male IDUs are found to be HIV positive, they can be linked with the local networks of people living with HIV or agencies working with women, which can then follow-up with their treatment, care and support needs. Alternatively, if a female outreach worker is employed in the IDU TI, then she can also follow-up with the female sex partners of male IDUs to ensure that these women access and use health care services in a timely manner.

Limited information is available on non-spouse female sex partners of male IDUs and regular

and casual male partners of female IDUs who engage in sex work. Future studies need to explore these understudied areas.

Prisoners

Data demonstrated that virtually none of the participants who had been to prison in the past two years had access to either condoms or OST or free syringes/needles. This is despite the studies that have documented unprotected and forced sex and drug use within the prisons in Northeast India (like elsewhere India)[21]. Although access to ART was reported by some of the participants who had been to prison, other studies have shown that HIV-positive drug users face difficulties in getting ART within prisons[22]. Sexual abuse of women prisoners who are drug users have also been reported in some studies from India. All these point out the need to have a comprehensive harm reduction program for prisoners (men and women), both in relation to sex and drug use.

4.3 Individual Level vs. Structural/ Systemic Level Barriers

Knowledge about services

In general, the knowledge levels regarding HIV and availability of various services were quite high among this study sample – possibly due to their connection with NGOs as well as due to increased awareness about HIV/AIDS in general in Northeast India. Only female IDUs listed "lack of knowledge about where to get needles/syringes" as a top barrier to accessing clean needles. Previous studies too have documented that female IDUs compared with male IDUs are more likely to have less knowledge about needle/ syringe services – possibly because they are not well connected to NGOs and have small closed drug-using networks[23].

Even though the knowledge level regarding HIV was high, not all participants had undergone HIV testing; needle sharing continues to be reported; and treatment adherence (ART and OST) is not optimal. These indicate that factors other than knowledge play important role in accessing and using services.

Stigma, discrimination, and violence

Structural barriers influence individual level behaviours such as 'health care seeking' (traditionally seen as an individual level factor) in a variety of ways. "Fear of being identified by others as a drug user" and "fear of police harassment" were reported among the top three barriers to accessing most of the services – especially in accessing clean needles/syringes and OST. Both of these barriers are related to societal stigma and illegality of drug use – that is, structural factors. The stigma of being a drug user thus seems to prevent or hinder drug users – especially female IDUs – to access and continue to use free services. Other studies too have documented that police can stop and search suspected individuals in Manipur and can make arbitrary detention if they find syringes/needles with them. Similarly, 'anti-drug' or 'pressure' groups too, by acting as a kind of parallel police, can pose barriers to accessing services for IDUs and female sex workers (Chakrapani & Kumar, 2009). However, key informants felt that the anti-drug groups have, of late, considerably decreased harsh actions against drug users. This might possibly be due to the sensitization programs conducted by NGOs and SACS, but it could also be due to general increase in the understanding that drug use needs to be seen as a medical condition to be treated and not as a criminal act to be punished.

Contrary to the popular belief among health care providers, more than three-fourth of the

participants had disclosed their past or current drug use to their health care providers. Fear of discrimination from the health care providers could be the reason for the other participants not disclosing their drug use history. However, discrimination in the health care settings did not make it to the top three barriers for any one of the services – including ART and TB treatment, which are provided primarily in government hospitals. Key informants too reported the decreasing trend in stigma and discrimination in the government health settings (a systemic barrier), but added that still more needs to be done to make it stigma-free for IDUs to use government's free clinical services. In spite of the otherwise decreasing trend in stigma in health care settings, some proportion of IDUs continues to rely on the NGO staff to accompany them to government centres because of fear of potential discrimination from the health care providers.

4.4 Conclusion

This study has shown that a majority of IDUs and people on OST face specific barriers to accessing services, both while getting into the services for the first time as well as in continuing to use those services. Specific populations such as female IDUs, female spouse of male IDUs and prisoners have unique needs and continue to face barriers in accessing services. Often structural and systemic barriers such as the stigma of being identified by others as a drug user or fear of police harassment prevent people from initial access or continued use of services. Our findings suggest that taking steps for overcoming barriers, including establishing systems for their identification and handling by the service providers may assist in improved outcomes in relation to HIV prevention and treatment of IDUs and their partners.

