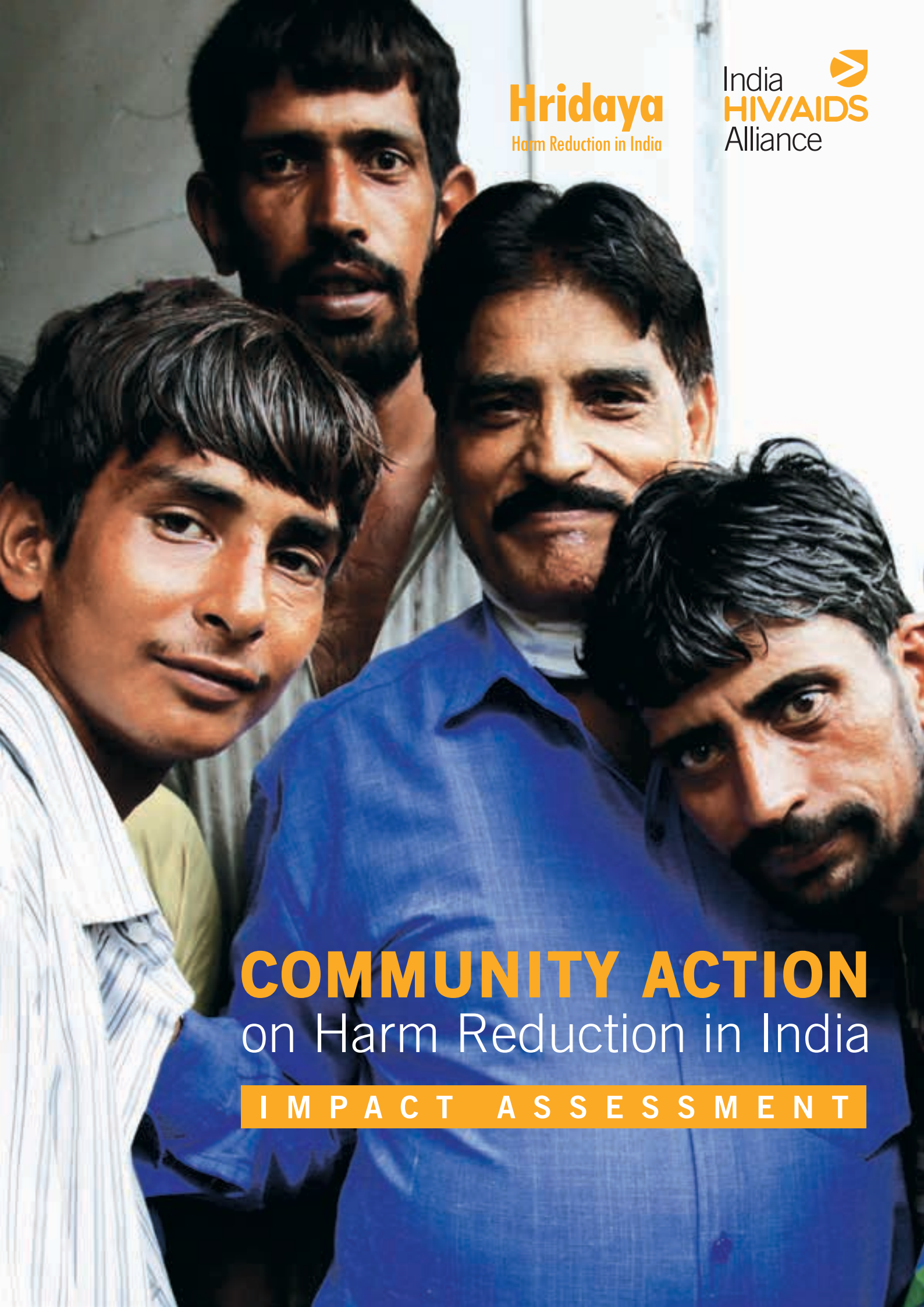
Hridaya
Harm Reduction in India

India HIV/AIDS Alliance



COMMUNITY ACTION
on Harm Reduction in India

IMPACT ASSESSMENT

Acknowledgements

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CONTENTS

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Treatment
CAHR	Community Action on Harm Reduction
HBV	Hepatitis-B Virus
HCV	Hepatitis-C Virus
HIV	Human Immunodeficiency Virus
ICTC	Integrated Counselling and Testing Center
IEC	Information Education and Communication
M&E	Monitoring and Evaluation
MSM	Men who have Sex with Men
N/S	Needle/Syringe
NSP	Needle Syringe Program
ORW	Outreach Worker
OST	Opioid Substitution Therapy
PLHIV	People Living with HIV/AIDS
PWID	People Who Inject Drugs
SACS	State AIDS Control Societies
SASO	Social Awareness Service Organization
STI	Sexually Transmitted Infection
STRC	State Training and Resource Center
TB	Tuberculosis
TI	Targeted Intervention
ToT	Training of Trainers

Preface

The Government of India currently estimates that there are approximately 177,000 People who inject drugs (PWID) in India (NACO annual report 2014-15), although other studies indicate that the numbers could be much higher. Surveillance shows HIV prevalence among PWID in India at 7.14% (NACO, 2010-11).

Community Action on Harm Reduction (CAHR), which spans five countries (India, China, Indonesia, Kenya and Malaysia), is an initiative that expands harm reduction services to more than 180,000 PWID, their partners and children. The program protects and promotes the rights of these groups by fostering an enabling environment for HIV and developing harm reduction programming. CAHR is supported by the Ministry of Foreign Affairs, Government of Netherlands through a grant to the International HIV/ AIDS Alliance.

As a part of CAHR, India HIV/AIDS Alliance has implemented the Hridaya program at 35 sites in the Indian states of Bihar, Haryana, Jammu and Uttarakhand since 2013. Hridaya provided an additional package of harm reduction services to 11,842 registered PWID and 52,351 family members, complementing services provided through Targeted Interventions of the National AIDS Control Program. Additional services include outreach to the families and spouses of PWID, awareness generation on safe injecting and sexual behaviours, and provision of information on legal rights and hepatitis C.

To understand the impact of the services provided by Hridaya, a baseline study was conducted in program implementing states at the beginning of the program in 2012. In 2014, a follow-up study was done using the same methodology and tools to measure the outcome and effect of the program. This report describes the impact of Hridaya on PWID communities. It provides insights into the lives of PWIDs, including their patterns of service utilisation, injecting practices, sexual behavior and health. Finally, the report offers suggestions and recommendations for improvement and advancement of harm reduction services in India.

Introduction

SECTION 1

1.1 Background

People Who Inject Drugs and HIV

Alliance India's Hridaya Program, which is a component of the five country Community Action on Harm Reduction initiative, reinforces and scales up targeted harm reduction interventions for people who inject drugs (PWID) in the states of Bihar, Haryana, Jammu & Kashmir, Manipur and Uttarakhand. India is estimated to have 230,900 people living with HIV (PLHIV) (NACO, 2009), with an adult HIV prevalence of 0.31%. Surveillance data confirms that PWID, who commonly acquire HIV through the high-risk behavior of sharing injecting equipment as well as by sexual transmission, are perhaps the population most-at-risk of acquiring and spreading HIV[1]. Sharing of needles/syringes and other equipment also increases the incidence of other blood-borne viruses, namely hepatitis-B (HBV) and hepatitis-C (HCV), making co-infection highly common[2]. Inadequate access to healthcare services (e.g. testing, regular physical examinations) also leads to co-infection with other easily spreadable diseases like tuberculosis (TB). Though epidemiological data on India's PWID communities are scarce, it can be assumed that HIV incidence and prevalence continue to expand among PWID in India.

NACO adopted the harm reduction approach in NACP III to prevent HIV amongst PWID and scaled up interventions through targeted interventions (TI) implemented by NGOs with the highest potential to access communities of PWID[3].

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[1] *Technical report India HIV estimates (2010). India: National Institutes of Medical Statistics and National AIDS Control Organization, Government of India; 2010*

[2] *http://harmreduction.org/issues/hepatitis-c/overview/hepatitis-c-transmission/*

[3] *Annual Report 2011–12. New Delhi: Department of AIDS Control, Ministry of Health and Family Welfare, Government of India; 2012.*

Community Action on Harm Reduction (CAHR)

CAHR is implemented by the International HIV/AIDS Alliance through the support of the Ministry of Foreign Affairs of the Government of the Kingdom of the Netherlands and includes projects in five countries – India, China, Indonesia, Kenya, and Malaysia–that aims to expand harm reduction services to more than 180,000 people who inject drugs (PWID), their partners and children. The objective of CAHR is to protect and promote the rights of these groups by fostering an enabling environment for HIV and harm reduction programming in the five countries.

CAHR aims to achieve the goal that "People Who Inject Drugs, their partners and children are healthier, less marginalized and more engaged in social and community life". This will be achieved through the following four approaches: i) increasing access, ii) building capacity, iii) promoting human rights, and iv) brokering knowledge.

As the CAHR program partner in India, India HIV/AIDS Alliance implements CAHR under the Hridaya program name. Hridaya has been designed to fill the capacity and implementation gaps of Targeted Interventions (TI) in the states of Bihar, Haryana, Jammu, Uttarakhand, Manipur and within Delhi.

The project has *two goals*:

1) Increase access to services for PWID in underserved areas.
2) Support the development of more comprehensive services in areas where services already exist.

1.2 Hridaya Implementation Plan

The Hridaya program was implemented based on the following principles:

a) Active engagement of State AIDS Control Societies (SACS)
b) Partnering with Civil Society Organizations
c) Community involvement and participation
d) Sustainability
e) Strong monitoring and reporting mechanisms
f) Evidence-based and need-based services
g) Avoiding duplication of services

Implementation Focus of Hridaya

Technical Support: Hridaya focused primarily on providing technical support to all five states at SACS, district and TI-level. The SACS were provided with greater clarity on the relevance of harm reduction interventions, such as understanding drug use patterns of PWID and providing guidelines to respond to the needs of PWID. The project also provided technical support in the following broad areas:

- Sensitization and advocacy among stakeholders.
- Coordination between various agencies providing services to PWID.
- Quality assurance for TIs and Opioid Substitution Therapy (OST) centers
- Development of appropriate government responses to the PWID-HIV situation.

Capacity Building: Hridaya worked in close coordination with SACS and its supporting structures (Technical Support Units (TSU), State Training and Resource Center (STRC)) where they exist in each state. TI NGOs were strengthened by supporting field level implementation and the addition of technical training and guidance for managing OST interventions. Technical trainings on program implementation were organized annually on relevant issues such as dual-risk, sexual and reproductive health and legal literacy. TIs were supported to institute systems to respond to harassment and discrimination of PWID.

TI-Plus Activities: The focus was to ensure essential services were available in all sites where significant populations of PWID have been identified. The project attempted to increase the service utilization by supplementing the available services and making services such as general health care, detoxification and psychosocial services available to PWID.

1.3 Objectives of the Study

A Baseline Survey was conducted from January to May 2012 before the start of the project. Impact assessment survey was conducted in order to evaluate the changes made among the project beneficiaries and to track the key outcome indicators in the two years implemented CAHR Program.

The **primary objectives** of the Impact Assessment Survey are to examine:

1. Knowledge, attitudes, behavior and practice of PWID in relation to HIV/AIDS.
2. Well-being and quality of life of PWID.
3. Relations with police; compulsory rehabilitation/detoxification centers.
4. The extent to which services are demand-driven, and key factors that reduce/increase interest in obtaining services

A **secondary objective** of the Impact Assessment Survey is to:

Analyze the effectiveness (added-value) of additional wrap-around services (additional community-oriented interventions other than the nine interventions included comprehensive package of HIV and harm reduction endorsed by the World Health Organization) for PWID and their families provided through the Hridaya program.

SECTION 2

Research Methodology and Sampling Design

2.1 Introduction

This section provides details about the methodology adopted for selection of respondents and other stakeholders. In addition, it explains the various study tools used for data collection and specific components of the study, including recruitment of field staff, their training and deployment for data collection. The study was implemented with 12 partners in 12 districts spread over five states.

2.2 Methodology

The study involved both quantitative and qualitative data collection and analysis. The required information was collected through key informant interviews from the target group using structured/ semi-structured questionnaires.

Sample design and size

Statewide lists of PWID receiving services through TIs served as the sampling frames for selection of PWID. Samples were selected through a two-stage random sampling design.

Selection of sites: In total, 12 sites spread across five states were covered- four in Bihar, four in Haryana, two in Uttarakhand and one each in Jammu and Manipur. These sites were selected randomly on the basis of TI made by the NGOs under Hridaya intervention.

Selection of PWID respondents: The PWID respondents were selected at the second stage. They were selected through simple random sampling procedure. The procedure adopted involved following steps:

- The list of PWID was provided by the local NGOs involved in Hridaya intervention.
- These PWID registered with Hridaya were then allotted a unique number– 1, 2, 3… n

- Different sets of random numbers were generated for each study site to select a total of 600 respondents (50 from each site).
- The field teams marked and then selected the listed PWID as per the random numbers given to them.

