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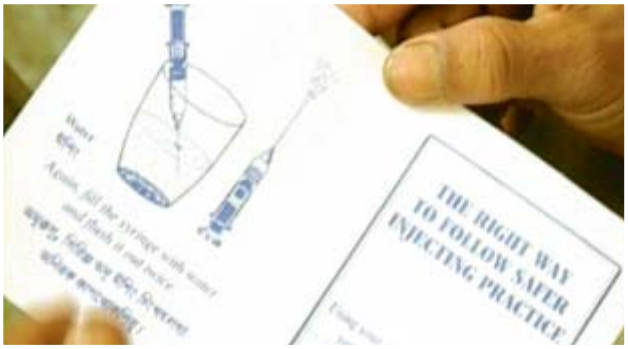
An Outreach Intervention in Manipur

Injecting Drug Users and their Sexual Partners



Foreword

In the state of Manipur in North-Eastern India, the Swedish International Development Cooperation Agency, Sida, has supported three NGOs – Centre for Social Development, Institute for Social Disease and Lifeline Foundation. The support has focussed on outreach intervention work undertaken by these organisations among injecting drugs users and their sexual partners. The support from Sida lasted for nine years, 1993–2002.

The three organisations encountered numerous challenges and hurdles, but gained a lot of insights and experiences. Over the years they have been able to develop their capacity to fight the HIV/AIDS battle. Manipur became the first Indian State to adopt the harm reduction approach. These organisations contributed to this new policy.

The organisations have also made it possible for other NGOs in Manipur as well as in neighbouring states to address the HIV/AIDS issue in a collective and collaborative way.

The aim of this study is to document how the three organisations have dealt with the challenge of drug use and HIV/AIDS in Manipur.

We are happy to share with you their experiences.

New Delhi, 29 March 2004

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Abbreviations

CAPART	Council for Advancement of People's Action and Rural Technology
CSD	Centre for Social Development
DFID	UK Fund for International Development
DIC	Drop-In-Centre
DOTS	Direct Observation and Treatment Short course
HIV/AIDS	Human Immune Virus/Acquired Immune Deficiency Syndrome
ICMR	Indian Council of Medical Research
IDU	Injecting Drug User
IEC	Information, Education and Communication
ISD	Institute for Social Disease
LLF	Lifeline Foundation
MNP+	Manipur Network of Positive People
MSACS	Manipur State AIDS Control Society
NACO	National AIDS Control Organisation
NGO	Non Governmental Organisation
NH	National Highway
NSEP	Needle Syringe Exchange Programme
NSS	National Service Scheme
ODA	Overseas Development Agency
PHC	Primary Health Centre
RIAC	Rapid Intervention and Care
RSH	Reproductive and Sexual Health
SHG	Self Help Group
Sida	Swedish International Development Co-operation Agency
STI	Sexually Transmitted Infection
UNDCP	United Nations Drug Control Programme
UNDP	United Nations Development Programme
WORC	Women's Organisation for Reintegration and Consolidation

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1. Executive summary

Manipur, one of the seven north-eastern states has been impacted by the high prevalence of drug use and HIV/AIDS among its populace. The state has less than 0.2 percent of the Indian population but accounts for nearly 8 percent of the people living with HIV/AIDS in India. The social and economic dynamics of the state has been adversely impacted by drug use, ethnic conflict, insurgency and poverty.

Manipur shares nearly 350 kilometres of its border with Myanmar. Many of its roads lead to nations known as the "golden triangle" of South East Asia. The quantities of drugs being transported to other parts of the world were small, it was sufficient to play havoc among the young, who in need of any kind of employment would interact with the allied business on the highways. Easy availability of both illegal drugs and pharmaceutical combinations has also contributed to the spurt of drug users in Manipur over the 80s. What was also apparent to all concerned was that the issue could be tackled only if communities accepted ownership of the problem and if behaviour change processes were initiated among IDUs and their sexual partners.

This study documents, through numerous stakeholder interviews and group discussions, the experiences of three Swedish International Development Co-operation Agency (Sida) partners – Centre for Social Development (CSD), Lifeline Foundation (LLF) and Institute for Social Disease (ISD) while dealing with the challenge of drug use and HIV/AIDS in Manipur.

Lifeline Foundation set up by a group of seven ex-drug users initially began to collectively search for a more humane and inclusive process of de-addiction and rehabilitation. As the number of inmates in their rehabilitation increased, the challenges of managing such a response also grew and appropriate partnerships, technical assistance, adequate funding and effective leadership also became vital.

Dr. Jayanto's experiences of assisting local clubs conduct detoxification camps were his initial foray into rehabilitation. He however realised "that these camps were subscribing to a coercive approach and treating the drug-users in a highly inhuman fashion that did not take into account the social dimensions of the problem."

