

How Effective are Harm Reduction Programmes for Drug Users? Some Insights from an Evaluation of the Programme at Sharan in Delhi*

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Drug use and the physical, psychological and social problems associated with it have been one of the major concerns among professionals in the domain of health and health psychology. One important reason for drug use being a matter of deep concern is the risk of HIV infection associated with it. Apart from the practice of unsafe sex among drug users, in recent decades sharing of needles/syringes by injecting drug users has contributed substantially to the spread of HIV/AIDS. The WHO has noted that the harm reduction approach provides an anxiety-free atmosphere (denied by the traditional abstinence-based intervention programmes) for drug users where they learn and discuss the personal social significance of not sharing needles/syringes and exchanging free needles/syringes. Importantly, apart from needle/syringe exchange, oral substitution of drugs, medical care and education to prevent HIV/AIDS, a harm reduction programme provides a psychological space to drug users that not only acts an emotional support but also enables them to reflect upon their life and risk behaviour. Apart from indicating the need of harm reduction programmes, this article also evaluates the effectiveness of such a programme run by Sharan, an NGO in Delhi, during 1999–2002. Apart from various components of the programme, unconditional acceptance of the drug users by the service providers has brought about substantial reduction in risk behaviour and noticeable improvement in their quality of life.

Drug Use: A Potential Gateway to HIV Infection

It is shocking to note that sexual risk behaviours, often with multiple partners, are common among injecting drug users (IDUs) as well as non-IDUs

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as a substantial number of them visit commercial sex workers (CSWs). In addition, they do not regularly use condoms with either CSWs or non-CSWs (Kumar 2000; Manning 2001; Panda et al. 1997). Currently 86.2 per cent of HIV infections in India are from sexual transmission (WHO 2001). Recent rapid situation assessment (RSA) in India has shown that most IDUs had at some stage (often within the past six months) shared their needle and syringe. The rates of ever sharing are: Chennai 76 per cent; Delhi 50 per cent; Imphal 86 per cent; Kolkata 78 per cent; and Mumbai 61 per cent (Manning 2001). Also, among Delhi participants it was noted that in the past six months, 17 per cent of IDUs shared their injecting equipment almost always (Dorabjee et al. 2001), and in Kolkata 52 per cent of the IDU participants shared their needle and syringe the last time they injected (Panda 2000). While many IDUs clean their injecting equipment, the majority did so inappropriately for protection against blood-borne viruses such as HIV/AIDS and hepatitis C.

According to Naik et al. (1991) and Sarkar et al. (1993), it was in Manipur that the first HIV infections appeared among IDUs. In Manipur HIV infection among IDUs increased from 0 in September 1989 to 50 per cent within six months. Recent data show that 4.16 per cent of the total HIV-infected people in India have been infected through injection drug use (Reid and Costigan 2002). In Manipur HIV infection in 1998 was estimated at 80.7 per cent of IDUs (Dorabjee and Samson 2000; Salunke et al. 1998). In 2000 HIV infections among IDUs in other cities and regions were also generally high as follows: Delhi 44.8 per cent; Chennai 31 per cent; Mumbai 23.7 per cent; Kolkata 2 per cent; Mizoram 9.6 per cent; Nagaland 7 per cent; and Bangalore 4.2 per cent. Many places are experiencing a prevalence nearing or above the critical levels of 10 per cent and this is causing great public health concerns (Dorabjee and Samson 2000; Reid 2003). WHO (2004) considers the HIV/AIDS epidemic in India alarming, as the estimated number of HIV-positive people in the year 2003 was 3.8 to 4.6 million. And drug users (especially IDUs) are the largest sufferers and transmitters.

Physical Health and Quality of Life of Drug Users

Apart from being potential sufferers and transmitters of HIV, drug users in India also suffer from a variety of other physical, psychological and social problems. Their health condition is generally poor. Anaemia, weight loss and lack of hunger are quite common among all drug users. Excessive use of drugs severely weakens the immune system making the user prone to various physical diseases.