TABLE 1: Geographic sample coverage distribution

State	Districts	Quantitative	Qualitative	
		PWID to be covered	Key Informant Interviews	Case Studies
Bihar	1. Patna	50	4	15
	2. Muzzaffarpur	50		
	3. Bhojpur	50		
	4. Siwan	50		
Haryana	1. Gurgaon	50	4	19
	2. Sonipat	50		
	3. Ambala	50		
	4. Sirsa	50		
Jammu	1. Jammu	50	1	3
Uttarakhand	1. Haridwar	50	2	7
	2. Nanital (Haldwani)	50		
Manipur	1. Imphal East	50	1	6
Total		**600**	**12**	**50**

2.3 Study Tools

The following tools were used for data collection:

Semi-structured questionnaire: A semi-structured questionnaire was developed and used for data collection. The questionnaire was written in Hindi for use in Bihar, Uttarakhand, Jammu and Haryana. An English questionnaire was used in Manipur.

Key Informant Interview guide: For qualitative data collection, Key Informant Interviews (KII) were conducted with the Project Manager and Outreach Staff.

Case study guide: Case studies were selected as the most appropriate methodology to capture how project interventions affected quality of life. In this document, these are represented as testimonials (all translated to English).

2.4 Field Operations and Data Collection

Training of Field Teams: Training of Trainers (ToT) at the central level was conducted in Delhi during 8th-9th June, 2014. The research and field coordinators who participated in ToT were responsible for conducting the training and the field work in each state. Both central and state-level trainings consisted of instructions on interviewing techniques and field procedures for the survey, a detailed review of each item in the questionnaire and mock-interviews between participants present in the training.

Recruitment of Field Teams: One field team of two interviewers was employed for the fieldwork in each study site. In all, 24 investigators were deployed for data collection across the 12 study sites. Four Field Managers were responsible for supervising all selected states. Throughout the survey, staff from the research agency in Delhi maintained close contact with all the teams to provide support and advice to the field staff and to ensure data quality and efficiency of interviewers.

Field Work: The field work commenced on 13th June, 2014 and was completed on 30th June, 2014. Each team took around 4-5 days at each site to complete the field work.

Quality Assurance: The following steps were taken for data quality assurance.

- Supervisors back–checked 15% of the filled-in questionnaires of all the field investigators in their teams on daily basis.
- Supervisors scrutinised all the filled in questionnaires on daily basis for completeness and consistency.
- Field coordinators and researchers also randomly selected 5% of the filled-in questionnaires during their field visits for monitoring and data quality assurance.

2.5 Data Management and Analysis

Data management: All the filled questionnaires were reviewed in the field on the same day so that the respondents could be contacted again, if required, to get additional or missing information. The completed questionnaires were dispatched at regular interval from the field to the respective state offices, where editing was accomplished. Data cleaning was carried out simultaneously during data entry by referring to the completed questionnaires.

Data analysis and tabulation plan: The data processing was done in–house using SPSS 18 software. Before analysis of data, tabulation plans were developed and shared tables were generated according to the tabulation plans.

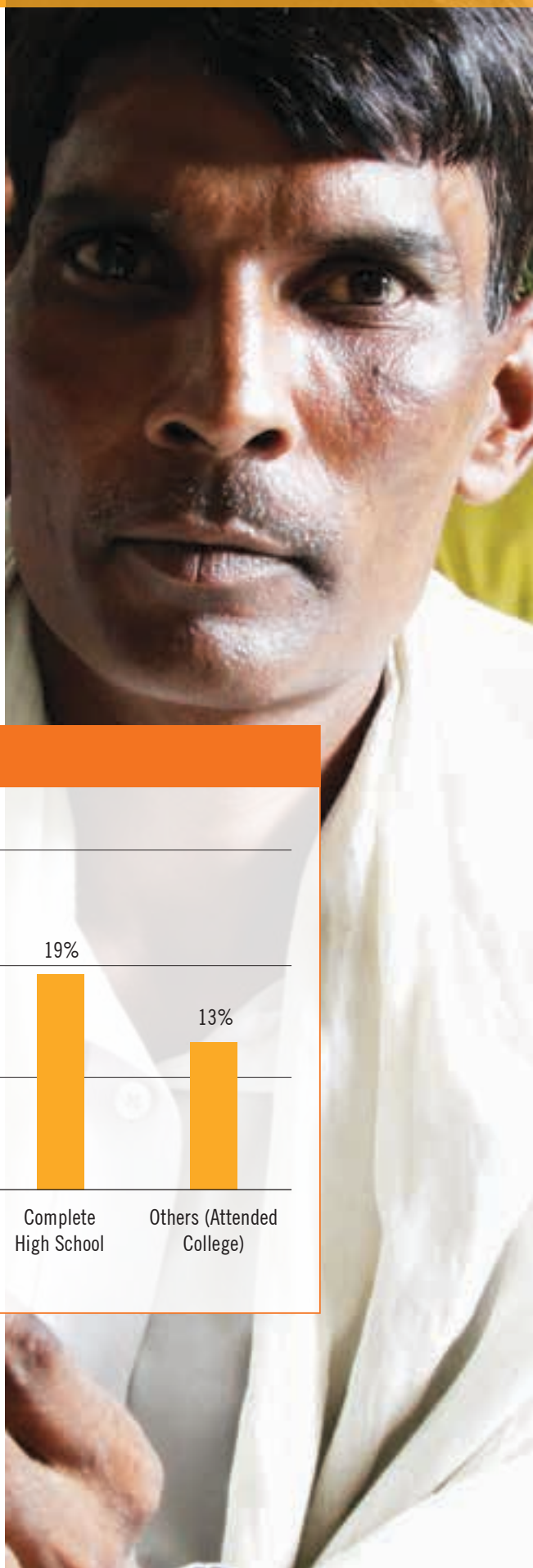
2.6 Study Limitations

All quantitative data reported comes from survey responses, which are inherently subject to response-bias and respondent honesty. Though the 600-respondent sample was randomly selected and well-distributed in areas where Hridaya provides services, results do not necessarily reflect the situation in each specific site.

The Baseline Study was conducted in three sites, Delhi, Imphal (Manipur) and Sonipat (Haryana), with 183 samples. The present study was conducted in 12 sites from Haryana, Bihar, Uttarakhand, Jammu and Imphal with 600 samples. As the Baseline and Impact Assessment studies were not conducted in the same sites with the same respondents, we advise caution when directly comparing the two studies.

Summary of Findings

SECTION 3



The following section summarizes key findings from the complete results annexed to this report and includes all datasets.

3.1 Socio-Demographic Profile

The majority of the respondents were young (mean age: 31.7 years), received no education or only primary education (51.4%), were unskilled workers (38.5%), were married (49.7%), had a permanent partner residing with them, and lived in a home (94.3%). The majority of the respondents were residing in the same city where they were born (79.3%). A very small percentage (4%) of sex-partners with whom the respondents reside also injected drugs. The mean duration of registration with the NGO TI was approximately three years, while duration of registration with Hridaya services was approximately one year.

FIGURE 3.1: Educational profile of respondents

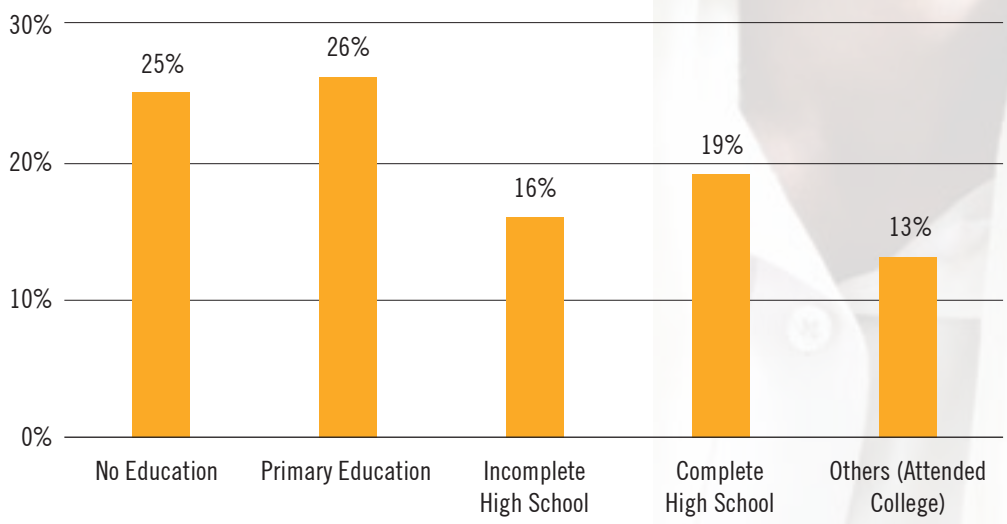


FIGURE 3.2: Occupational distribution of respondents

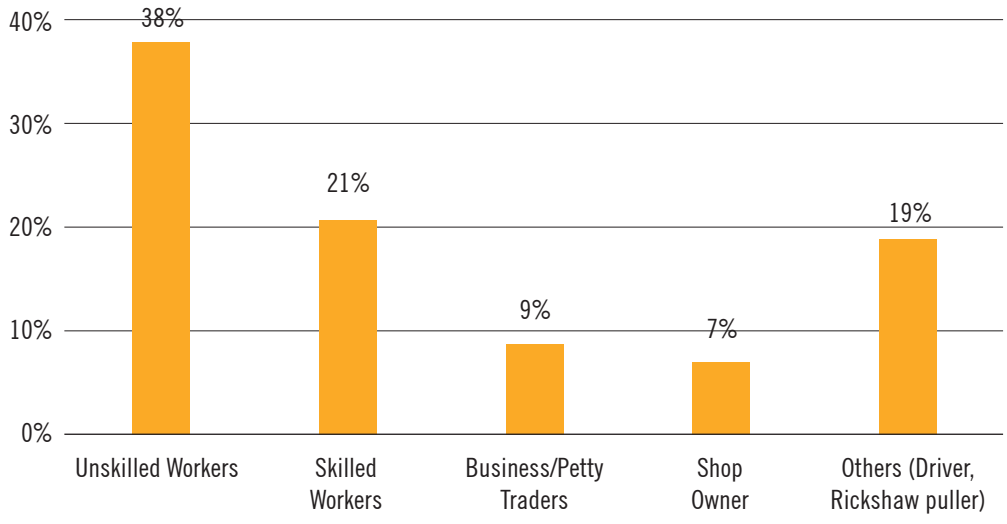
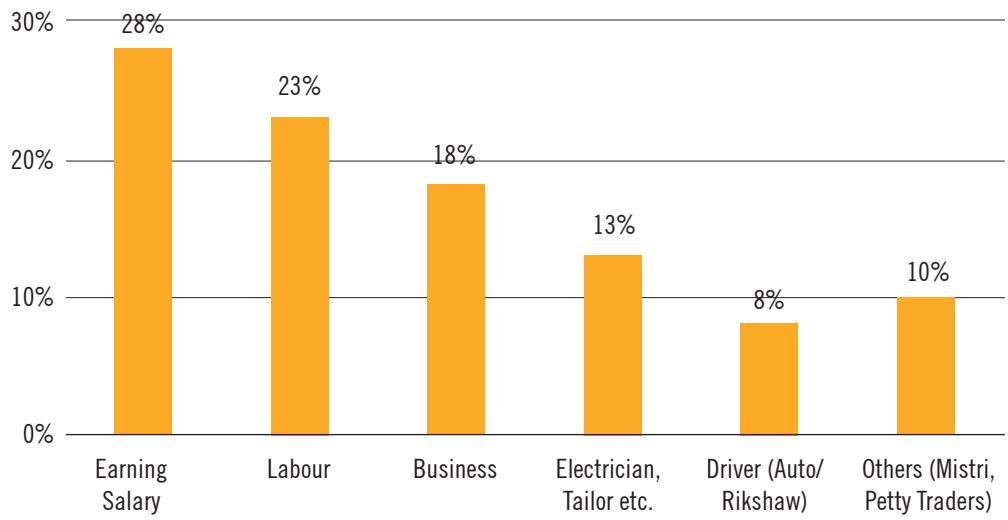


FIGURE 3.3: Income source distribution of respondents

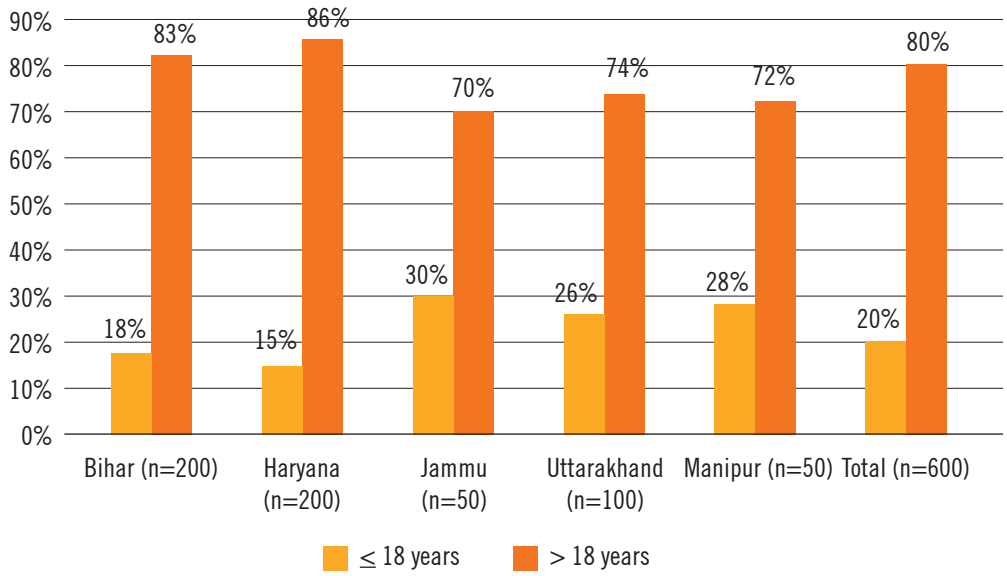


3.2 Drug use Pattern and Injecting Practices[4]

Initiation, experience and frequency: A significant portion, about 20% of respondents, initiated injections before 18 years of age. The mean age to begin injecting was 23.9 years, with a mean of about 7 years' injecting experience. The most common frequency of injections was daily (38.7%) with injecting 1–3 times on the injection day the most common at 93.5%, followed by 6.5% reporting four or more times per injection day.