5

RECOMMENDATIONS

The following steps are suggested for overcoming service barriers and improving HIV prevention and treatment outcomes for IDUs and their partners.

1. Address structural barriers to accessing services

- Develop and implement comprehensive stigma reduction plan to **increase support from family and society** through education (mass media) and counselling (one-to-one or group counselling for family members) to provide accurate information about drug use and HIV.
- Sensitize police (at all levels) and anti-drug agencies on drug dependency and need for NSP and OST.
- Implement stigma reduction measures in the **health care settings** and sensitize health care providers on the health and human rights issues of IDUs and people living with HIV.

2. Address financial barriers to accessing services

- Provide financial support at least to needy IDUs for **travel costs** related to accessing services such as ART and OST which require daily travel. This financial support can be in the form of providing travel allowance for appointment-related trips.
- Provide **free or affordable drug and alcohol de-addiction** treatment for IDUs and IDUs living with HIV.
- Ensure **free laboratory screening** of all IDUs – especially those living with HIV – for Hepatitis-B and -C viruses. Consider providing free field-based rapid tests for HIV, HBV and HCV for IDUs to encourage uptake of testing and for early diagnosis and referral.
- Develop mechanisms to **support treatment for HCV and HBV** infections among IDUs, regardless of their HIV status.

3. Address barriers to services for specific populations

a. Service delivery for female IDUs

- Take steps to strengthen linkages between agencies serving female sex workers and IDUs since majority of female IDUs engage in sex work or female sex workers also inject drugs. Alternatively or in addition, consider introducing IDU-specific components within the sex worker TIs if a critical number of female sex workers also inject drugs.
- Provide housing support and night shelter for homeless/needy female IDUs.
- Employ female outreach workers and peer educators to reach out to female IDUs.

b. Service delivery for female sex partners of male IDUs

- Female sex partners (especially spouses) of male IDUs can be indirectly reached through male IDUs by encouraging them to disclose their HIV or STI status and ask their spouses to attend the nearby government hospital or agency serving women for HIV and STI screening and treatment.
- Where possible, male IDUs can be encouraged to bring their spouses during a particular time slot to the drop-in centre where couple counselling and referral services can be provided.
- Where acceptable to male IDUs, with their consent, female outreach workers can talk to female regular partners of male IDUs, provide them prevention education and refer them to HIV/STI screening and treatment services.

c. Prisoners

- Introduce harm reduction services (condoms, needles/syringes and OST) and ensure treatment, including ART, for prisoners.
- Develop mechanisms to ensure continuity in care for IDUs on OST and ART even after their release from the prison.

4. Meet the gaps in the demand for existing services

- Develop fool-proof mechanisms to ensure that adequate number of needles/syringes areavailable for IDUs because the current ceiling (about fourneedles/syringes per day) is not sufficient for high frequency users, resulting in needle-sharing.
- Rapidly scale-up OST program to ensure adequate coverage of all IDUs who are wait-listed for this service and who require this service. Ensure adequate 'slots' for female IDUs. Where female IDUs are large in number, consider having a separate OST centre for women or have separate timings for women in the OST centre accessed by both males and females.
- Scale-up the availability of free drug and alcohol de-addiction services (increase the capacity of existing centres and increase the number of centres) and ensure that they offer high quality and non-discriminatory treatment.

5. Prepare tools for identifying and removing barriers to accessing services

- Prepare a simple set of tools for identification of individual, systemic/institutional and structural level barriers faced by IDUs so that a tailored plan for each IDU to overcome the barriers is developed. These tools can be used by both NGOs and government health care providers for identifying barriers and following-up with IDUs to ensure that barriers no longer exist.
- Prepare a referral checklist tool that can be used by government centres and NGOs to ensure relevant and timely referral services for IDUs and their partners.