Among IDUs there is wide prevalence of ulcers, abscesses, cellulitis and thrombophlebitis as they generally do not inject properly. Many are undernourished and a substantial number have experienced drug overdoses (Tellis et al. 2000). Among IDUs in Chennai the prevalence of hepatitis C was 93 per cent (Kumar et al. 2000). Yaima et al. (1995) found meningitis to be the commonest diagnosis among IDUs in Manipur.

Also of serious concern is the increase in transmission of HIV infection among IDUs to their non-injecting wives from 6 per cent in 1991 to 45 in 1997 (Panda et al. 2000). Manipur has also witnessed an increasing rate of pregnant mothers with HIV infection; increasing from 1.3 per cent in 1994 to 2.7 per cent in 1999 (Mehra 2000).

Many drug users are from a lower socio-economic background, with substantial numbers having poor education, working in insecure positions or experiencing high levels of unemployment. Gross alienation is another harsh reality for drug users. Society generally looks down upon them and at times even medical professional does not show the required sensitivity. Yaima et al. (1995) in a study (as part of an Indian Council for Medical Research units study) found that HIV-positive IDUs ($n = 340$) in Manipur were very reluctant in going to the hospital for medical help. Various reasons found for this were, fear and guilt among them (of being an HIV-positive case), fear of discrimination by health care professionals, and lack of confidentiality in the hospital setting.

People from economically weaker sections who migrate from villages to big cities in search of employment have to survive in unhealthy and unhygienic conditions apart from facing hassles and estrangement characteristic of such cities. Among such migrants, it is not uncommon to find high prevalence of alcoholism, drug use, unsafe sex and HIV infection. Being drug user and HIV positive further enhance their estrangement whether they remain in the city or return to their villages (Vermuri 2004).

Why 'Harm Reduction' Rather Than 'Abstinence'?

MacCoun (1998), in his influential article titled, 'Toward a Psychology of Harm Reduction', has critiqued the policy of 'eliminating drug use' as it employs harsh enforcement to achieve its effect. This policy in itself is a source of many drug-related harms, either directly or by exacerbating the harmful consequences of drug use. The author quotes the example of the USA, where there are probably more than 1 million IDUs and injection drug use accounts for about one-third of all AIDS cases. There, needle

exchange programmes can bring about significant reduction in HIV transmission. Lurie and Drucker (1997) recently estimated that between 4,394 and 9,666 HIV infections could have been prevented in the United States between 1987 and 1995 if a national needle exchange programme had been in place. MacCoun (1998) emphasises that by almost exclusively relying on use reduction—especially drug law enforcement—as an indirect means of reducing harm, the opportunities to reduce harm directly is foregone; not to mention some harm increased in the process.

The WHO too recognises that harm reduction carries significant HIV preventive potential for both injecting drug users and the general population. In the absence of harm reduction activities, HIV prevalence among IDUs can rise to levels up to 40 per cent or more within one or two years of introduction of the virus in their communities. Interventions for IDUs that reduce HIV risks also have the potential to engage drug users in drug dependence treatment services that may ultimately lead to abstinence from drug use. Finally, such programmes can help avoid other harmful consequences of drug use, including hepatitis B/C infections and overdose deaths (WHO, no date).

Marlatt (1996) too has clearly put forward the importance of incorporating harm reduction in health policies for: (a) harm reduction is a public health alternative to the moral/criminal and disease models of drug use and addiction; (b) it recognises abstinence as an ideal outcome but accepts alternatives that reduce harm; (c) it has emerged primarily as a ‘bottoms-up’ approach based on addicted advocacy, rather than a ‘top-down’ policy established by addiction professionals; and (d) it promotes low threshold access to services as an alternative to traditional high threshold approaches.

Harm Reduction Programme and Its Components

According to Peele (2002), harm reduction is a term best known in the substance abuse field as a way of reforming drug policy. Replacing the zero tolerance policy, it recognises the certainty that some people will continue to use drugs and, therefore, that drug use will remain a fact of life in our society. With this in mind, it seeks to protect drug users—and non-drug users exposed to drug users—from the worst consequences of such use.

According to the WHO, in public health ‘harm reduction’ is used to describe a concept aiming to prevent or reduce negative health consequences associated with certain behaviours. In relation to drug injecting, ‘harm

reduction' components of comprehensive interventions aim to prevent transmission of HIV and other infections that occur through sharing of non-sterile injection equipment and drug preparations (WHO, no date).