CSD working on varied issues of development was born in 1986 at a time when civil strife in Manipur was on the rise. "Civilians were stuck in

between. As a consequence of civil strife and unrest, food, health care, safe drinking water became constant casualties. Members of CSD also began to find that drug use amongst the youth population was repeatedly hampering their developmental efforts. There was a growing understanding that in the long run drug use amongst the youth would harm productivity and the development of the state.

Meanwhile, the levels of HIV/AIDS amongst the injecting drug population began to rise. In just one year (1990–91) HIV prevalence rate among IDUs in Manipur went up from 0 to 50 percent. By 1994, it was 60 percent and by 1997 it had touched 80 per cent . By 1990, international agencies and the Manipur government had realised the gravity of the problem and were aware of the magnitude that the epidemic would assume if a concentrated response were not mounted.

A situational assessment done by two consultants for Sida in 1993, made it clear that the State had not developed any kind of response to HIV/AIDS while also suggesting:

- Targeted interventions among injecting drug users to motivate them to use clean needles and syringes and stop sharing equipment.
- Initiatives to make the larger community aware of their social and ethical responsibility towards preventing the further spread of HIV/AIDS.
- Interventions that would ensure that the NGOs spearheading the interventions were gender sensitive and capable of addressing the specific needs of women.

The assessment also opined that NGOs involved in the initiative would need to 'unlearn before learning'. The primary aims of Sida's intervention emerging from this assessment were to:

- Encourage the use of clean needles and syringes and motivate IDUs to stop sharing equipment.
- Increase awareness levels of the community to undertake their social responsibility to participate actively in preventing the further spread of HIV.
- The strengthening and linking of training to the actual implementation of the activities.

The new harm reduction approach decided on by the NGOs and Sida marked a strategic shift from the abstinence model. It was oriented towards intervening and preventing the further spread of HIV/AIDS. Sida undertook an innovative training with the objective of supporting participating NGOs, to ensure the optimal implementation of activities that would reduce the risk of HIV transmission among injecting drug users and their sexual partners. In keeping with Sida's own belief on providing implementing partners with the space to design their own initiatives, the training focused on making available technical support to catalyse the process. This often required the trainers to set aside what they had initially planned and create new designs and strategies.
Four trainers imparted training in three areas outreach and counselling, assessment, monitoring and evaluation and information, education and communication (IEC).

Transition to harm reduction

In implementing the harm reduction approach it was clear to all three organisations that a new beginning had to be made and a major attitudinal change had to be ushered in to guarantee that inhumane reactions and unviable responses do not further exacerbate the problem.

They also became aware of the fact that if any meaningful shift towards harm reduction had to be made they would have to adopt a multi-pronged approach. This meant that the organisations needed to have the capacity and skills to motivate disparate sections of society to re-think on this issue, trigger a radical shift in their perceptions and urge each of them to go beyond their present potential.

They decided to constantly undertake community needs assessments and put their new approaches with the target audience, influential individuals and groups as well as the general populace. In an environment of distrust of their project intentions the organisations decided to respond by taking a conscious decision to be flexible, eclectic and allow the exigencies of the situation to determine the quality of response and not to be swayed by moral and emotional considerations.

CSD's experience as a development organisation also enabled them to comprehend the effect deep-seated structural inequities could have on such an issue and prompted the adoption of a rights-based approach.

The organisation felt compelled to conduct awareness programs among the community, especially amongst those that had been personally affected by the problem, so as to create an enabling environment for their outreach workers to reach the IDUs and provide them with the necessary clinical and counselling services.

Lifeline Foundation found their primary problem was that of regaining the confidence of people as well as official agencies. Meanwhile many members of the organisation also felt uneasy with the newfound approach of harm reduction. However they were constantly learning about the inexorable relationship between injecting drug use and HIV/AIDS.

Tempered by this realism they decided to be a part of the harm reduction intervention and publicly justified this approach on the grounds that it could make a great difference to HIV/AIDS prevention and help them to motivate the drug-user to move towards abstinence in a phased and friendly manner.

For ISD the challenge was of transforming individual capacities and expertise into an appropriate organisational response. According to Dr. Jayanto, "When the problem of HIV came we realised that to address the drug problem along with programme components such as de-addiction and detoxification, it was equally important to address the issue of HIV/AIDS".

In fact, by the end of 1994 a substantial number of local clubs had undergone basic information training sessions and though there was initial reluctance, in time people began to attend these sessions. Meanwhile in the process of conducting these awareness-raising programmes,

Dr. Jayanto's approach towards information dissemination also began to change and he began to disseminate behavioural change communication.