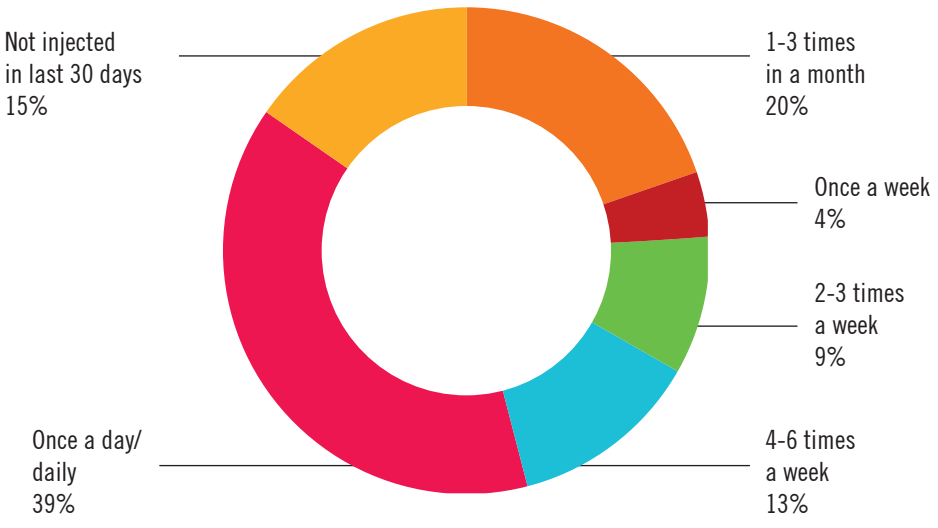
[4] *Refer to Annex IV*

FIGURE 3.4: Distribution of PWID participants by age at which they started injecting



Needle Sharing: Only about 4.7% of respondents had injected with a needle used by another person in the previous 30 days, and the majority of those reporting sharing did not disinfect their equipment before injecting. The most common reason for doing so was non-availability of clean needle/syringe, while only two out of 41 respondents felt that they did not feel the need to use a clean needle/syringe. The majority of respondents (91%) had not sold or loaned their used needle/syringe in the last 30 days.

FIGURE 3.5: Average frequency of injection among respondents over previous 30 days



Substance Variety: Respondents generally reported using more than one type of drug, but were able to report a default or predominant substance. Pharmaceutical opiates were the most preferred class of drug, with buprenorphine the most popular predominant injected drug at 69%, followed by pentazocine (38%). Street heroin, including brown sugar, was the third most commonly used on a regular basis (10%). Sedative drugs were also popular, but probably used in order to increase or optimize the effects of opiates; the mild sedatives promethazine and pheniramine, used by 68% of respondents, are known to be purchased for mixture with the buprenorphine brands Lupigesic and Sangesic as a way to dilute the injection mixture and increase solubility and are likely not often used without a combination of one or more other drugs. Promethazine and pheniramine are similarly used to better dissolve moderately polar (not ideally water soluble) benzodiazepines such as Valium (diazepam)[5], which 13% of respondents reported using. Stimulant use, including all amphetamine type stimulants, was markedly rare at <1%.

CASE STUDY 1: Supporting Spouses of PWID

Yogendra Yadav, a 29 year old sweet maker from Maharajganj, Siwan (Bihar) and his wife Madhu Devi are an illiterate couple who have been beneficiaries of the Hridaya project and whose lives have been transformed on both a personal and social level. The couple were unaware of their HIV status before attending Hridaya services but the staff and services provided by Hridaya, provided them with the information and support they needed to ensure that they were able to be better informed about their sexual health options and were able to make informed decisions regarding how to improve their sexual health and adopt harm reduction measures to minimize negative impacts of Yogendra's drug use. Through the project they were educated on sexual and reproductive health, family planning, testing for TB, HIV & STI and their treatment thereafter. Referral services for HIV were also provided under this project. Yogendra and Madhu give credit for improvement in their lives to the Hridaya project, and he now ingests fewer drugs than earlier and focuses more on his family. After he was tested for HIV and the results turned out to be negative, Yogendra admits to being very relieved. As he puts it, *"I feel much better now. Because of services such as free condoms and syringes, my expenditure has reduced and I do not have to burden myself with such expenses".*

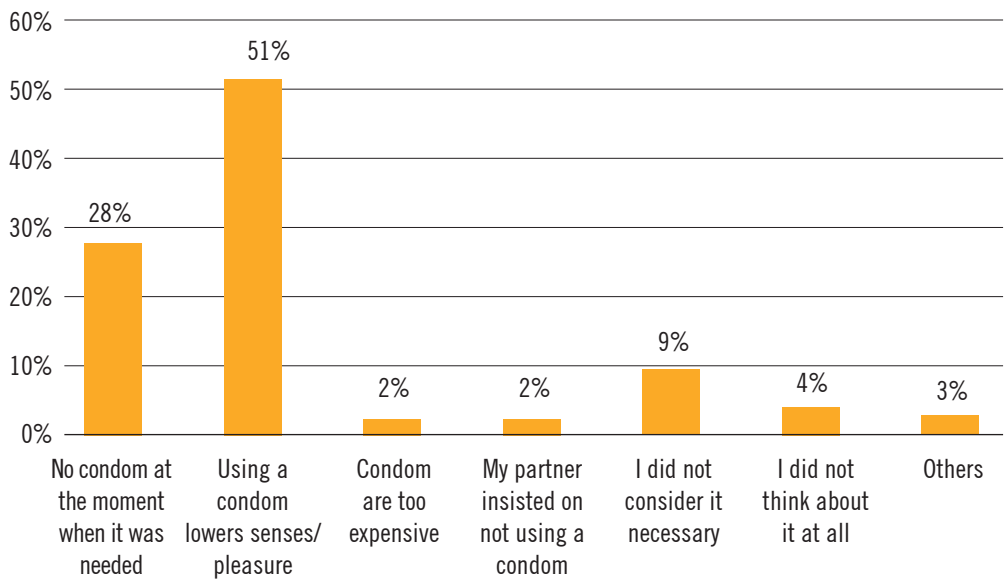
Manoj Kumar and Mamta Devi are from Haridwar (Uttarakhand) who are both laborers and have been beneficiaries of the project. They were not in a position to take up any other work to earn money as they are both illiterate. They were very poor and it was becoming increasingly difficult for them to meet their daily living expenses, mainly because Manoj's wages were spent on his drug consumption. His addiction was not allowing them to improve their financial condition. Through the Hridaya program, their lives took a better turn and many of their problems were resolved. They got guidance and counseling on health concerns, free medical checkups, syringes, medicines, etc. This was a big help to the couple as they could not afford all these on their own because of lack of money. The outreach/health workers visit their home on a regular basis, discuss their problems and provide them with appropriate assistance. The couple's most memorable moment associated with Hridaya was the day when outreach workers visited Manoj's house and informed about him that he was HIV-negative. They also counselled him about safe sex practices and to keep away from things that could negatively affect their life. Manoj has drastically cut down on his drug dosages and is now able to contribute to his family expenses.

[5] *G. Charanjit Sharma, Senior Drug Use Expert, Alliance India*

3.3 Sexual Behaviors

The majority of the respondents (77%) had sexual intercourse at least once in the last 12 months. The most common sexual partner was a permanent spouse or domestic partner, followed by casual partner. Only 14% respondents had sexual intercourse with a commercial sex worker. Vaginal sex was the most common type of intercourse, while anal sex accounted for <3% of sexual intercourse across all types of sex partner in last 12 months. While only half of respondents had used a condom during their last sexual act with their permanent sexual partner, the majority of respondents used condoms during their last sexual act with a casual partner or sex worker (83% and 90% respectively). For the majority of respondents, condoms were used consistently with non-permanent partners.

FIGURE 3.6: Reasons for not using a condom during last sexual intercourse



Most respondents preferred to use a condom; among the majority (83%) who considered condom use to be socially acceptable, prevention of STIs served as the primary motivation. When asked to cite reasons for not using a condom, displayed in *Figure 3.6*, very few believed condoms to be totally unnecessary. In line with a previous finding[6] that increased sexual pleasure is a prominent motivation for using drugs and a primary cause for habit formation, over half cited reduced sensation as their reason to omit prophylaxis. Aside from this willingness to risk unprotected sex in favor of greater pleasure, the second most common reason (28%) was simply not having a condom available. Condom unavailability was likely due to inadequate planning; only 2% reported that condoms are too expensive.

[6] *Double Trouble: Injecting Drug Use and Sexual Behaviour. India HIV/AIDS Alliance, 2015.*

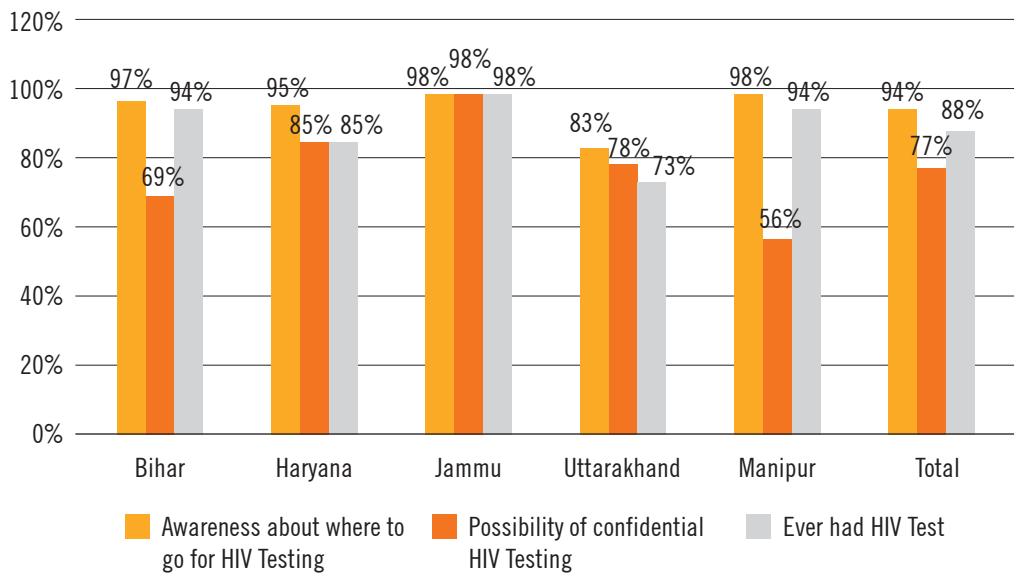
CASE STUDY 2: "My life is worth living due to Hridaya"

This is the story of Ravi, a resident of Govind Nagar, Sonipat, aged 32 years, who has expressed his gratitude to Hridaya for offering him and his family support in his livelihood. Ravi, a 12th class pass-out, started taking drugs in his teens. Things began to really get out of control when he found himself totally dependent on drugs in his early twenties. He had always believed that he was different from others and this would not develop into a habit. However he realised quite early that he could not manage without drugs and was addicted to them. He tried to give up drugs a number of times but remained unsuccessful in his attempts. He says he is fortunate to have established contact with the Modern Education Society (MES), a Hridaya partner, who have helped him make the transition back into society. The MES, through its initiatives, counseled him and his family and advised them the right way to deal with him. The MES also offered him financial support during his treatment and also encouraged him to study and clear the senior secondary exams so that he can stand on his own feet. Prior to his contact with the MES, his life was in tatters, it was difficult for him to keep a steady job and he did not bother about personal care and hygiene. Moreover his relationship with his parents and brother was volatile, with him hurling verbal and mental abuse on them. The help and counseling he received from the MES staff convinced him to mend his ways and now his life is back on path. Presently with the NGO's assistance, he is working in a private company and his manager is satisfied with his performance and dedication. Today he is respected by his peers, parents and his brother. He says, *"My life has been greatly enriched by Hridaya and my existence is worth living due to Hridaya."*

3.4 HIV-Related Attributes

The majority of respondents were aware of where they could get their HIV test done, and had been tested.