The WHO (*ibid.*) has recommended the following methods of harm reduction for drug users:

1. **Needle/syringe programming (NSP)** aims to ensure that those drug users who continue injecting have access to clean injection paraphernalia, including needles and syringes, filters, cookers, drug containers and mixing water. Specific interventions that equip drug users with sterile injection equipment usually also collect used needles and syringes, and are commonly known as 'needle/syringe exchange programmes' (NSEPs). Such programmes can also serve as information points and may engage drug users with drug treatment services. Their ability to break the chain of transmission of HIV and other blood-borne viruses is well established.
2. **Drug substitution treatment** involves medically supervised treatment of individuals with opioid dependency based on the prescription of opioid agonists such as methadone. Whilst the primary goal of drug substitution treatment is abstinence from illicit drug use, many patients are unable to achieve complete abstinence despite improvements in their health and well-being. However, there is clear evidence that methadone maintenance significantly reduces unsafe injection practices of those who are in treatment, and hence the risk of HIV infection.
3. **HIV/AIDS-related treatment and care** primarily aim to help drug users living with HIV/AIDS cope with the infection. Involving HIV-positive drug users in primary health care and/or antiretroviral treatment programmes provides an opportunity for them to adopt and consolidate safe behaviours and may yield significant HIV preventive effects. This applies in particular to HIV/AIDS treatment and care that are provided in the context of specific information and counselling services.
4. **Information, education and communication (IEC)** on HIV transmission through injecting drug use provides information that will assist drug users in avoiding or modifying drug injecting behaviours. Involving IDUs in the development and design of information material is critical to increase its appropriateness, context of HIV testing and counselling.

Sharan: The Research Site

The NGO Sharan (Society for Service to Urban Poverty) came into existence in 1979 with its engagement in areas of community empowerment, health and the general welfare of people in low-income areas of Delhi with a focus on developing strong partnerships between the community and development workers. Since 1994, with its involvement in supporting the National AIDS Control Organisation (NACO) in the project of rapid assessment of high-risk behaviour related to HIV in 65 large cities of India, STD/HIV prevention, management and care became Sharan's major thrust area.

In continuation with efforts in this direction, a Comprehensive HIV/STD Treatment and Care Programme for Injecting Drug Users and their Sexual Partners in Five Indian Cities was launched by Sharan in 1999. The duration of the programme was three years. The five cities for intervention were Delhi, Mumbai, Kolkata, Chennai and Imphal. This programme was also called the Five City Project or Harm Reduction Programme. In Delhi the programme was run through the drop-in centre (a place where drug users could drop in any time during the daytime) at Yamuna Bazar, a place on the banks of river Yamuna. The major objectives of the programme were to:

1. reduce the spread of HIV/AIDS and hepatitis B and C among IDUs;
2. reduce behaviours (unsafe sex, sharing of needles and syringes, etc.) that facilitate the spread HIV/AIDS and other harms;
3. reduce criminal activities and improve the quality of life of IDUs; and
4. provide a range of treatment and care services to improve the physical and mental health of IDUs and their sexual partners.

It was from 1 June 2000 to 28 February 2001 that Kumar Ravi Priya joined Sharan for fieldwork as a part of his master's course in psychology at the University of Delhi. The main assignment he worked on was to evaluate the Harm Reduction Programme for drug users.

Planning the Programme Evaluation

For the purpose of programme evaluation of Sharan's Harm Reduction Programme, the 'development stage approach' to evaluation was used.

According to this, the evaluation is closely associated with the programme's stage of development. The following are the four segments of this approach (Pancer 1997; Pancer and Westhues 1989):

1. **Need assessment:** This is conducted to find out the need of the programme for its different stakeholders *at the beginning of the programme* and *during evaluation*.
2. **Evaluability assessment:** This is conducted to find out—
 - i. whether programme goals were clear, specific and measurable;
 - ii. whether the major activities of the programme were coherent and clearly articulated; and
 - iii. the rationale as to why the programme activities should be expected to achieve the programme's major goals.
3. **Process evaluation:** This determines what elements of the programme are helpful in allowing it achieve its intended outcomes and what are not.
4. **Outcome evaluation:** This assesses whether the goals of the programme are being achieved to the extent it was expected during its development.