Mainstreaming the harm reduction intervention

Between 1995 and 1997, the three organisations gave a qualitative shape to the approach and demonstrated its usefulness in intercepting the transmission of the virus. They ensured that various programmatic components were implemented simultaneously. These programmatic components were:

- Developing a quality outreach programme for injecting drug users by providing them integrated and need-based service.
- Educating and sensitising the community on the linkage between harm reduction therapy and preventing HIV/AIDS transmission.
- Sensitising key agencies such as law enforcement personnel, health-care professionals to engage with the issue in a more informed and sustainable manner.

A key element of achieving quality outreach was the role of outreach workers. With the entire process dependent on the organisational link provided by outreach workers, much of the effectiveness of the initiative hinged on the capacity of the workers to develop a steadfast and client-based relationship with the injecting drug users.

Given this highly labour-intensive commitment, the outreach worker often found himself, physically, emotionally and even financially drained. They had to also deal with their own periodic fatigue and in extreme cases even burn out and a feeling of being overwhelmed by the problem. However through constant interactions they were encouraged to re-work strategy, question the assumptions that were made or learning that were drawn by the programme staff, which helped them to stay connected with the problem and renew their commitment.

It must be stressed that much of the success of this intervention was because of the kind of sustained support Sida gave to capacity building, not as a top-down process but as a way of catalysing a leadership that was rooted in the issue and aware of its stake in creating long-term solutions and alternatives.

It was also necessary to motivate current and recovering users to become peer educators and assist the intervention in locating and educating the injecting drug users. Some services like needle and syringe distribution and exchange programme were essential strategies that needed to be promoted on a decisive scale so as to ensure the effective prevention of transmission of HIV/AIDS. In an intervention of this kind what finally counts is the organisation's ability to persuade people to adopt a new practice. To sustain contacts with injecting drug users, it became necessary to provide an environment, free of any form of reprisal, condemnation and pressure.

The organisations were able to motivate users to adopt safer practices through the needle exchange project and provide friendly spaces such as drop-in-centres for users to gather without fear. Confidence in the process was built slowly and gradually, creating as wide a consensus and as much social acceptance as possible.

So decisive was the impact of the intervention that the official agency of the State Government, the Manipur State AIDS Control Society (MSACS) decided in 1998 to adopt the approach and take ownership of

it. With the State having decided to make the harm reduction intervention as the flagship programme of the official focal point – MSACS and these three organisations found that they were supporting an equally challenging process of scaling up and mainstreaming. The policy legitimised this approach and perhaps more importantly the State, for the first time enunciated a public health perspective shaped by human rights and development imperatives.

Manipur became the first Indian State to officially adopt the harm reduction approach as an intervention measure to prevent transmission of AIDS amongst injected drug users and their partners. According to the Project Director of the Manipur State AIDS Control Society, Dr. Sukumar Singh, it created a public-private partnership and paved the way for decisive measures and the launch of a response to the spiralling epidemic on a war footing.

Modelled on the harm reduction approach the project included community sensitisation and mobilisation, NSEP, bleach and teach, condom promotion, drug substitution, STI treatment, home detoxification, referral services and formation of self help groups amongst its primary services. The objective was to create awareness about HIV/AIDS while stressing on the importance of the harm minimisation philosophy, so as to effect a change in the community perception towards IDUs and their partners.

Mainstreaming the harm reduction approach provided the three organisations an opportunity to share their experiences within the RIAC intervention. It further enabled them to undertake key activities of providing care and support services and establishing referral network partnerships while also scaling up and creating a regional network to provide a coordinated response to drug use and HIV/AIDS.

Lessons learnt

The experience of the three organisations have provided some key lessons:

HIV/AIDS is not a stand-alone problem and needs to be located within the paradigm of development.

The interventions should seek to deal with the root cause of the problem rather than be diverted by its manifestations.

The problem needs to be addressed in a concerted manner with a decisive partnership between grassroots organisations, concerned community, stakeholders and an experienced donor agency.

Training and creating capacities forms a critical part of the initiative. An organisations capacity needs to be developed as a long-term strategy to ensure ownership towards the initiative.

Creating a supportive environment around the initiative enables a more effective implementation. The organisations were able to

- Increase the circle of concerned and sensitised people
- Impact official structures and systems
- Generate people – centred initiatives such as positive people, self – help groups set up by women widowed by HIV/AIDS and drug use and forums of concerned citizens.

2. Introduction

The seven North Eastern states of India have for long been impacted by the high prevalence of both drug use and HIV/AIDS among their populace. Of them, the worst affected is Manipur, which has less then 0.2 percent of the Indian population but accounts for nearly 8 percent of people living with HIV/AIDS in India, with as much as 72 percent of infection being transmitted by injecting drug users[1].