FIGURE 3.7: Respondent awareness about HIV testing



For those who had not been tested, the main reason cited was not knowing where they could be tested. The majority of those who got their tests done had done so within the last 12 months, and obtained their test results. Only 5.7% of those tested and ready to disclose their diagnosis were HIV positive. Almost all of the respondents who divulged their status as HIV positive were registered in an ART center. The majority of the respondents (>90%) were aware of the ways in which HIV can be transmitted and of ways to prevent infection.

3.5 Receipt of TI Services

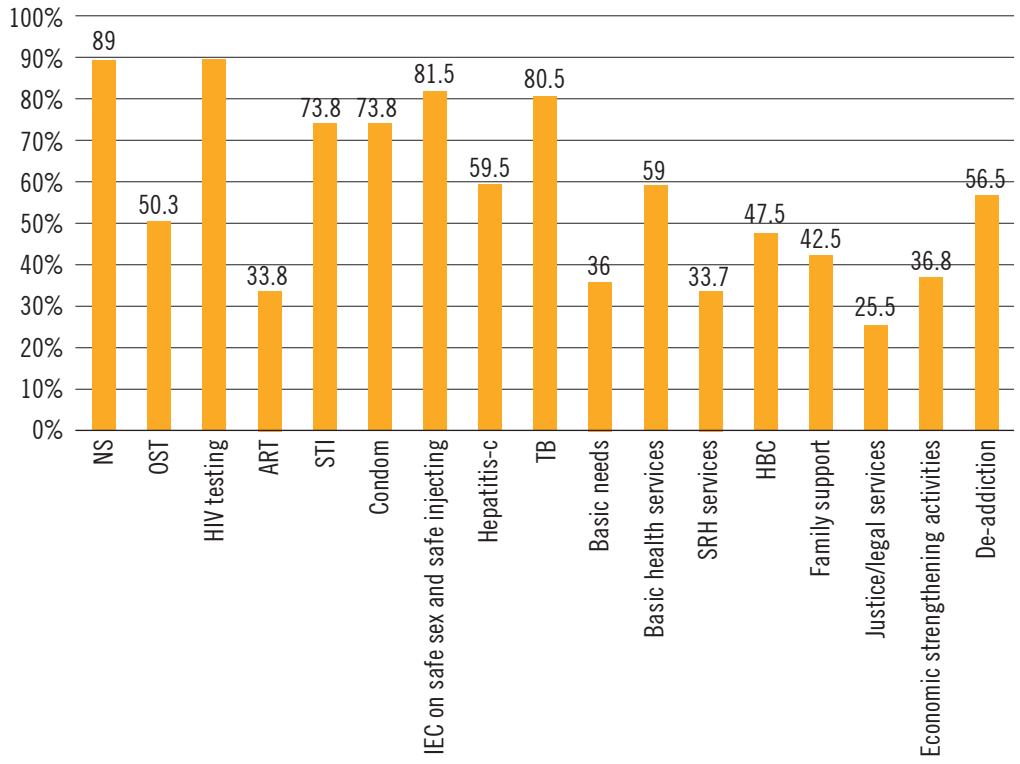
Close to 60% of respondents reported that they receive services at the frequency of two to three times a month or more. The majority of respondents received the following services:

- Needle/syringe provision
- HIV testing and counselling
- Information regarding safe injecting and safe sex
- TB related service

Less than 50% respondents received the following services:

- Opioid substitution therapy
- Provision of shelter, food and other basic services
- Sexual and reproductive health services
- Home-based care (for HIV-positive PWID)
- Family support
- Legal support
- Support for strengthening finances

FIGURE 3.8: Percentage of clients receiving TI services



CASE STUDY 3: From East to West – Hridaya's impact

Luv Khush Paswan is a 31 year-old uneducated labourer from Anaith Arrah (Bihar). His wife, tired of his drug addiction, took him to meet the Hridaya team. Hridaya's female outreach worker then started visiting his house regularly and provided him with counseling and advice regarding the risks of drug overdose, the safe and consistent use of sterile needles and syringes when injecting, and information about safe sex and reproduction. She also proved to be a great support to his wife. Hridaya also helped the couple to get free health checkups and they were both tested for HIV and found to be HIV negative. They were also given legal advice and adult education. Luv has now reported that he has reduced his drug intake and is hopeful of stopping completely. The Hridaya project has made him realise that even people like him can take advantage of the support system provided by the organization.

Sanjay, a resident of Braham Nagar Sonipat, Haryana, got a new life in his 40's because of Hridaya's intervention. Sanjay had attended regular school up to 9th standard. Due to his drug dependence he could not study further and ended up living on the streets of Sonipat. After being counseled by the Hridaya team he has begun a recovery period and is presently leading a happy life as an auto driver. He has started contributing to the family expenses and looking after his elderly parents. He has regained respect in his family and neighborhood. He feels joy in sharing what he has learned from the program and has started helping other drug users. He quoted that earlier there was no one to guide him about right and wrong, so now he wishes to transform the lives of those who are in the same darkness that he passed through. According to him *"I will always be grateful to HIV Alliance program, Hridaya, for giving me a new life".*

3.6 Hridaya-Specific Services: Delivery and Satisfaction

Services listed below were introduced as part of the Hridaya program.

Overdose

The majority of respondents received information on overdose, while half of the respondents reported that their family also had received such information. Of those respondents who reported having an overdose in the past 12 months, about half reported to have received help from the service providers for their overdose; the most common mode of help was putting the victim in recovery position, while about 10% received naloxone. More than 50% of respondents answered correctly to questions testing their knowledge on overdose.

Tuberculosis (complementary service)

Almost all of the respondents who reported to have any symptom of tuberculosis were referred to the DOTS center and were tested/treated for TB. More than 80% and 60% respondents

claimed that they and their family members, respectively, have received information on signs/symptoms, prevention and treatment of TB. More than 60% respondents answered correctly to questions testing their knowledge of TB. Education is an essential component and should be strengthened in order to create awareness.

Hepatitis C

About one-fifth of the respondents were referred for HCV testing, and half of the respondents were educated on HCV. Only one-third of the respondent's family members were educated on HCV. Just 43% knew that HCV is a curable condition. Further education is required to enhance hepatitis-C awareness.

Opioid substitution therapy (complementary service)

The majority of the respondents who were ever initiated on OST, 93%, had started OST within the past year; all of these respondents received information on OST, as well as were encouraged to be regular on OST. Furthermore, majority of those respondents who discontinued their OST were contacted and encouraged to restart OST. Only one-third of the respondents' families were provided information regarding the benefits of OST. About 50% respondents answered correctly to questions testing their knowledge on OST.

Sexual and reproductive health services

Among the respondents who lived with their spouse, about 35% of the spouses were referred for HIV testing and 50% for STI check-up. About 50% of spouses had received information on SRH services.

Family support

Among those respondents who were staying with their families, about 66% of the families were contacted by NGO staff, and the majority of those received counselling. About 76% of the respondents reported improvement in their relationship with family members. About 6% of families were supported by an NGO to earn money via financial support or training, while 2.5% of respondents' children received assistance to attend school.

Other services

Approximately 15% of the respondents and 7% of the respondent's spouse were part of a support group. Only few respondents faced a crisis in their life, during the period when Hridaya services were implemented. Six respondents reached out to their crisis response team, and four respondents confirmed a successful CRT response.

Among those who received services, more than 60% respondents were highly satisfied with the following services: needle/syringe, opioid substitution therapy, HIV testing and counselling, TB services, and drug treatment services. On the other hand, less than 40% were highly satisfied with the following services: services for basic needs, family support services, and economic strengthening services. Very few respondents were highly unsatisfied with any of the services being provided.

TABLE 2: Client satisfaction with services specific to and enhanced by Hridaya (%)

TI-Plus (Hridaya-specific) services	Very satisfied	Fairly satisfied	Not satisfied
Opioid substitution therapy	79	19	2
Diagnosis, treatment and vaccination of viral hepatitis	61	37	2
Prevention, diagnosis and treatment of TB	68	31	1
Basic health services including vein care and overdose prevention and management	53.5	45.5	<1
Sexual and reproductive health services (including PMTCT/ PPTCT, family planning, access to safe abortion and maternal health services	48	51	1
Family support (for you and your relatives)	36	63	1
Pre-existing services enhanced by Hridaya			
Needle/syringe provision	69	30	1
HIV Testing and Counselling	73	27	0
Antiretroviral Therapy	45	53	2
Targeted information, education and communication about safe sex and safe injecting	58	42	
Home based care and support for HIV positive drug users	48	52	
Justice/Legal services	50	43	7
Economic strengthening activities	37	56	7
De-addiction-Counselling and linkage service	81	18	1
Shelter, shower, food, other services that satisfy basic needs	39	59	2
Median	**57**	**41**	**2**

The key factor in service delivery for majority of the respondents was accessibility of the services – the service should be located close to their home. Most respondents felt that their basic needs are met, their family supports them, and are satisfied with their economic status. Only one in four respondents felt highly stigmatized, and only 10% felt themselves to be very vulnerable. Very few experienced any negative attitudes/action by law enforcement authorities, or lack of support from their communities. Close to 50% respondents felt that the health services that they need are fully accessible.

CASE STUDY 4: "The staff loves us as family members"

Mohammad Boro, a 47 year old unemployed resident of Khergao Awang, Manipur and his wife, Thoibi were finding it difficult to survive in the community as he was injecting drugs for several years and had also been diagnosed HIV positive. Hridaya's contribution has changed their lives in many positive ways, helping them emerge from immense isolation and discrimination. They received family counseling, labor card, intense support by the outreach worker, awareness regarding TB & hepatitis-C support, SRH support, ART referral and follow up. The greatest benefit that they have received from this project is that Boro's health has improved drastically. The STI problem has been cured and they were guided and educated about TB, Hepatitis-C and co-infections. As Thoibi puts it *"the outreach worker and the other staff love us as their family members and we are thankful to them"*.

The son of Kafkoo Devi, a resident of Ambala, Haryana was a drug user and used to be abusive to his parents. They were therefore at a total loss as to how to handle their son. Hridaya staff counseled the parents about dealing with a drug user and advised them to be patient with him. They also offered the son counseling and opioid substitution therapy. Moreover, they obtained complete testing for the son and also looked after his basic needs during the course of OST. After six months, the son of Devi has stopped abusing his parents and is on the road to recovery and securing employment. As Kafkoo Devi puts it *"Hridaya has helped us greatly in our times of need and I will always remain deeply grateful to Hridaya for guiding my son in the right direction"*.

3.7 Findings from Qualitative Assessment

Key Informant Interviews

Key informant (KI) interviews with project managers and outreach workers associated with Hridaya project showed that the TI was able to go beyond provision of needle/syringe and other basic services for PWID to linkage with OST services, provision of education on various illnesses, and formation of peer support groups and crisis response team.

For the KI, the most important contribution of Hridaya project has been to provide services to the spouses and family members of PWID clients. The project has been able to make resources available to provide these services, so that spouses and family members could be contacted and services necessary for them, including STI services, SRH services, HIV testing services could be provided. At some places, PWID were made aware of their rights; support group formation has helped to collectivise the PWID for raising issues about their rights. The case studies of PWID also bear testimony to the value addition of these services.

The KIs also pointed out certain gaps and needs of PWID that were still unmet. For PWID, employment is a major issue, and the KIs felt that helping PWID with gainful employment will help in PWID staying away from high risk behaviors and ultimately benefit the HIV prevention program. Hepatitis-C diagnosis and treatment is another major issue that KIs feel is not being addressed by any program.

3.8 Discussion on Key Findings in Comparison with Baseline Findings

In the discussion, a comparison of the findings in the current study has been made with the findings from the Baseline Survey; however, a statistical comparison is not possible, as the Baseline Survey was conducted at different sites and states. Table 3 presents key findings from the Baseline and Impact Assessment Survey.