6

GLOSSARY

Buprenorphine: A medication used in opioid substitution treatment programs. It is included in the WHO Model List of Essential Medicines.

CD4: An immunological marker for HIV infection, the level of which in an individual indicates the immune status. Used in initiating and monitoring the response to ARV drugs.

Drop-In Centre: A facility for IDUs where services are accessed. It also serves as a place for IDUs for recreation, trainings and for sustaining drug abstinence.

Harm Reduction: Refers to a set of interventions designed to diminish the individual and societal harms associated with drug use, including the risk of HIV infection, without requiring the cessation of drug use. In practice, harm reduction programs include syringe exchange, drug substitution or replacement treatment using substances such as methadone, health and drug education, HIV and sexually transmitted disease screening, psychological counselling, and medical care.

Heroin: A widely used opiate. It has the chemical names diacetylmorphine or diamorphine. It comes in different forms; brown, white and pink. Brown heroin is smoked or chased by inhaling the vapour from the heated substance, but in this form it is unsuitable for injection. White heroin is typically in the form of the water soluble salt diamorphine hydrochloride and is suitable for injection. The purity of white heroin is often graded, e.g. 'number 4'. Pink heroin, heavily adulterated with caffeine powder, is found in some South-east Asian countries. *(Adapted from: Demand Reduction: A Glossary of Terms. UNODC. New York, 2000)*

Integrated Counselling and Testing Centre (ICTC): An integrated counselling and testing centre is a place where a person is counselled and tested for HIV ofhis/her own free will or as advised by a medical provider. The main functions of an ICTC include: early detection of HIV; provision of basic information on modes of transmission and prevention of HIV/AIDS for promoting behavioural change and reducing vulnerability; and link people with other HIV prevention, care and treatment services. *(Adapted from: 'Operational Guidelines for Integrated Counselling and Testing Centres'. NACO, 2007)*

Injecting Drug User (IDU): In this report, a broad definition of 'IDUs' has been used to cover people who have injected experimentally or continue to inject occasionally, up to and including heavily dependent drug users who may inject several times each day. IDUs may inject legal or illegal drugs, stimulants (such as amphetamines and cocaine), depressants (such as heroin and benzodiazepines) or other drugs such as steroids. They may inject intramuscularly (into the muscle) or intravenously (into the vein). A criterion of "injected in the past three months" was used for denoting a person as a current injecting drug user, in line with NACO's definition. *(Adapted from the definitions of the WHO and UNODC:http://www.cdc.gov/outreach/who/Glossary.pdf;http://www.unodc.org/pdf/report_2000-11-30_1.pdf)*

Opioid Substitution Therapy or Treatment (OST): Substitution or replacement treatment is the administration of a psychoactive substance pharmacologically related to the one

creating substance dependence to substitute for that substance (For example, substituting sublingual buprenorphine or methadone syrup for heroin). Substitution treatment seeks to assist drug users in switching from illicit drugs of unknown potency, quality and purity to legal drugs obtained from health service providers or other legal channels, thus reducing the risk of overdose and HIV risk behaviours, as well as the need to commit crimes to obtain drugs. Some prefer the term "medication-assisted treatment for opiate dependence" instead of OST.

7

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7. The term 'barriers' is used to refer to any objects, ideas, practices, structures or systems that prevent or discourage use of prevention or treatment services.

8. This design decision was taken because of the difficulty in reaching out to female regular sex partners to directly conduct a survey among them. Hence, information about the female regular sex partners was obtained from the key informants. In the survey, data on condom use and disclosure of HIV status to female regular sex partners was, however, obtained directly from male IDUs.

9. The IDUs who are categorized as 'Non-NSP' IDUs are those who were not receiving any of the services directly from the NGOs. The needles/syringes from the NGOs were sometimes indirectly given to them through other IDUs (who directly access services from NGOs). Thus, it is a peer-driven sampling and in some cases respondent-driven sampling (a kind of snowball sampling) in which the person who is not receiving services directly from the NGOs connects the (study) recruiters to other persons who are not accessing services from the NGOs.

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