Socio-economic background

Manipur, spread over an area of 22,327 sq. km has 67 percent of its geographical area under hills and forest cover. Two national highways NH 39 and NH 53 known as the Indo–Burma Road and New Cachar Road respectively, serve as vital lifelines for the people. The state is home to 29 diverse tribal communities with the dominant tribe being the Meteis. The total literacy rate was recorded as 68.87 percent with urban literacy figures being as high as 80 percent of the population.[2] Manipur's internal sex ratio has shown considerable improvement in the last decade[3] and at 978 females per thousand males it fares much better than the corresponding national figure of 933. Manipur has also fared consistently well on the Human Development Index, being ranked ninth at 0.536 and third in terms of the gender disparity index at 0.815 in 1991.[4]

However, *the social and economic dynamics of the state has been adversely impacted by drug use, ethnic conflict, insurgency, and poverty.* Unemployment is widespread resulting in increasing numbers of young people becoming vulnerable to substance abuse. According to the State's Employment Exchange, in 2003 the number of people applying for jobs had crossed one sixth of the state's total population of 2.4 million. What is also known is that in 1999–2000 nearly 61 percent of job seekers were in the 15–34 age group of whom over 67 percent had a minimum matriculation qualification.[5] Unfortunately, a feeble industrial sector has never

1 National AIDS Control Programme. 2001–2002, Status report, Manipur AIDS Control Society.

2 Selected Educational Statistics. 2001–2001, Department of secondary and higher education, ministry of human resource development, government of India.

3 In 1991 the sex ratio was recorded at 958, which has in the 2001 census improved to 978. In 1991 Manipur's sex ratio was only marginally above the national figures of 927. However, by 2001 there was a vast improvement in Manipur's sex ratio leaving behind the national average at 933.

4 Rajya Sabha Unstarred Question No. 5459, dated 17.05.2002

5 Singh, A. 2003. Challenge of employment for all.

been able to provide a stable source of employment resulting in excessive dependence on the State government.

Manipur is in fact a predominantly agrarian society with a large segment of the population dependent on agriculture for subsistence. However, according to estimates 80–90 percent of the cultivable land remains unused due to poor agricultural methods for nearly six months of the year thereby further burdening the fragile economic infrastructure. The States' inability to utilize Central funds allocated for development purposes has also had a direct adverse impact on its development.[6]

Apart from these larger issues arising from the failure to mainstream the North Eastern states, what has also worked to the detriment of Manipur is that it has been affected by the traditional chasm existing between the hill areas where Nagas live and the valley region inhabited mostly by the Meitei community resulting in strife and conflict.

Prevalence of drug use

Numerous studies have shown that injecting drug use spreads in areas close to drug production areas or along drug trafficking routes and that IDU prevalence is lower in areas further away from such routes. In fact, Manipur is often cited to substantiate this premise. It shares nearly 350 kilometres of its border with Myanmar. Many of its roads lead to nations known as the "golden triangle" of South East Asia and much of its urban areas straddle National Highway 39, which originates in Myanmar and continues on to Nagaland. *Though the quantities of drugs being transported to other parts of the world were small, it was sufficient to play havoc among the young, who in need of any kind of employment would interact with the allied business on the Highway.* By the late 70s Manipur, Nagaland and Mizoram were showing a significant increase in drug use but with communities taking a very negative stance on the whole issue it remained neglected and marginalised.

In the beginning, the addiction was in the form of mild tranquilizers and methaqualone, which was followed by injectable morphine and pethidine. By the 80s heroin, locally known as 'Number 4', became the most popular drug of choice amongst the young drug users. This was used along with other pharmaceutical combinations like phensydyle, spasmoproxyvon, buprenorphine, cough syrup, nitrazepam and substances like opium, alcohol and ganja.[7] *Indeed, easy availability of both illegal drugs and pharmaceutical combinations has also contributed to the spurt of drug users in Manipur over the 80s.*

By the early 80s, when there were an estimated 30–40,000 IDUs in the state, communities and NGOs realized that the drug problem had reached a critical stage. What was also apparent to all concerned was that the issue could be tackled only if communities accepted ownership of the problem and if behaviour change processes were initiated among IDUs and their sexual partners. Also obvious was the need for awareness and sensitisation programs among young people who were seen as particularly vulnerable to substance abuse.

6 In 2001–2002, only 47 percent of the total outlay was utilized and in 2002–2003 about 59 percent of the planned money was spent. A major factor hampering the smooth flow of the work force has been the law and order situation and financial mismangement of allocated funds. Anand, November, 2003.

7 Singh, A. Combating drug abuse and HIV/AIDS in Manipur, October 2003.

3. The study process

Aim

The aim of this study is to document the experiences of the three Swedish International Development Co-operation Agency (Sida) partners – Centre for Social Development (CSD), Lifeline Foundation (LLF) and Institute for Social Disease (ISD) – their beneficiaries, stakeholders and networks while dealing with the twin challenges of drug use and HIV/AIDS in Manipur. The focus will be on understanding how these experiences affected their initiatives while catalysing the harm reduction philosophy in Manipur, the processes and structures they had adopted to deal with these issues and their impact on the growth and development of their organisations.