TABLE 3: Qualitative comparison of key results from Baseline and Impact Assessment Surveys

Sl. No	Variable	Baseline finding	Present finding
1	Not selling/lending needles/syringes in past 30 days	74%	91%
2	Injecting with used needle/syringes in past 30 days	22%	5%
3	Injected with new needle/syringe during last injecting act	79%	87%
4	Use of condoms during last sex act with commercial sex partner	52%	90%
5	Use of condoms during last sex act with casual sex partner	64%	83%
6	Ever tested for HIV	76%	88%
7	Did not know the place where one gets tested for HIV	80%	23%
8	Received the following services in past 12 months:		
(a)	Needle/syringes	98%	90%
(b)	Opioid Substitution Therapy	46%	51%
(c)	HIV testing and counselling	83%	91%
(d)	Condoms	82%	75%
(e)	Tuberculosis	51%	81%
(f)	Hepatitis C	32%	60%
(g)	Home-based care	29%	48%
(h)	SRH services for spouse	18%	34%
(i)	Support to family members	12%	43%
(j)	Legal services	7%	26%
9	Perception that basic needs are fully met	8%	28%
10	Not satisfied with their economic well-being	25%	11%
11	Family support available	12%	61%
12	Do not feel stigmatized	4%	45%
13	Feel constantly safe and secure	7%	41%
14	No negative attitude/action from police	34%	80%
15	Receive support from community	3%	48%

Findings of HIV risk behaviors in terms of injecting with used needle/syringe and sexual intercourse without condoms show that very few respondents indulge in high-risk behaviors. Less than 5% of respondents had injected with used needle/syringe in the past 30 days, and

87% had used a new needle/syringe at last injection. This is considerably less as compared to the Baseline Survey findings, where about 22% had injected with a used needle/syringe in past 30 days, and 79% had used a new needle/syringe at last injection. With regards to sexual behavior, 90% of respondents who had sex with commercial sex worker in the last one year had used a condom in their last sex act; this has considerably increased as compared to Baseline Survey, where only 52% did so. Similarly, the use of condoms during last sexual intercourse with casual sex partner increased from 64% at Baseline to 83% at present.

The vast majority (91%) of present respondents, as compared to 74% at Baseline, had not sold/loaned their injecting equipment in the last 30 days. Of those who reused a needle/syringe in their last injection, the majority cited 'non-availability of needle/syringe' as the reason for reuse. This is despite the fact that all the clients were registered recipients of TI. Clearly, there is a need to explore other avenues of needle/syringe distribution apart from the most commonly employed strategy of peer-based distribution. Secondary distribution systems, including pharmacies and possibly drug peddlers themselves, can be explored for stocking and provision of needle/syringes.

The proportion of respondents who ever had been tested for HIV considerably increased from 76% in the Baseline Survey to 88% in the Impact Assessment Survey. Also, the proportion of respondents who reported that they did not know the place of HIV testing came down from 80% in Baseline to only 23% in present survey. As compared to the Baseline Survey, the proportion of respondents who received needle/syringe, condoms, HIV counselling/testing and OST services did not differ considerably. This is despite the provision of more staff in terms of peer counsellor and monitoring officer. Efforts to ensure that the core HIV prevention services are delivered consistently must be made. Focusing on other services at the expenses of core HIV prevention services will lead to misplaced priorities on part of TI service providers.

The introduction and provision of novel services introduced by Hridaya improved respondents' quality of life - most respondents received information relating to overdose, TB, Hepatitis C, and OST. The proportion of respondents with adequate knowledge on these issues and those who received the add-on services was also not remarkably high. However, compared to Baseline Survey, the proportion of respondents receiving these services has considerably increased - from 51% to 81% for TB, 32% to 60% for hepatitis-C, from 29% to 48% for home-based care, from 18% to 34% for SRH services to spouses, from 12% to 43% for support to family members, and 6.5% to 26% for legal services. The mean duration of receiving Hridaya services was 12 months. Comparison with Baseline figures show progress; continued efforts in this direction will permit required changes in ensuring that additional services reach those in need.

The impact of the additional support and services provided through the project is reflected in the respondents' rating of their well-being and perceived stigma. As compared to 8% at Baseline, 28% respondents at the Impact Assessment felt that their basic needs were fully met. There was a considerable increase from 12% to 61% of respondents at the Impact Assessment who felt that their family is now supporting them. There was a positive decrease, from 25% to 11%, in dissatisfaction with economic wellbeing. Similarly, 45% respondents, as compared to 4% at Baseline, did not feel stigmatized; 41%, as compared to 7% respondents felt constantly safe and secure; 80% as compared to 34% did not experience negative attitude/action from the law enforcement authorities; and 48% as against 3% respondents at Baseline felt that they receive support from the community. Clearly, the indirect benefits of the project are reflected in the overall quality of life of the PWID.

SECTION 4

Conclusions and Recommendations

Conclusions

PWID are in need of services over and above those which directly are linked to HIV prevention. These include services for TB, overdose, economic and livelihood support, health services for the spouses of PWID, and education of family members, as expressed by considerable proportion of respondents in the survey. Provision of these services also leads to an overall improvement of satisfaction, well-being of PWID and reduced perceived stigma among PWID. Hridaya project has been able to demonstrate these findings. Programs designed for PWID should take these into consideration, and provide support to PWID in the form of these services.

Recommendations

- Introduce a continual quality improvement process for all services offered that includes a communication loop with service users to increase levels of service satisfaction from 57% to a minimum of 85% that is consistently maintained or improved.
- Increase efforts to reach out to the PWID early in their injecting career. Early identification of PWID who have recently initiated injecting, and educating as well as providing HIV prevention services will help avert sharing and other risk behaviors. This can be achieved through intensive outreach programs. Providing basic services to those drug users who are chasing heroin/using opioids through other routes will also help to monitor this population for potential transition to injecting.
- Ensure that there is both an appropriate gender mix of staff, and that the TI teams consist of multi-disciplinary specialists (i.e. social workers who are both able to work with families of PWID and to provide OST counseling). Provision of

female outreach staff has helped the project in reaching out to two distinct populations hitherto not reached in a TI program – family of PWID and spouses of PWID. The Impact Assessment Survey has shown that these two populations too are in great need of these services, as they have not been practically accessible. Providing female outreach staff to reach out to the spouses of PWID will help in addressing SRH and HIV issues in this population. All HIV prevention programs for PWID should include female staff for their outreach services.

- Ensure that there is a comprehensive package of services available at PWID sites and that staff are fully trained on clinical and psycho-social aspects of each service, including adequate information and counseling. The project has emphasised provision of TB, Hepatitis C, OST and ART services through training, supervision and provision of staff for referral. This has resulted in improvement of access to these services.
- Provide naloxone to every TI site and to every outreach worker. The administration of naloxone can help avert a fatal overdose. It is important for programs working with PWID to ensure that their staff are trained on education and primary intervention for overdose and naloxone injections are available with the staff to treat overdose.
- Design more comprehensive awareness programs to include targeted IEC materials for clients and their families. Though training and supervision has been regularly conducted, the proportion of respondents who had adequate knowledge on overdose, TB, Hepatitis C, OST and ART is modest. Alternative ways to enhance the knowledge on these issues must be considered. This may include creation of issue-specific IEC materials, conducting regular knowledge drives, providing job-aids to the outreach staff on these issues, etc. The lack of sufficient IEC materials has also been voiced by the project staff in qualitative interviews. The project/program needs to focus on this aspect in its next implementation phase.

ANNEXES

Contents

Introduction

These Annexes contain tabulated collection of response data obtained in the Impact Assessment Survey questionnaire and Key Informant interviews. The annexes are meant to serve as supplemental accompaniment to the main report.

The accuracy of all information herein is subject to respondent bias and honesty.

ANNEX 1: Respondent overview

This section characterizes respondent sample demographics, and also gives an overview of respondents' sexual behavior, drug use habits, TI registration history and legal history.

TABLE 1.1: Age, education and occupation

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Age (yrs)						
Mean age	33	31	34	28	36	**32**
SD	7	6	7	7	6	**7**
Education (%)						
No education	38	10	4	50	4	**2**
Primary education	25	37	8	27	4	**26**
Partial high school	19	11	24	15	20	**16**
Complete high school	12	24	36	4	40	**19**
Higher education	5	17	28	4	30	**13**
Occupation (%)						
Unskilled worker	35	47	20	50	12	**38**
Skilled worker	20	17	32	28	18	**21**
Business/petty trader	12	4	8	13	8	**9**
Shop owner	8	6	12	2	10	**7**
Other (driver, rickshaw puller)	21	18	8	4	48	**19**
Source of income (%)						
Salaried	16	17	74	48	28	**28**
Labourer	23	41	6	3	8	**23**
Business (incl. shopkeeper)	20	17	14	11	32	**18**
Electrician, tailor, etc.	13	8	2	32	0	**13**
Driver (auto/rickshaw)	20	3	0	0	2	**8**
Others (mistri, petty traders)	7	12	4	6	30	**10**

TABLE 1.2: Family demographics, sexual partners and spouse/partner injection drug use

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
Children among married respondents						
n married =	***158***	***84***	***21***	***42***	***29***	***518***
Children (%)	87	86	95	81	72	**85**
n with children=	***138***	***72***	***20***	***34***	***21***	***334***
Number of children						
Mean	2.1	2.0	1.8	2.0	2.2	**2.1**
SD	0.84	0.77	0.96	1.16	1.07	**+/- 0.90**
Current marital status (%)						
n =	**200**	**200**	**50**	**100**	**50**	**600**
Currently married	74	38	38	26	58	**49.7**
Widow/Widower/Divorced/ Separated/Deserted	5.5	4.5	2	16	0	**6.2**
Never married/Unmarried	20.5	57.5	60	58	42	**44.2**
Current sexual partner(s) (%)						
Married or have a permanent partner, no other sexual partners	76	37	40	32	60	**51.3**
Married or have a permanent partner, have another sexual partner or partners	1.5	17	2	1	8	**7.2**
No permanent partner, have occasional sexual partner or partners	10.5	30	28	21	14	**20.5**
No sexual partners	12	16	30	46	18	**21**
n =	**138**	**68**	**20**	**26**	**27**	**279**
Spouse/sexual partner living at home injects drugs	0	6	0	15	11	**4**

TABLE 1.3: Durations of registration with a TI, with Hridaya

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	***200***	***200***	***50***	***100***	***50***	***600***
TI registration duration (months)						
Mean	28.55	38.36	17.34	53.82	67.6	**38.45**
SD	12.5	10.54	7.87	12.74	39.52	**20.76**
Hridaya registration duration (months)						
Mean	9.06	15.88	8.06	10.57	21.66	**12.58**
SD	4.35	5.07	3.66	4.15	5.72	**+/- 6.21.**

TABLE 1.4: Arrest and compulsory treatment (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	***200***	***200***	***50***	***100***	***50***	***600***
Ever arrested for drug related crime?	17.5	2.5	46	19	46	**18**
n =	***35***	***5***	***23***	***19***	***23***	***105***
…..in the past year?	28.6	80	8.7	78.9	21.7	**34**
n =	***200***	***200***	***50***	***100***	***50***	***600***
Ever undergone compulsory treatment?	10.5	0.5	2	3	28	**7**
n =	***21***	***1***	***1***	***3***	***14***	***40***
…..in the past year?	0	0	100	66.7	0	**8**

ANNEX 2: Injection history, patterns, substances and safety

Data presented in this section cover respondents' drug use history (e.g. age of commencement, duration of use), substance preferences, habits (e.g. place of injection, frequency of use). It also characterizes the prevalence of risky drug related behaviors and assesses respondents' awareness of overdose safety as well as awareness of infection risks associated with drug use.