Method

Participants

Eighty drug users (50 IDUs and 30 non-IDUs) at the drop-in centre (DIC) at Yamuna Bazar participated in the study. Non-IDUs belonged to the lower middle class, with most of them having small shops or grade-IV government employment. A number of them were IDUs when they had joined the DIC. They (most of them being from Delhi) had a better social and familial life than those of the IDUs. Among the IDUs more than 70 per cent were migrants from Uttar Pradesh, Madhya Pradesh, Rajasthan and Bihar. Most of them were ragpickers (*kabadiwala* or *kabadi*). The footpath was their sleeping place. They were hardly capable of earning their living. They had severe health problems (including HIV/AIDS and hepatitis B/C) and no family members to take care of them.

Procedure

A survey was conducted among these 80 drug users between 1 and 10 July 2000 by using an interview schedule comprising items related to need assessment, process evaluation and outcome evaluation. During this period participant observation was also done by Kumar Ravi Priya to aid to process evaluation. For the purpose of need assessment, data were collected from the findings of the RSA of injecting drug use in Delhi and other research reports at Sharan regarding health conditions, and awareness and prevalence of HIV/AIDS among IDUs. For the purpose of process evaluation data were collected from the records about the regularity of clients in different activities of the programme at the DIC. Also, for process evaluation and outcome evaluation, two management staff at the DIC were interviewed. These interviews were conducted between 11 and 16 July 2000.

Results and Discussion

Need Assessment

One of the main reasons for the Harm Reduction Programme to be started was to make certain interventions on the risk behaviour among IDUs so that further spread of HIV/AIDS might be reduced. The following studies conducted by Sharan confirmed risk behaviour and the prevalence of HIV/AIDS among IDUs:

1. According to the RSA of injecting drug use in Delhi (Sharan 1998c), 55 per cent of IDUs had little or no knowledge whatsoever about HIV/AIDS.
2. According to the *Report of the Baseline Survey of IDUs at Dholakwala* (Sharan 1998a), 86 per cent were sharing needles/syringes and 76 per cent sharing drug mixing containers.
3. According to the *Report of the Survey and Biological Study to Find Out the Awareness and Prevalence of HIV/AIDS in the IDUs in Delhi* (ibid. 1998b), only 33 per cent had heard of AIDS, and out of these 21 per cent believed that AIDS could be cured and 33 per cent thought that one could prevent AIDS with a vaccine.

Table 1 gives an insight into the needs of the drug users that they sought at the time of joining the DIC.

Table 1
Main Purpose of IDUs for Coming to the DIC (%)

Main purpose of coming to the DIC	At the time of joining DIC			At the time of evaluation		
	IDUs (n = 50)	Non-IDUs (n = 30)	Total (n = 80)	IDUs (n = 50)	Non-IDUs (n = 30)	Total (n = 80)
Free treatment	44	47	45	16	7	13
Oral substitution of drugs	14	0	9	58	63	60
Medical help	18	7	14	16	0	10
Needle/syringe exchange	4	—	—	22	—	—
Deaddiction/rehabilitation	74	73	74	62	67	65

There was a decrease (from 45 to 13 per cent) in the number of total drug users mentioning free treatment as their main purpose of coming to the DIC, and there was an increase (9 to 60 per cent) in the number of those saying oral substitution of drugs was the main purpose. Also, importantly, among the IDUs, at the time of joining, for only 4 per cent was needle/syringe exchange the main purpose. Whereas, at the time of evaluation, the proportion increased to 22 per cent. It is clear from the results that the programme did bring about a shift in the attitude of drug users, as merely free treatment and medical help did not remain the motivation behind coming to the DIC. Rather, they started engaging in the programme by availing of the services offered. This strengthens the assertion that the need for the programme was very much there at the time of evaluation.

In recent studies among IDUs in Canada and the USA, a large majority expressed the need to utilise the services of 'safer injection sites' (which is a legal facility that allows people to prepare and inject pre-obtained drugs in a hygienic, anxiety-free atmosphere under the supervision of health personnel) or 'supervised injection facility' (Broadhead et al. 2003; Green et al. 2004; Kerr et al. 2003).