Methodology

The study was based on 45 indepth interviews with IDUs, their partners, widows, families and communities. As also with various stakeholders, including doctors, community leaders, peer educators and NGOs working in the areas of harm reduction and HIV/AIDS and officials of the Manipur State AIDS Control Society (MSACS).

In addition to this, six informal group discussions (GDs) were held with IDUs, women's self-help groups and self-help groups of widows of IDUs, followed by two formal focus group discussions (FGDs) with the heads of the three Sida partners, their managerial staff and outreach workers.

4. Tracing the origins

Lifeline Foundation – Search for a humane response

The groundswell for a harm reduction approach goes back to 1990 when a small but highly significant effort was made by a group of seven ex-drug users led by Vikram Singh and Raghumani[8].

Having developed close personal ties and associations with each other while undergoing rehabilitation, this group formed a support group called *Lifeline Foundation and began to collectively search for a more humane and inclusive process of de-addiction and rehabilitation.*

They founded a commune on a piece of land donated to the group by Vikram Singh's mother and developed a fishery and pig-rearing farm. Alongside they made a "kuchha" [9] building to provide space for current drug users. Even today many of these individuals recollect the sense of fulfilment and self-worth they had experienced. "We worked together during the day, planted trees, tended fingerlings for four-to five months … did the fencing, mended the *kuchha* buildings and performed selfless service", recalls Raghumani while adding, "Our idea was to be part of a self-help group to support ourselves".

The activities of this commune in fact inspired others to join this initiative and contribute to the many tasks within it. Many in the community began to feel that if the drug user in their family was exposed to this sort of environment there was the possibility of getting him to get rid of his habit. Soon the efforts of this group began to take the shape of an initiative.

Looking back Sharat, one of the founding members and client, felt that this modestly built rehabilitation centre had a great impact on him. He came to realise his "faults and …started correcting himself with the help of the counsellor and peers". Even after coming out of the centre he found himself spending his day there, to share his "feelings with other inmates". *As the number of inmates increased, the challenges of managing such a response also grew and appropriate partnerships, technical assistance, adequate funding and effective leadership also became vital.* This coincided with the advent of Sida.

8 Raghumani died in November 2003.

9 temporary

Institute for Social Disease – Aspiring for a social response

As a practising doctor, Dr. Jayanto Kumar, found that the community in Singjamei, on National Highway 39, that he was closely associated with both as a doctor and as an active citizen were extremely susceptible to drug intake and use. Initially, he responded as a clinician and even assisted the local clubs to conduct several detoxification camps. But as president of several local clubs and organisations his interactions with community leaders and concerned officials made him realise that he needed to go beyond his skills as a clinician and build a community-centred response. Because "unless affected people had a say in the matter, no sustainable solutions would emerge". *What he also realised was "that these camps were subscribing to a coercive approach and treating the drug-users in a highly inhuman fashion that did not take into account the social dimensions of the problem."*

To some extent this adverse community environment could be attributed to the murder of a young child in 1986 by a drug-user who pawned the jewellery she was wearing to sustain his habit. It sent shock waves across Imphal and evoked a deep distrust of all drug-users. So forced detoxification was seen as the most appropriate solution and the focus was primarily on keeping people away from drugs with scant attention being paid to the reasons why people were in fact turning to drugs. Looking back at those efforts Jayanto said, "there were a lot of things that we were doing wrong. We were not approaching it professionally and most importantly, our emphasis lay on just the drugs rather than viewing the environment of the user as an integral part of the problem".

Centre for Social Development – Linking drug abuse to lack of development

The Centre for Social Development was set up in 1986 by individuals from such divergent professional backgrounds as law, education and social work. It was born at a time when civil strife in Manipur was on the rise. Nobo Kishore could see the effect of this unrest on the people, especially those living in remote areas. *"Civilians were stuck in between. As a consequence of civil strife and unrest, food, health care, safe drinking water became constant casualties.* The government was also finding it difficult to respond. He recalls how it was at this juncture that," CSD decided to address the concerns of people who were being marginalised because they were living in remote areas." With financial support from the Ministry of Social Welfare, CAPART and Government of India, CSD initiated activities in fifteen villages in Manipur, "providing services to enable terrace cultivation, tractors on low rent, low cost housing and latrines".

However the debilitating role of drugs was repeatedly hampering the developmental efforts of the CSD workers. "We came across the devastating impact that drugs was having on young people. *We felt that if the youth got affected by drugs then it would harm productivity in the long run and finally the development of the state", states Nobo Kishore.* It was this realisation that enhanced his resolve to address this problem.