2.1 Injection history and patterns

TABLE 2.1.1: Age at first injection and years of experience

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Age at first injection						
≤18 years (%)	17.5	14.5	30	26	28	**20**
>18 years (%)	82.5	85.5	70	74	72	**80**
Mean age (years)	24.94	23.5	23.56	23.03	23.44	**23.9**
SD (years)	7.11	4.94	7.51	6.39	6.82	**+/- 6.37**
Duration of injecting behavior						
Mean duration (years)	7.22	7.09	10.34	5.63	12.33	**7.59 yrs**
SD (years)	4.98	4.2	5.2	4.36	6.84	**+/- 5.14 yrs**

TABLE 2.1.2: Average frequency of injection during the last 30 days (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Avg. frequency of injection in last 30 Days (%)						
1-3x/month	19.5	24	10	11	30	**20**
4x/month	3.5	8.5	0	0	4	**4**
2-3x/week	5.5	18	2	3	8	**9**
4-6x/week	1	30	6	5	14	**13**
1x/day	56	17.5	14	67	22	**39**
Have not injected in last 30 days	14.5	2.0	68	14	22	**15**

TABLE 2.1.3: Average number of injections taken in a day (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*198*	*49*	*98*	*44*	*589 PWID*
1-3 times in a day	93.5	97	94	91	84	**94**
At least 4 times a day	6.5	2	4	7	4	**5**

TABLE 2.1.4: Usual place of preparing and injecting drugs (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
At home by yourself	39.5	15	26.0	9.0	42	**25**
At friends home together with other drug users	10.0	6.5	28.0	7.0	14	**10**
In the street/yards/other public areas	42.5	73.0	42.0	75.0	6	**55**
Other Places(Under flyover, Field and Near Railway line)	8.0	5.5	4.0	9.0	38	**10**

TABLE 2.1.5: Injection assistance at very first injection (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Injected yourself	4.5	14.5	2	12	20	**10**
Friend helped	16	67.5	80	37	30	**43**
Friend prepared injection	48.5	14	18	47	30	**33**
Others (Doctor/RMP/ Compounder/Senior etc.)	31	4	0	4	20	**14**

2.2 Substances used

TABLE 2.2: Type of drug injected (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
OPIOID						
Heroin/Brown Sugar/Smack	5	0	0	1	96	**10**
Liquid opium extract	0	0	0	0	12	**1**
1Dextropropoxyphene	0.5	0	10	17	52	**8**
Buprenorphine (Norphin/ Tidigestic/Lupigesic/Sangesic)	47.5	85	96	98	0	**69**
Pentazocine	78.5	28	6	6	8	**38**
Stimulants						
Amphetamine	0	0	0	0	6	**<1**
Ecstasy/Yaba/ICE/Speed	0	0	0	0	4	**<1**
Sedatives						
Benzodiazepine	9	1.5	84	1	32	**13**
Avil/Phenargan	66.5	64	94	97	4	**68**
Ketamine	1	0	0	0		**<1**
Most Commonly Injected Drugs						
Norphin (buprenorphine)	47.5	85	96	98	0	**69**
Fortwin (pentazocine)	78.5	28	6	6	8	**38**
Heroin	5	0	0	1	96	**10**

2.3 Safe injecting practice

TABLE 2.3.1: Sharing and cleaning/disinfection of injecting equipment among respondents who inject opiates (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*3*	*9*	*0*	*21*	*5*	*38*
Disinfected needle in last 30 days?						
Always	0	0	0	0	5	**5**
In majority of the cases	1	0	0	0	0	**1**
Sometimes	0	1	0	2	0	**3**
Never	2	8	0	19	0	**29**
n =	*200*	*200*	*50*	*100*	*50*	*600*
Sold or lent used needle/syringe in the last 30 days?						
Always	1.5	0.5	0	2	0	**1**
In majority of the cases	0	1	0	3	0	**>1**
Sometimes	4.5	3	4	15	16	**7**
Never	94	95	96	79	84	**91**
Injected yourself by preloaded syringe in last 30 days?	2.5	5	0	3	10	**4**
Shared Injecting equipment (spoon, cup, cotton, filters, water, etc.) in the last 30 days?						
Always	1.5	2.5	0	1	2	**2**
In majority of the cases	0	0.5	0	0	2	**>1**
Sometimes	0.5	2.5	0	13	28	**5**
Never	98	93.5	100	86	66	**92**

TABLE 2.3.2: Blood flushing (filling) practices and use of used needles/syringes during the last 30 days (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Have you…						
Blood Filling Activity in last 3 months	20	11	38	7	48	**19**
Ever injected by someone?	34.5	20	70	19	72	**33**
Last time: injected drug by clean needle not used previously	92.5	84	70	89	84	**87**
Last 30 days: PWID injected drug with a needle that was previously used by another person	2	0.5	0	20	6	**5**
n =	*5*	*10*	*0*	*21*	*5*	*41*
Reason for using used syringe/needle in the LAST 30 DAYS (n who cited a reason)						
No clean needle/syringe was available	2	5	0	19	2	**28**
Did not see the need to use a clean or new needle/syringe	0	2	0	0	0	**2**
I was using the needle/syringe after the person whom I trust	1	2	0	1	2	**6**
Needles/syringes are expensive to buy	1	0	0	1	0	**2**

2.4 Overdose safety

TABLE 2.4.1: Overdose frequency, situation-handling in the event of overdose, and services obtained (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
OD history						
Ever suffered from overdose?	51	30.5	16	19	24	**34**
n =	*102*	*61*	*8*	*19*	*12*	*202*
Overdose in the past year?	52.9	60.7	50	84.2	33.3	**57**
n =	*54*	*37*	*4*	*16*	*4*	*115*
Received help for last overdose?	57.4	43.2	75	43.8	50	**51**
n =	*31*	*16*	*3*	*7*	*2*	*59*
Kind of help received for last overdose?						
Recovery position	96.8	31.3	66.7	28.6	0	**66**
Naloxone injection	0	18.8	33.3	14.3	50	**10**
Hospitalisation	3.2	25	0	57.1	50	**17**
Others	0	25	0	0	0	**7**
n =	*200*	*200*	*50*	*100*	*50*	*600*
Informed by NGOs about overdose?						
Provided information by the NGO staff about why overdose occurs, how can it be prevented, and what to do if one has overdose in the past year	62.5	97	80	67	96	**79**
Information provided to family members by the NGO staff about overdose	48	59	56	29	50	**49**

TABLE 2.4.2: Awareness of overdose risks

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Individual have overdose if alcohol or sedative Tablets are mixed with injections (Yes) (%)	60	85	82	47	60	**68**
Overdose can be treated by making the overdosed person drink/inject salt water (Yes) (%)	62.5	37	86	77	16	**55**

ANNEX 3: Drug treatment

This section covers questionnaire items pertaining to opioid substitution therapy (OST), a service available through Hridaya. Opiates are the most commonly injected type of drug for all respondents (see *Table 2.2*).

TABLE 3.1: OST history and knowledge of OST among respondents who inject opiates (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Ever on OST?	20.5	47.5	100	53	96	**48**
n =	*41*	*95*	*50*	*53*	*48*	*287*
Initiated on OST in the past year?	95.1	92.6	100	94.3	81.3	**93**
n =	*39*	*88*	*50*	*50*	*39*	*266*
Advised by NGO staff to be regular on OST in the past year?	100	100	100	100	100	**100%**
Discontinued OST in the past year?	7.7	42	70	26	64.1	**43%**
n =	*3*	*37*	*35*	*13*	*25*	*113*
Encouraged to resume OST upon contacting NGO?	100	91.9	97.1	76.9	80	**89%**
n =	*200*	*200*	*50*	*100*	*50*	*600*
Received information from NGO staff about benefits in the past one year	23	86	96	79	100	**66%**
Family member/s received information by the NGO staff regarding the benefits	17.5	56	48	25	54	**37%**

TABLE 3.2: Respondent impressions of appropriate OST treatment duration (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
In your opinion, is it appropriate to take OST medication every once in a while?						
Yes	1	46	24	9	8	**20%**
In your opinion, is it appropriate to take OST medication for only a few days or weeks?						
Yes	0.5	36.5	8	6	34	**17%**

ANNEX 4: Sexual reproductive health (SRH)

This section covers all questionnaire items pertaining to general SRH including sexual partners, sexual behaviors, birth control and STI protection habits (perspectives and statistics on condom use), dissemination of SRH information, and use of the SRH services available through TIs.

TABLE 4.1: Sexual partners and sexual activity (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	***200***	***200***	***50***	***100***	***50***	***600***
Had sex in the past 12 months?	90.5	81.5	72	50	68	**77**
n =	***181***	***163***	***36***	***50***	***34***	***464***
With who? [multiple responses possible]						
Permanent Partner	82.9	44.8	55.6	54	88.2	**65**
Casual Sexual Partner	9.4	45.4	27.8	32	8.8	**26**
Commercial Sexual Partner	17.7	12.9	16.7	14	2.9	**14**
At last sexual act with each type of partner, engaged in which sexual behavior? [multiple responses possible]						
Permanent partner, n =	***150***	***73***	***20***	***27***	***30***	***300***
Vaginal	98.7	98.6	95	100	100	**99**
Other (anal/oral)	1.4	1.4	5	0	0	**1**
Casual partner, n =	***17***	***74***	***10***	***16***	***3***	***120***
Vaginal	94.1	100	100	87.5	100	**97**
Other (anal/oral)	5.9	0	0	12.6	0	**3**
Commercial partner, n =	***32***	***21***	***6***	***7***	***1***	***67***
Vaginal	96.9	90.5	100	85.7	100	**94**
Other (anal/oral)	3.1	0	0	14.3	0	**3**
In the last 30 days, had sex with which type of partner? [multiple responses possible]						
n =	***150***	***73***	***20***	***27***	***30***	***300***
Permanent Partner	95.3	98.6	90	92.6	90	**95**
n =	***17***	***74***	***10***	***16***	***3***	***120***
Casual Sexual Partner	52.9	70.3	40	50	66.7	**63**
n =	***32***	***21***	***6***	***7***	***1***	***67***
Commercial Partner	68.8	57.1	33.3	71.4	100	**63**

TABLE 4.2: Social acceptance of condom use and reasons for using a condom (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*181*	*163*	*36*	*50*	*33*	*463*
Belief that condom use is socially acceptable	86.7	89	50	72	90.9	**83**
Reasons for using condom						
Preventing undesired pregnancy	81.2	99.4	91.7	94	75.8	**89**
Prevention of HIV and STIs	92.8	98.8	94.4	94	100	**96**

TABLE 4.3: Reasons for not using a condom (by n people citing a reason)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*109*	*84*	*16*	*20*	*17*	*246*
No condom at the moment when it was needed	30	26	2	4	6	**68**
Using a condom lowers senses/ pleasure	66	38	10	9	3	**126**
Condom are too expensive	2	3	1	0	0	**6**
My partner insisted on not using a condom	0	3	1	2	0	**6**
I did not consider it necessary	7	9	1	3	3	**23**
I did not think about it at all	3	4	0	1	2	**10**
Others	1	1	1	1	3	**7**

TABLE 4.4: Reaching out to respondents' families (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Proportion of PWID living with their families	97.5	86	100	45	96	**85**
n =	*195*	*172*	*50*	*45*	*48*	*510*
NGO staff contacted family in the past year	63.6	68	62	73.3	64.6	**66**
NGO staff counseled family in the past year	47.7	70.3	70	66.7	56.3	**60**

TABLE 4.5: Sexual and reproductive health, and SRH services for spouses of PWID (as reported by PWID) (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*141*	*83*	*20*	*24*	*28*	*296*
Have been staying with permanent sex partner/spouse in the past one year	72.3	48.3	40	53.3	58.3	**58**
NGO staff referred spouse/ permanent sex partner for HIV test in the past one year	25.5	42.2	35	37.5	60.7	**35**
NGO staff referred spouse/ permanent sex partner for check-up in the clinic for STI in the past one year	44	73.5	35	25	42.9	**50**
Spouse/permanent sex partner of PWID suffered from any problems related to SRH in the past one year,	9.9	38.6	20	4.2	25	**20**
Spouse/permanent sex partner of PWID received any services related to SRH in the past one year	17.7	44.6	30	8.3	35.7	**27**
NGO staff provided information to spouse/permanent sex partner regarding SRH in the past one year	38.3	69.9	35	20.8	50	**47**

ANNEX 5: Disease awareness, testing and treatment

This section characterizes respondents' knowledge, testing and treatment history for the diseases most relevant in reducing harm for PWID: HIV/AIDS, hepatitis-C and tuberculosis.

5.1 HIV/AIDS

TABLE 5.1.1: Awareness about HIV/AIDS and safe injecting (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Aware that one can avoid HIV by having sex only with one faithful partner who is not infected	98.5	97.5	100	91	98	**97**
Aware that one can avoid HIV by using a condom correctly every time during the sexual intercourse	99	97	90	95	98	**97**
Aware that using a shared needle even once can increase the risk of HIV transmission	90.5	92	90	88	98	**91**
Aware that not using another person's injecting equipment reduces the risk of HIV	83	62	98	77	90	**77**
Aware that HIV Infection can be transmitted from an HIV - Positive mother to her child during pregnancy	81.5	85	98	80	84	**84**
Aware that HIV Infection can be transmitted from an HIV - Positive mother to her child during Delivery	83	87.5	100	81	86	**86**
Aware that HIV Infection can be transmitted from an HIV - Positive mother to her child during breast feeding	23	82	100	78	70	**62**

TABLE 5.1.2: Recent testing history, HIV status and disclosure (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*188*	*169*	*49*	*73*	*47*	*526*
HIV test in last 12 months?						
Yes within last 12 months	97.3	84.6	59.2	93.2	57.4	**86**
No more than 12 months ago	2.7	14.8	40.8	4.1	42.6	**14**
No answer	0	0.6	0	2.7	0	**<1**
Got results in the last test						
Yes	97.3	97.6	81.6	82.2	95.7	**94**
No	1.6	2.4	12.2	12.3	4.3	**5**
Still waiting for the result	1.1	0	6.1	0	0	**1**
No answer	0	0	0	5.5	0	**<1**
HIV Status?						
n willing to disclose =	*183*	*165*	*40*	*60*	*45*	*493*
HIV Positive	1.1	6.7	0	8.3	22.2	**6**
HIV Negative	98.4	92.1	90	90	75.6	**93**