Evaluability Assessment

Table 2 presents the four main programme goals and major activities related with them that were carried out under the programme at the DIC.

Except for the first, all other programme goals were measureable with the help of research in social sciences. Also, it is quite clear that major activities of the programme are complementary to each other for the goals to be achieved. For drug users to manage their lives in a better way, all the services

Table 2
Programme Goals and Associated Major Activities

<i>Programme goals</i>	<i>Major activities</i>
1. Reducing the spread of HIV/AIDS and Hepatitis B/C among IDUs	Providing oral substitution of drugs, needle/syringe exchange, condoms, counselling
2. Bringing in behaviour change to reduce their risk behaviour towards HIV/AIDS	Counselling and support group meetings
3. Reducing criminal activities and improving quality of life of IDUs	<ul style="list-style-type: none"> ● All the services being free of cost ● Counselling and support group meetings
4. Providing treatment to improve physical condition of IDUs by the referral network	Referring them to various hospitals and care centres

they needed were being provided free of cost and the counselling process aided the improvement in their quality of life. Support group meetings were held especially for HIV-infected drug users (other users also used to join them) to help them manage their time and financial resources. It also aided in the management of their risk behaviour.

Process Evaluation

Process evaluation is conducted to determine what elements of the programme are helpful in allowing it to achieve its intended outcomes and what are not. Let us find out in the following paragraphs the extent to which the elements of this programme are functional in achieving programme goals.

Distribution of Oral Substitution of Drugs As far as the regularity of clients for availing oral substitution of drugs is concerned, out of about 3,400 of them, on an average, only 200 had been coming to the DIC in June and July 2000. This was the area where intervention was needed.

Counselling and Support Group Table 3 shows that 58 per cent of the drug users were provided counselling. Forty-six per cent felt that it has been of some benefit to them. Seventy-three per cent attended support group meetings at least once; 50 per cent felt that these meetings have been of some benefit to them.

Table 3
Percentage of Drug Users who Availed Counselling and
Attended Support Group Meetings At Least Once (%)

	IDUs (n = 50)		Non-IDUs (n = 30)		Total (n = 80)	
	Availed	Benefited	Availed	Benefited	Availed	Benefited
Counselling	56	38	60	60	58	46
Support group	74	42	70	63	73	50

Referrals It was also worth noticing that since the beginning of the programme, 282 clients were referred to different hospitals and care centres of Delhi. Those clients or drug users who wanted deaddiction or rehabilitation were referred to detoxification centre or Sahara House (a rehabilitation centre and sister organisation of Sharan) respectively.

Needle/Syringe Exchange Programme (NSEP) At the time of evaluation, 40 per cent of the total number of registered IDUs were regularly availing the NSEP. The following are their frequency of injecting drug use and regularity of availing NSEP:

1. 65 per cent injected drugs daily among IDUs; 54 per cent came for the NSEP daily and 46 per cent three to five times a week;
2. 25 per cent injected drugs two to four times a week and among them 80 per cent came for the NSEP two to three times a week and 20 per cent did not come at all; and
3. 10 per cent injected drugs once or twice in a month and among them 50 per cent came for the NSEP once in a month and 50 per cent did not come for the same at all.

The results explicate that the frequent users of drug injection are quite regular at availing the NSEP. Other studies have also reported this phenomenon. In a study of characteristics of 2,719 clients (71 per cent of them males) as well as predictors of their frequent attendance in the first 12 months of the Sydney Medically Supervised Injecting Centre's (MSIC) operation, Kimber et al. (2003) found that characteristics associated with frequent attendance at the MSIC were reporting previous attendance at the local primary health service for IDUs, reporting sex work, injecting at least daily, and injecting in a public place.

Condom Distribution Out of the total number of clients at the DIC, 6.25 per cent reported that they indulged in premarital or extramarital sex at the time of evaluation. But out of them only 20 per cent availed condoms from the DIC. As mentioned earlier, among drug users in India, sexual risk behaviours, often with multiple partners, are common and the use of condoms is very infrequent. This study also shows that sex education has to be provided efficiently to the drug users who are a high risk of getting HIV infection.