5. Advent of HIV/AIDS

It was amidst these efforts to combat the challenge of drugs, that the first case of HIV/AIDS was reported in December 1989. Quite clearly, the link that had emerged world wide of unsafe injecting practices and HIV/AIDS was also beginning to manifest in Manipur.

In just one year (1990–91) HIV prevalence rate among IDUs in Manipur went up from 0 to 50 percent. By 1994, it was 60 percent and by 1997 it had touched 80 per cent.[10]

However, from early 1992, evidence[11] was also pointing to an increase in drug use among women with an unlinked, anonymous screening of antenatal women showing one percent of HIV infection. It led to the realisation that there were virtually no treatment facilities for women and that social sanction against women drug users was so strong that they had been forced into self-denial and a marginalised existence. But interestingly, sero-prevalence among IDUs did show a declining trend from 1998 onwards.[12] In 1998 it dropped to 72 percent and by 2000 it was 66 percent and by 2001 it reduced further to 56 percent. Be that as it may, the sero-prevalence rate among IDUs in Manipur even today remains one of the highest in the world.

HIV/AIDS – Donor initiative

By 1990, international agencies and the Manipur government had realised the gravity of the problem and were aware of the magnitude that the epidemic would assume if a concentrated response was not mounted. This concern was first voiced at the 'North Eastern State Sub – Regional Conference on HIV/AIDS' in January 1992; by representatives of the Department of Health, Government of Manipur and various agencies including DFID (Department for International Development), UNDP (United Nations Development Programme, ODA (Overseas Development Agency), Sida, UNDCP (United Nations Drug Control Programme), WHO and Aus Aid. It was also felt that given the experience of many countries the harm reduction approach would be more effective in controlling the spread of HIV/AIDS among drug users. Commenting on the significance of the meeting

10 All HIV/AIDS incidence and prevalence figures – National AIDS Control Organisation, 2003.

11 Sarkar et el. (1993).

12 Manipur State AIDS Control Society report, (2003)

Nobo Kishore said, “our efforts grew out of this mandate. It was at that time that the concept of harm reduction was introduced to us.”

But, despite the urgency of the situation, not all donor agencies at that point of time were willing to take it forward. Many factors ranging from a difficult environ to growing insurgency, lack of governance mechanisms etc inhibited the response. Voluntary organisations like CSD nevertheless persisted. “We sent proposals to many of the donors who had attended the meeting but they deferred on one ground or the other”, remembers Nobo Kishore while Yasmin Zaveri Roy, Programme Manager, Sida recalls how, “Nine project proposals came out of that meeting. But there were no takers for those proposals. Finally, Sida along with NACO stepped in and decided to conduct feasibility studies to translate this mandate into a concrete initiative”.

6. Developing a mandate

A situational assessment done by two consultants for Sida in 1993 *made it clear that the State had not developed any kind of response to HIV/AIDS* and that the concept of community centred work was totally alien to them. Furthermore, it lacked financial resources for any development or community-based work.

Seeking a paradigm shift

Given this state of affairs, the situational assessment stressed on the need for a paradigm shift while suggesting:

- Targeted interventions among injecting drug users to motivate them to use clean needles and syringes and stop sharing equipment.
- Initiatives to make the larger community aware of their social and ethical responsibility towards preventing the further spread of HIV/AIDS.
- Interventions that would ensure that the NGOs spearheading the interventions were gender sensitive and capable of addressing the specific needs of women.

'The assessment also opined that NGOs involved in the initiative would need to 'unlearn before learning' and that the effective training of all organisational staff would help in transforming the way drug users are dealt with in the region. Moreover, it would reinforce the efforts being made by the pilot project to establish a broader message of safe drug use to a larger population of IDUs and motivate IDUs to seek and demand help for detoxification and residential treatment services.

Yasmin Zaveri – Roy, who was providing training on outreach and counselling says, "Following the inputs of the two consultants Joe Kittleson and Praveen Singh who went in the preparatory phase, capacity building of the organisations was emphasised as the first area that needed strengthening. The organisations were already implementing rehabilitation and drug demand reduction programmes. Therefore this meant a major shift to a harm reduction approach, which required a lot of concept clarification".

The entry of Sida

Subsequent to this report and following a series of workshops in the North Eastern states, Sida in 1993 decided to step in and contribute in checking the transmission of HIV/AIDS among IDUs using the harm reduction approach[13]. Initially five NGOs – Prodigal Home, Dimapur, Nagaland, the AIDS Prevention Society, Guwahati, Assam; Lifeline Foundation, Imphal, Manipur, Institute for Social Disease, Imphal, Manipur and Centre for Social Development, Imphal, Manipur – were selected as Sida's partners for interventions in the region. However only three – Lifeline Foundation, Institute for Social disease and the Centre for Social Development – underwent training and participated in the intervention.[14]

The targeted intervention among drug users primarily sought to:

- Encourage the use of clean needles and syringes and motivate IDUs to stop sharing equipment.
- Increase awareness levels of the community to undertake their social responsibility to participate actively in preventing the further spread of HIV.
- Strengthen and link training to the actual implementation of the activities.[15]

The new harm reduction approach decided on by the NGOs and Sida marked a strategic shift from the abstinence model. It was oriented towards intervening and preventing the further spread of HIV/AIDS and had taken into account the complicated processes necessary for complete rehabilitation, the high rate of relapse amongst users and the need for an interim solution to the growing instances of HIV amongst users.