TABLE 5.1.3: HIV/AIDS testing awareness, knowledge and testing history

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
HIV testing awareness						
Awareness about where to go for HIV Testing	96.5	95	98	83	98	**94**
Possibility of confidential HIV testing	69	84.5	98	78	56	**77**
Ever had HIV Test	94	84.5	98	73	94	**88**
n =	*10*	*30*	*1*	*20*	*3*	*64*
Reason for no HIV test						
Did not know where to go	20	12.9	0	42.9	0	**23**
Afraid that my HIV status or my drug use will be made public	20	16.1	0	4.8	0	**12**
Working schedule of such HIV testing point/station/center does not match my needs	10	9.7	0	9.5	33.3	**11**
Location of HIV testing point/ station/center does not match my needs	0	6.5	100	14.3	0	**9**
The staffs attitudes are a problem for me	0	19.4	0	0	0	**9**
No HIV Testing point/station/ center where such tests are available in my city/village	10	0	0	0	0	**2**
Do not know where the HIV Testing point/station/center is located	10	0	0	0	0	**2**
No money for HIV Test	0	3.2	0	0	0	**2**
No answer	30	32.2	0	28.6	66.7	**32**

** Multiple responses possible*

TABLE 5.1.4: Belief in myths about HIV Transmission (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
A person looking healthy can be HIV-positive (no)	19.5	32	12	12	14	**21**
A mosquito bite can infect with HIV (yes)	41	27	24	30	12	**31**
A person can get HIV by drinking from a glass of HIV-positive person (yes)	32.5	33	30	37	6	**31**
A person can get HIV by sharing a toilet, swimming pool, or sauna with an HIV-positive person (yes)	31.5	27.5	42	36	4	**29**

TABLE 5.1.5: ART center registration (n)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n HIV+ =	*2*	*11*	*0*	*3*	*9*	*25*
Yes	2	11	0	3	7	**23**
No	0	0	0	0	2	**2**

TABLE 5.1.6: ART initiation, continuation and education about ART/CD4 testing among HIV-positive PWID *(n)*

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*2*	*11*	*0*	*5*	*10*	*28*
Have you initiated & continued to receive ART in the past year?	2	9	0	5	8	**24**
n =	*2*	*9*	*0*	*5*	*8*	*24*
Have NGO staff emphasised importance of regular ART regimen in the past year?	2	7	0	5	6	**20**
n =	*2*	*11*	*0*	*5*	*10*	*28*
Have NGO staff informed on importance of CD4 testing in the past year?	1	11	0	3	7	**22**
Have NGO staff facilitated costs of CD4 testing in the past year?	1	11	0	4	7	**23**
Have family member(s) been provided information by NGO staff regarding the benefits, dos and don'ts of CD4 testing?	2	9	0	4	6	**21**

TABLE 5.1.7: Awareness of risky behaviors while taking ART (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*2*	*11*	*0*	*5*	*10*	*28*
It's not OK to stop ART for some months	100	72.7	0	80	70	**75**
Need to wear condom while having sex with sexual partner, if the person is diagnosed as HIV positive	100	100	0	100	70	**89**

5.2 Hepatitis-C

TABLE 5.2.1: Hepatitis-C education and referral for testing by NGOs (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Have been referred for hep-C testing in the past year	21	13.5	48	10	58	**22**
PWID Have been educated by NGO staff regarding signs and symptoms, treatment and methods of preventing Hep-C in the past year	38	76.5	58	33	88	**56**
Family member been educated by the NGO staff on signs and symptoms, treatment and methods of preventing Hep-C in the past year	30.5	39	28	13	42	**31**

TABLE 5.2.2: Awareness of Hepatitis-C treatment and risks (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Consumption of alcohol is unsafe for a person with Hep-C	35.5	77	56	36	92	**56**
With proper treatment a person with Hep-C can be completely cured	24	62.5	36	29	76	**43**

5.3 Tuberculosis

TABLE 5.3.1: Known instances of TB, development (and respondent awareness) of TB symptoms, and referral to DOTS (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Ever suffered from TB	2.5	7	2	5	10	**5**
n =	*5*	*14*	*1*	*5*	*5*	*30*
Any symptoms of TB in past year	0	71.4	100	60	40	**53**
n =	*0*	*10*	*1*	*3*	*2*	*16*
Have been referred to DOTS center	0	100	100	100	0	**88**
Have undergone testing for TB	0	90	100	100	0	**81**
Have started on treatment for tuberculosis in the past year	0	90	100	100	0	**81**
n =	*200*	*200*	*50*	*100*	*50*	*600*
Received information from the NGO staff on signs and symptoms, and treatment of tuberculosis in the past year	60.5	69	50	22	42	**55**

TABLE 5.3.2: Awareness of TB symptoms and risks (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
A person who has a cough for > 3 weeks and has fever must be tested for TB	80.5	95.5	88	89	96	**89**
Tuberculosis can be spread by sharing food of a person with tuberculosis	38.5	74	96	76	62	**63**

ANNEX 6: Overall service assessment

This section covers questionnaire items pertaining to service reach, degree of utilization of services and quality of services (in terms of respondent satisfaction). Responses meant to assess quality of life for service recipients are also presented herein for use, in combination with the service quality assessment, in identifying services and strategies which require improvement.

6.1 General Assessment

TABLE 6.1.1: Reach of all services received through TI (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Needles and syringes	94.5	89.5	80.0	78.0	96.0	**89**
Opioid substitution treatment	22	55.5	96.0	52.0	94.0	**50**
HIV testing and counseling	92.5	91	94.0	75.0	94.0	**89**
Antiretroviral therapy (ART)	22	43	0.0	29.0	36.0	**29.9**
Prevention and treatment of sexually transmitted infections	56.5	97	70.0	55.0	92.0	**74**
Condom	73.5	95	58.0	33.0	88.0	**74**
Targeted information, education and communication about safe sex and safe injecting	81	98	80.0	45.0	92.0	**82**
Diagnosis, treatment and vaccination of viral hepatitis	44	77.5	70.0	36.0	86.0	**60**
Prevention, diagnosis and treatment of TB	70.5	96.5	72.0	70.0	86.0	**81**
Shelter, shower, food, other services that satisfy basic needs	4.5	73.5	18.0	23.0	56.0	**36**
Basic health services (including vein care, and overdose prevention and management)	41.5	80.5	26.0	48.0	98.0	**59**
Sexual and reproductive health services (including PMTCT/ PPTCT, family planning, access to safe abortion and maternal health services)	16	48.5	24.0	23.0	76.0	**34**
Home based care and support for HIV positive drug users	18.5	84.5	22.0	28.0	80.0	**48**
Family support (for you and your relatives)	12	84	8.0	20.0	78.0	**43**
Justice/legal services	6	46	8.0	11.0	68.0	**26**
Economic strengthening activities	2.5	86	4.0	11.0	62.0	**37**
De-addiction-Counselling and linkage service	29.5	94	42.0	28.0	86.0	**57**

TABLE 6.1.2: Frequency of receiving any kind of preventative/treatment services (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*48*	*94*	*50*	*592*
Once/twice in the last year	5.5	1.5	0	0	14	**4**
3-5 times in the last year	25.5	1.5	0	2.1	26	**12**
6-11 times in last year	25.5	9.5	0	1.1	20	**14**
About once a month in the past year	10	16	12.5	4.3	10	**11**
2-3 times a month in the last year	3	52	8.3	7.4	20	**21**
About once a week in last year	11	16.5	33.3	47.9	2	**20**
Twice a week or more often in last year	19.5	3	45.8	37.2	8	**18**

TABLE 6.1.3: Awareness and utilization of Crisis Response Teams (*n*)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
Awareness about existence of CRT	26	23	3	6	31	**89**
Faced any crisis in the past one year	4	2	1	2	5	**14**
Informed the CRT members during the crisis	2	1	1	1	1	**6 (of 14)**
Confirmed response from CRT	1	1	1	1	0	**4 (of 6)**

TABLE 6.1.4: Support group participation, financial support by NGOs and skills training assistance by NGOs (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
NGO staff helped PWID to earn money by providing financial support or training for specific skills in the past year	9	39	2	14	8	**72**
Spouse/other family members supported by the NGO staff to earn money by providing financial support or by training in the past year	4	22	0	6	4	**36**
NGO staff helped to get your children for school in the past year	3	3	0	1	8	**15**
Have been a part of some support group in the past year	19	26	2	6	40	**93**
Spouse been a part of some support group in the past year	7	10	2	2	19	**40**

6.2 Satisfaction

TABLE 6.2.1: Types of services available and service quality as measured by client satisfaction (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*189*	*179*	*40*	*78*	*48*	*534*
Needles/syringes						
Not satisfied	0	0.6	0	1.3	2.1	**>1**
Fairly satisfied	28.6	44.1	7.5	16.7	29.2	**30**
Highly satisfied	71.4	55.3	92.5	82.1	68.8	**69**
n =	*44*	*111*	*48*	*52*		*302*
OST						
Not satisfied	0	3.6	0	0		**2**
Fairly satisfied	4.5	28.8	16.7	15.3		**19**
Highly satisfied	95.5	67.6	83.3	84.6		**79**
n =	*185*	*182*	*47*	*75*	*47*	*536*
HIV testing, counseling						
Not satisfied	0	0	0	1.3	2.1	**<1**
Fairly satisfied	13	55.6	38.3	17.3	12.7	**27**
Highly satisfied	87	54.4	61.7	81.3	85.1	**73**
n =	*44*	*86*	*26*	*29*	*18*	*203*
ART (%)						
Not satisfied	0	0	0	3.4	16.7	**2**
Fairly satisfied	61.4	62.8	0	20.7	38.9	**50**
Highly satisfied	38.6	37.2	0	75.9	44.4	**48**
n =	*113*	*194*	*35*	*55*	*46*	*443*
Prevention/treatment of STI						
Not satisfied	0	0	0	1.8	2.2	**<1**
Fairly satisfied	32.8	61.9	48.6	43.6	30.4	**48**
Highly satisfied	67.3	38.1	51.4	54.5	67.4	**52**
n =	*147*	*190*	*29*	*33*	*44*	*443*
Condom services						
Not satisfied	0.7	2.1	0	0	0	**1**
Fairly satisfied	51	49.5	37.9	36.4	25	**46**
Highly satisfied	48.3	48.4	62.1	63.6	75	**53**
n =	*162*	*196*	*40*	*45*	*46*	*489*
Targeted info, education and communication about safe sex and safe injecting						
Not satisfied	0	0	0	0	2.2	**<1**
Fairly satisfied	18.5	57.1	62.5	48.9	32.6	**42**
Highly satisfied	81.5	42.9	37.5	51.1	65.2	**58**
n =	*88*	*155*	*35*	*36*	*43*	*357*
Diagnosis, treatment and vaccination of hepatitis-C						
Not satisfied	0	1.3	0	0	9.3	**2**
Fairly satisfied	6.8	48.4	48.6	38.9	51.1	**36**
Highly satisfied	93.2	50.3	51.4	61.1	51.2	**62**

(Contd...)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*141*	*193*	*36*	*70*	*43*	*483*
Prevention, diagnosis and treatment of TB						
Not satisfied	0.7	0.5	5.6	0	2.3	**1**
Fairly satisfied	34.7	27.4	27.8	28.5	41.9	**31**
Highly satisfied	64.5	72	66.7	71.4	55.8	**68**
n =	*9*	*147*	*9*	*23*	*28*	*216*
Shelter, shower, food and other basic needs services						
Not satisfied	0	0.7	0	0	10.7	**2**
Fairly satisfied	55.6	64.6	33.3	26.1	71.4	**60**
Highly satisfied	44.4	34.7	66.7	73.9	28.6	**38**
n =	*83*	*161*	*13*	*48*	*49*	*354*
Health services (inc. vein care, OD prevention & management)						
Not satisfied	0	0.6	0	0	0	**<1**
Fairly satisfied	30.1	65.8	53.8	27.1	24.5	**46**
Highly satisfied	69.9	33.5	46.2	72.9	75.5	**54**
n =	*32*	*97*	*12*	*23*	*38*	*202*
SRH services						
Not satisfied	0	0	0	0	7.9	**2**
Fairly satisfied	21.9	62.9	66.7	56.5	34.2	**50**
Highly satisfied	78.1	37.1	33.3	43.5	57.9	**48**
n =	*37*	*169*	*11*	*28*	*40*	*285*
Home-based care/support for HIV-positive individuals						
Not satisfied	0	0	0	0	0	**0**
Fairly satisfied	40.5	58	63.7	50	32.5	**52**
Highly satisfied	59.5	42	36.4	50	67.5	**48**
n =	*24*	*168*	*4*	*20*	*39*	*255*
Family support services						
Not satisfied	4.2	0.6	0	5	2.6	**2**
Fairly satisfied	54.2	71.4	25	45	43.6	**63**
Highly satisfied	41.7	28	75	50	53.8	**35**
n =	*12*	*92*	*4*	*11*	*34*	*153*
Justice/legal services						
Not satisfied	0	1.1	0	0	29.4	**7**
Fairly satisfied	16.7	47.8	50	45.5	38.2	**43**
Highly satisfied	83.3	51.1	50	54.5	32.4	**50**
n =	*5*	*172*	*2*	*11*	*31*	*221*
Economic strengthening services						
Not satisfied	0	0	0	0	51.6	**7**
Fairly satisfied	80	62.2	0	36.4	25.8	**56**
Highly satisfied	20	37.8	100	63.6	22.6	**37**
n =	*59*	*188*	*21*	*28*	*43*	*339*
Detoxification						
Not satisfied	1.7	0	4.8	0	7	**2**
Fairly satisfied	17	6.9	23.8	39.3	51.2	**18**
Highly satisfied	81.4	93.1	71.4	60.7	41.9	**80**