Service Provided by Staff Members Eighty-eight per cent of the clients felt that the service provided by staff members was adequate for their needs. The remaining had complaints regarding either discrimination, misbehaviour, clashes among themselves, or sale of oral substitute of drugs. Although these complaints were occasional, the programme coordinator needed to look into the matter to improve services. The two management staff interviewed mentioned that the constant demands placed on the staff often created a stressful atmosphere at the DIC and might be contributing to the occasional lapse in the quality of service.

Outcome Evaluation

The **first goal** of the programme was to reduce the spread of HIV/AIDS and hepatitis B and C among IDUs. It was not possible to directly measure this reduction. It is likely that awareness of the causes will stem the spread of these diseases. With this rationale in mind, the awareness of drug users was investigated.

Table 4 shows that at the time of evaluation, 75 per cent of drug users were aware of the fact that sharing needles and syringes may cause HIV/AIDS. Especially among the IDUs, although this awareness had spread (from 28 per cent before joining the DIC to 74 per cent at the time of evaluation), it had yet to be improved upon further keeping in mind their risky drug use habits. Also, as presented in Table 5, 46 per cent of IDUs and 47 per cent of non-IDUs were aware (at the time of the evaluation) that indulging in 'unsafe sex' may lead to HIV infection. It is clear that further efforts are needed to spread awareness about various causes of the spread of HIV/AIDS.

However, keeping in mind very poor socio-economic and educational background of IDUs, who do not have an access to mass media for sex education or AIDS-related education, such a spread of awareness is significant as it is comparable to that of the general population with access to mass media. In a study carried out in a slum area of south Kolkata to assess the

Table 4

Drug Users with Awareness that Sharing Needles/Syringes may Cause HIV/AIDS (%)

	<i>IDUs (n = 50)</i>	<i>Non-IDUs (n = 30)</i>	<i>Total (n = 80)</i>
Before joining DIC	28	40	33
After joining DIC	74	77	75

Table 5

Drug Users with Awareness about Various Causes of the Spread of HIV/AIDS (%)

	<i>Three reasons</i>	<i>Two reasons</i>	<i>One reason</i>	<i>None</i>
IDUs (<i>n</i> = 50)	4	46	24	26
Non-IDUs (<i>n</i> = 30)	3	47	27	23
Total (<i>n</i> = 80)	4	46	25	25

impact of the mass education programme (through media) against AIDS among 206 participants, Poddar et al. (1996) found that the participants generally had access to mass media (95 per cent to television or radio and 66 per cent to newspapers) and 59 per cent of them knew about persons vulnerable to contracting AIDS. But most of them associated it to promiscuity only. Also, avoiding promiscuity was the main means known to them for preventing AIDS and yet only 2.5 per cent residents knew the role of condom in it.

The **second goal** of the programme was to bring about behaviour change in IDUs to reduce their 'risk behaviour' towards HIV/AIDS. The following results show significant improvement in the area of reducing risk behaviour:

1. 60 per cent of the clients who joined the programme as IDUs had quit injecting drugs and shifted to oral substitutes; and
2. out of the current IDUs (40 per cent of those originally joined as IDUs), 90 per cent were not sharing needle/syringes at the time of evaluation.

There are evidences from all over the world that needle/syringe exchange programmes have succeeded in reducing risk behaviour (sharing needle/syringe) and blood-borne infections. In a study with a similar goal, Jenkins et al. (2001) have found in Bangladesh a significantly higher positive behavioural change among IDUs who participated in the needle/exchange programme than those who did not. Crofts (1992) has found out that as a harm reducing strategy, needle and syringe exchange programmes in Victoria, Australia, has decreased rates of HIV, hepatitis B and C and other

blood-borne infections among the IDUs. It is an economically viable programme, given the alternatives of AIDS-related health cost, and has disproved the fallacy that injecting drug users cannot change risky behaviours.

The **third goal** of the programme was to reduce criminal activities and improve the quality of life of the drug users.