Consequent to this decision, Sida supported a series of training workshops to build capacities of the NGOs between April 1993 and December 1996. These training sessions were held for 40 days in a year spread out for 10 days at a time. *The specific objective of this training project was to support the participating NGOs so as to ensure the optimal implementation of activities that would reduce the risk of HIV transmission among injecting drug users and their sexual partners.*

Creating capacities

Sida's role in creating capacities was a critical component that shaped the course that these three organisations took in refining their approach to implement the intervention. Consequent to its decision to support the organisations, Sida decided to provide them technical input to mount an effective strategic intervention to respond to the growing epidemic.

In the initial stages, Sida's funding was aimed at creating technical capacities amongst the project staff. The support enabled each of the

13 Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of interventions from safer use, to managed use to abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula implementing harm reduction. www.harmreduction.org

14 Only three organisation documented in this study remained with the project. AIDS prevention society, Assam did not continue beyond the initial training period and support to Prodigal's Home, Nagaland was discontinued from 1999 onwards.

15 Memo, Sida, May 30, 1993.

organisations to set up its project teams, start basic services of condom promotion and initiate community sensitisation on a small scale. In the second phase by the mid 90s and after completion of the training the assistance increased to include provisions to set up drop in centres and initiate the needle and syringe exchange programme in full earnest. As the organisations began to appreciate the importance of outreach in the success of the intervention, this component was given greater emphasis.

Tarun Roy, one of the trainers associated with the project since its inception, said of the relationship that developed between Sida and the organisations, "Sida as an agency was not interested in controlling the organisations that they were working with. They worked on the proposals through a process of dialogue. *They (Sida) were of the mindset that the people on the ground implementing were the best judge.* If they were having difficulties a technical team would be brought in to assist but not to dictate what should be done."

For the training, Sida selected five trainers in three areas – outreach and counselling, assessment, monitoring and evaluation and information, education and communication (IEC)[16].

Seeking to move beyond the modular pattern of imparting training, the trainers sought to understand the needs of the three organisations and the environment within which they were undertaking the intervention. *In an assessment conducted by the Sida trainers, key differences were found in the three NGOs, vis-a-vis their organisational development, organisational identity, criteria of staff recruitment in the outreach project, staff background and exposure, leadership style and the understanding of outreach work and concept of harm reduction.*[17]

According to Tarun, understanding these differences was an important part of the manner in which the training proceeded. "We realised that the three organisations would take total different perspectives when looking at the issue because they were different. CSD had a development background and could therefore look beyond the perspective of service provision. Lifeline, an organisation of ex-users would be involved in the day-to-day issues of care. Jayanto from ISD, though he had undergone medical training later began to realise the necessity of community empowerment and the importance of building local partnerships".

In keeping with Sida's own belief on providing implementing partners with the space to design their own initiatives, the training was as Roy pointed out, also focused on making available "technical support to catalyse the process". *This often required the trainers to set aside what they had initially planned and create new designs and strategies.* Tarun pointed out that, "In situations where you do not have an idea about the state of affairs and there are only quantitative indicators, it does not give you an idea of the community perspective, environmental factors and stigma and discrimination prevailing. *We found that a prepared module did not work. Having a basic idea of the skill areas that we needed to concentrate on, we needed to assess how those skills could be applied in those community situations, with the existing barriers."* Additionally, these strategies were developed often in response to the expressed needs of the members of organisations.

16 Outreach and Counselling – Sujit Ghosh, Amit Basu, Yasmin Zaveri Roy; IEC – Jogi Pangaal; Monitoring and Evaluation – Tarun Roy.

17 Roy, T. 1996. A journey from problem analysis to problem solving: HIV/AIDS in north-east India.

A critical component of the training was exposure visits to harm reduction projects in other countries. These visits were organised over a period of 3–4 years to varied areas like Nepal, Thailand, Singapore, Hong Kong. Niranjan's visit to the Nepal harm reduction project enabled him to "get used to the new concept" and he and other members were convinced that this approach could work. He said, "We expanded our programme after this visit and began to implement NSEP". Additionally the functionaries were also encouraged to travel to harm reduction meetings organised in Australia, Stockholm and Chengmei to share their experiences and learn from other presentations. Says Jayanto, "After returning from my visit to the Hong Kong methdane programme, I was encouraged to motivate drug users to try substitution therapy. Sharing our experiences allowed us to establish ourselves internationally".