TABLE 6.2.2: Satisfaction in relation to service delivery (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*48*	*94*	*50*	*592*
Service Center Logistics						
Service center is close to my home and open when I need it	70.5	89	76	88	60	**79%**
Cost of services is low enough	75.0	49.0	40	22	80	**55%**
Adequate range/menu of services being provided	14	54	30	23	46	**33%**
Staff						
Confidentiality - information about my drug use and HIV status will be anonymous and won't be given to Government authorities	39	28.5	8	21	62	**32%**
Staff are friendly and professional	18	81.5	94	87	66	**61%**

6.3 Quality of Life

TABLE 6.3.1: Satisfaction with basic needs and family support; economic wellbeing (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Basic needs (food, shelter, clothing, etc.)						
Basic needs are currently fully met	17.5	29.5	18	53	**20**	**28**
Basic needs are somewhat met	69.5	66	70	31	**70**	**62**
My basic needs are not met	13	4.5	12	11	**8**	**9**
Family support						
Feel that my family supports me	56.5	72	58	49	**58**	**61**
Feel that my family partially supports me	32	15.5	32	9	**36**	**23**
Feel that my family does not support me	7	8.5	10	5	**6**	**7**
Feel that my family does not want to have any relations with me	1.5	2	0	25	**0**	**5**
Satisfaction with economic wellbeing						
Fully satisfied	7	20.5	20	19	**4**	**14**
Satisfied	42	61	12	21	**6**	**39**
Somewhat satisfied	43.5	16	56	34	**52**	**34**
Not satisfied	7.5	2.5	12	21	**38**	**11**

TABLE 6.3.2: Self-reporting on mental health, stigma-related issues and security (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Anxiety/depression						
None	18.5	64.5	28	20	14	**34**
Moderate	68	33	30	25	66	**46**
Extreme	13.5	2.5	42	54	20	**19**
Stigmatization						
None	33.5	76	8	26	44	**45**
Some	43.5	21	24	8	46	**29**
Very much	23	3	62	63	10	**25**
No answer	0	0	6	3	0	**1**
Security						
Secure and safe	20	64	22	51	28	**41**
Somewhat vulnerable	68	33.5	52	23	56	**47**
Highly vulnerable	12	2.5	26	26	16	**13**
Negative attitudes/actions taken by police and law enforcement						
None	89	91	44	74	50	**80**
Moderate	8	8	50	8	50	**15**
Extreme	2.5	1	6	12	0	**4**
Support from community (neighbor/other drug users, etc.)						
No support	24.0	2	10	40	28	**17**
Some support	56.5	18.5	30	10	48	**33**
Lots of support	19.5	79.5	60	50	24	**48**

TABLE 6.3.3: PWID by their accessibility to health services (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*50*	*100*	*50*	*600*
Health services needed are fully accessible	14	65.5	42	78	44	**47**
Health services needed are somewhat accessible	77	32	50	8	52	**46**
Health services needed are accessible but experienced negative attitudes and actions by health service providers	3.5	1.5	4	4	2	**3**
Health services needed are not accessible to me	4.5	0.5	2	4	2	**3**

6.4 Need

TABLE 6.4.1: Services reported to be inadequate and/or unavailable (%)

	Bihar	Haryana	Jammu	Uttarakhand	Manipur	Total
n =	*200*	*200*	*48*	*94*	*50*	*592*
Needles and syringes	72	49	70.8	52.1	56	**60**
OST or other drug dependence treatment	50	62.5	100	74.5	64	**63**
HIV testing and counseling	29	45	81.3	56.4	86	**48**
Antiretroviral therapy (ART)	6.5	19	47.9	20.2	30	**18**
Prevention and treatment of sexually transmitted infections	26	34.5	45.8	25.5	72	**34**
Condoms	28.5	48	45.8	23.4	60	**38**
Targeted information, education and communication about safe sex and safe injecting	55	40.5	25	22.3	82	**45**
Diagnosis, treatment and vaccination of viral hepatitis	24	39	25	25.5	70	**33**
Prevention, diagnosis and treatment of TB	26	57.5	35.4	48.9	72	**45**
Shelter, shower, food, other services that satisfy basic needs	37	40	31.3	45.7	64	**41**
Basic health services (including vein care, and overdose prevention and management)	26	37	33.3	36.2	82	**37**
Sexual and reproductive health services (including PMTCT/ PPTCT, family planning, access to safe abortion and maternal health services)	17	28	8.3	23.4	64	**25**
Home based care and support for HIV positive drug users	18.5	48.5	20.8	36.2	84	**37**
Family support (for you and your relatives)	35	32	20.8	20.2	80	**34**
Justice/legal services	32	31	27.1	23.4	70	**33**
Economic strengthening activities	40.5	51.5	22.9	29.8	78	**44**
De-addiction	40.5	51.5	22.9	29.8	78	**44**

ANNEX 7: Key Informant Interviews

7.1 Profile of Key Informants

A total of three Program Managers and nine Outreach Workers were interviewed as key informants (KI). The Program Managers had been working with their organization for at least 1.5 years, covering the period that Hridaya was operational. The Outreach Workers, four female and five male, had been working in their organizations for the past 1-4 years.

Table of Key Informants

District/State	Name of NGOs/Sites	Official Interviewed
Patna, Bihar	Sister Nivedita Memorial trust	Project Manager
Sirsa, Haryana	Chaubisee Vikas Sangh	Program Manager
Nanital (Haldwani), Uttarakhand	Dharohar Vikas Sanstha	Program Manager
Muzzaffarpur, Bihar	Sewa Sankalp Evam Vikas Samiti	Outreach Worker
Bhojpur, Bihar	SEEDS	Outreach Worker
Siwan, Bihar	Narayani Seva Sansthan	Outreach Worker
Haridwar, Uttarakhand	Forum for Rural Infrastructural, Environmental & National Development Society (FRIENDS)	Outreach Worker
Jammu & Kashmir	JKSPYM Health Clinic, J&K SPYM PWID T.I. Project	Outreach Worker
Imphal East, Manipur	SASO Imphal	Outreach worker
Gurgaon, Haryana	Aident Social Welfare Organization	Outreach worker
Sonipat, Haryana	Modern Education Society	Outreach worker
Ambala, Haryana	Don Bosco Navjeevan Society	Outreach worker

7.2 Level of Awareness and Harm Reduction

The key informants (KIs) interviewed were found to be well aware of the Hridaya activities. As per their responses, the project provides additional facilities, over and above provided by the TI, to PWID, their families, their spouses and regular sexual partners. They reported that before the incorporation of Hridaya activities, they were providing only NSEP, condom promotion, HIV awareness and treatment of STIs.

As a result of the Hridaya project, more services are being provided to PWID and particularly to their families, including knowledge sharing (re: HIV, Hepatitis-C, overdose, legal rights, etc.), HIV testing for spouses, social entitlement services, emergency support for HIV-positive clients, OST, and crisis-response. Hridaya has also worked to increase professional training and build capacity of clinic staff,

Under this project, the PWID community is also assisted in making their Aadhaar card and identity card. They help in providing nutritional as well as legal services, and generating employment for the families of the PWID.

7.3 Hridaya Activities for Harm Reduction

Human Resources

- *Female outreach workers (FORW) and female peer educators (PE):* KI were of the opinion that the provision of female ORWs and PEs under this project has been very beneficial and effective as it facilitates the formation of connections with families of PWID. Prior to the deployment of FORW and PE, the exclusively male outreach workers could not effectively work with families (probably due to the inherent social connotations of a male presence). FORW seem generally more able to interact well with families, conducting dynamic discussions on education, the dual risk of injection coupled with STI and other issues with spouses of PWID. With this conscious inclusion of families in the TI strategy, core TI activities now reach more broadly to individuals indirectly affected by the behaviors of PWID.
- KI report, however, that PWID do not always appreciate the presence of outreach workers in their home. In some cases, ORW have inappropriately disclosed information about a client who injects. Some PWID do not wish to disclose their injecting behavior at home for fear of degrading familial relationships. Better methods are required for establishing clear home-visit consent with clients.
- *Provision of peer counselors:* Peer counsellors help PWID receive OST and encourage those who have dropped out to restart OST. Referrals to health services have increased after the involvement of peer counselors. They also help in the core TI activities by assisting in education, visiting drug use hotspots and providing information on where PWID can access services.
- *Project Officer (PO):* So far as the provision of this staff is concerned, respondents are of the view that this person is of immense importance as they are the only staff available for monitoring and evaluation. A PO is the link between the activities of both TI and Hridaya. They also play an important role in updating the program data entry, management and training of staff and conducting field visits.

Educational Services

With reference to the provision of educational services such as educating PWID and families about SRH, overdose, TB, ART, Hepatitis, legal rights, etc., the community has become more knowledgeable and is able to make informed decisions. It has helped support the core TI activities. Since the community members are educated about their rights and responsibilities, the families also cooperate and support the functions and this way, it has been of help to the core TI activities.

Direct Services

Provision of direct services such as peer progression support, PLHIV emergency support, de-addiction, etc., has helped in the execution of field-work and providing support to implement the services and necessary work. For the provision of referral services for ART, TB, SRH, nutrition, the respondents shared that it has been beneficial for the PWID as they are getting range of services under one roof, a “one-stop shop”. Before the Hridaya project, the TIs could not help the PWID because of lack of financial resources.

Referral Services

The referral services of Hridaya project help in the TI activities by increasing the services related to STI/STD, TB and ART. The value added of the referral services is that this component changed the lives of the PWID and their families. Because of the support received from this project, the TIs have supported the families and linked them to the nutrition schemes.

An improvement which is required is that the referral services after HIV testing should be made more efficient and within reach of large masses. The treatment should be available at all facilities and community participation should be ensured. Support from Government can be taken to improve services.

7.4 Achievements

- The Hridaya project has helped a great deal in reaching out to the community by offering care and support services. Its overall achievements include strengthening the community, promoting health, early diagnosis and treatment of diseases, educating the families regarding health and legal issues, getting children enrolled in schools, providing support to the families of PWID, instilling confidence in PWID that they are also like any other normal person. It has also helped the community to address social issues. Hridaya has been very successful in promoting health and early diagnosis and treatment.
- Due to Hridaya, the social status of the PWID has improved and now they are placed in a better position in the society. Family support to PWID has increased. Now family members themselves take their relative to the OST centers.
- Various teams have been formed and these teams helped PWID in providing support including registration of PWID for Adhaar cards/PAN card etc. They are now availing several schemes run by the Government for their sustainability and welfare.
- Before this scheme, the services which were being provided were confined to NSEP, condom promotion, STI/STD and referral services. But now, through Hridaya, services like social entitlement, peer progression support, emergency support, imparting education, drug treatment, etc. are being provided.

7.5 Key Challenges

Program managers and outreach workers mentioned various challenges which they faced during project implementation.

- The biggest challenge in the implementation of Hridaya project was to reach and gain the trust of the families of PWID and convince them about the project. Because of initial lack of cooperation from families of PWID, a targeted plan of action became challenging for the project.
- It was difficult to convince the families to accept the PWID with the same respect and position in the family.
- Some PWID did not wish to receive home visits, and methods of obtaining consent were not properly established.
- There were some operational issues in terms of validation of PWID, lack of direct services to engage the core population and lack of regular review of progress.
- Professional training of TI staff at the outreach level was difficult due to high turnover rate.

7.6 Gaps/Unmet needs of the PWID

Various gaps and unmet needs of the PWID were reported including:

- The needs of PWID are concerned with employment, health and nutrition services. Such identified needs should be considered on a priority basis and appropriate services provided.
- Sustaining a consistent information delivery mechanism and learning tools on Hepatitis C, timely availability of OST, addressing antenatal health issues etc.

7.7 Recommendations

- The Hridaya project can be further strengthened by mobilizing the community and enhancing the capabilities and capacities of the outreach workers. The TI and Hridaya should also work together in coordination with one another.
- To further strengthen this project, the PWID should be trained for different types of employment opportunities.
- Another suggestion is that to strengthen the project, monthly training of the staff should be done to keep them update about the latest information, TI services etc.
- Capacity building of the family members should be done to make them financially sustainable.
- Quarterly review of the implementing partners and lead agencies, mobilising the community and enhancing the capabilities and capacities of the workers.

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