Table 6 shows that the feeling of isolation had reduced considerably (from 82 to 68 per cent) among IDUs. The number of non-IDUs with such feeling had also reduced significantly (from 50 to 17 per cent). The number of drug users with harmonious relationships with friends or/and family had increased too (8 to 32 per cent among IDUs; 13 to 53 per cent among non-IDUs). They also expressed a better sense of time management (planning the time for routine activities like getting up, personal hygiene, eating, etc. and work for the day) as compared before joining the DIC. IDUs with good sense of time management increased from 20 to 48 per cent and non-IDUs from 17 to 43 per cent. Another significant change in the lifestyle of drug users was that their habit of spending day's earning on drugs. This reduced sharply after they joined the DIC. At the time of evaluation only 12 per cent of IDUs and none of the non-IDUs were left with such a habit as compared to 94 and 93 per cent respectively before. Antisocial activities like theft and pickpocketing too reduced significantly among drug users (from 22 per cent to nil among IDUs; 37 per cent to nil among non-IDUs). Sixty-eight per cent of IDUs and 43 per cent of non-IDUs had been jailed at least once before joining the DIC, whereas these figures dropped to 10 and 3 per cent respectively after.

Table 6
Drug Users with Various Attributes of Quality of Life
Before and After Joining the DIC (%)

<i>Attributes of quality of life</i>	<i>IDUs (n = 50)</i>		<i>Non-IDUs (n = 30)</i>		<i>Total (n = 80)</i>	
	<i>Before</i>	<i>After</i>	<i>Before</i>	<i>After</i>	<i>Before</i>	<i>After</i>
Theft, pickpocketing, etc.	22	0	37	0	28	0
Jailed at least once	68	10	43	3	59	8
Feeling of isolation	82	68	50	17	70	49
Harmonious relationships with friends/family members	8	32	13	53	10	40
Good sense of time management	20	48	17	43	19	46
Day's earning lost in purchasing drugs	94	12	93	0	94	7

Studies about the quality of life of drug users do indicate that apart from poor physical health, they often face an extreme alienation that tells upon their mental health. Drug users, especially those who are HIV infected, are looked down upon by society. Vemuri (2004) points out such a condition of a villager (who had migrated to big cities and got infected there) is such a taboo that even their family members do not disclose their HIV status to anybody in the village. At times even medical professionals do not show the required sensitivity in handling the delicate psychological state of drug users (Yaima et al. 1995). In such a situation, the harm reduction programme accepted them as they were and provided an anxiety-free atmosphere where they could participate in harm reduction activities.

Many of the drug users called the harm reduction site, the DIC, their 'family' as they found themselves accepted unconditionally by a set of service providers. One of the management staff interviewed during the research stated the same: 'The flexibility of the staff in adapting to changing circumstances and their attitude of acceptance play a vital role in creating a user-friendly and enabling environment, which in turn attracts large numbers of otherwise out-of-treatment drug users into treatment settings.' The two management staff interviewed also mentioned that most of the service providers at the DIC themselves had been drug users in the past, and after their abstinence and rehabilitation they had started serving at the DIC. It is noteworthy that staff members were able to provide unconditional space to the clients as they themselves had undergone the pain and agony of being drug users.

Conclusions

The programme activities were reasonably effective in achieving their goals. The ability to empathise with the physical and psychological condition of drug users seemed to be functional in improving the quality of life and reducing risk behaviour among drug users. The programme components served to create bridges for access to other treatment modalities and worked to complement a range of treatment options. However, to further improve upon the quality of service delivery at the DIC, more cohesiveness among the staff members was needed.

A limitation of the intervention was with regard to the sexual partners of IDUs. This component had not been effective in reaching out to the partners and their needs. The provision of timely risk reduction services coupled

with information and awareness could play an important role in reducing HIV and other sexually-transmitted infection among and from IDUs attending such a harm reduction programme.

Finally, an important issue related with drug use in India needs a mention. It is intricately linked with lower socio-economic class, lack of education and migration to big cities. Therefore, for a long-lasting impact of harm reduction programmes, public services in health, criminal justice, education and employment generation have to act hand in hand. Such a social action in domain of harm reduction has not been very frequent (for example see Veale 1994), yet such a combined effort from all stakeholders does have the potential to bring realistic and positive changes in the lives of drug users.

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