7. Making the transition to a harm reduction intervention

Between 1992 and 1994, all three organisations experienced a major transition in terms of organisational priorities and the strategic approach they adopted. Caught between the rising incidence of HIV/AIDS and not so successful efforts to decisively rehabilitate drug users, these organisations needed to reconcile many impending challenges, in particular the growing intolerance towards IDU.

A new beginning

All three organisations had realised that since much of the intolerance and discrimination faced by people habituated to drugs stemmed from earlier associations of drug-users with anti-social activities and more recently from the linkage with HIV/AIDS, the community's understanding of the issue was clouded by emotions of fear, distrust and a sense of betrayal. *It was also clear to all three organisations that a new beginning had to be made and a major attitudinal change had to be ushered in* to guarantee that the problem does not get further exacerbated by inhumane reactions and unviable responses.

Social mobilisation

They also became aware of the fact that *if any meaningful shift towards harm reduction had to be made they would have to adopt a multi-pronged approach. This meant that the organisations needed to have the capacity and skills to motivate disparate sections of society to re-think on this issue, trigger a radical shift in their perceptions and urge each of them to go beyond their present potential.* This included the drug-users wanting to get rid of the habit, the personal and professional caregivers trying every possible method to rehabilitate the drug-user and the enforcement agencies being rigidly dictated by archaic laws and codes.

Developing a coordinated response-what it entailed

First and foremost the organisations needed to have a prepared and coordinated response. Secondly they needed to develop allies and change agents in every section of society they worked with. This would involve identifying outreach workers, developing peer educators, and forming support groups. And last but not least they would have to building a caring leadership.

Moreover, in order to build a prepared and informed response, they also became aware of the fact that if any meaningful shift towards harm reduction had to be made they would have to adopt a multi-pronged approach. This meant that the organisations needed to have the capacity and skills to motivate disparate sections of society to re-think on this issue, trigger a radical shift in their perceptions and urge each of them to go beyond their present potential. They also became aware of the fact that if any meaningful shift towards harm reduction had to be made they would have to adopt a multi-pronged approach.

This meant that the organisations needed to have the capacity and skills to motivate disparate sections of society to re-think on this issue, trigger a radical shift in their perceptions and urge each of them to go beyond their present potential. It was a period of great stress for the leadership of the three organisations. None of the sections of society that they wanted to work with trusted them and their intentions. Nor did all the individuals associated with the initiative feel completely convinced and confident about what they were seeking to do.

The organisations decided to respond to this environment of distrust by taking a conscious decision to be flexible, eclectic and allow the exigencies of the situation to determine the quality of response and not to be swayed by moral and emotional considerations.

In keeping with this approach they used the process of training provided by Sida to constantly hone their skills, engage with the different perspectives and strengthen networking and coordinated response.

Centre for Social Development – Developing institutional perspective and capability

Though its core competence lay in the area of rural and community development CSD established the AIDS intervention cell for HIV/AIDS because the growing incidence of addiction to drugs and HIV/AIDS was virtually devouring the community they were working with. *Their experience as a development organisation also enabled them to comprehend the effect deep-seated structural inequities could have on such an issue and prompted the adoption of a rights-based approach.* Alongside there was the realisation that at the intervention level they would need to enhance their skill and capability to provide specific services to drug users even as they created awareness in civil society through processes that are essentially empowering and participatory.

Community Volunteers in a training session

The latter assumed even greater urgency because the interaction with the target audience was fraught with the risk of a community backlash. Niranjan, an outreach worker who joined the CSD project in 1993, recalls how as a peer educator the brief given to him was to identify drug users and their

sexual partners and contact community leaders. But he soon found that his efforts were resulting in reprisal from law enforcement agencies and from the community at large. "Families would get angry when we visited clients in their homes. They used to say "we don't have drug addicts in our family. Why are you spoiling our prestige? Go away! So we had to convince them about what we were trying to do".

Community meeting with youth

Meanwhile, CSD was also discovering that the sero-prevalence rate among drug users was as high as 70 percent. *"We could not stop treating the users just because they were positive.* But the problem was that after the first positive case was spotted, many users were sent to jail and beaten. It was at that time we decided that a response was required for these people. This ultimately compelled us (CSD) to do something for the young boys who were injecting drugs and getting HIV/AIDS", stated Nobo Kishore.

Reaching out to the community

The organisations felt compelled to conduct awareness programs among the community, especially amongst those that had been personally affected by the problem, so as to create an enabling environment for their outreach workers to reach the IDUs and provide them with the necessary clinical and counselling services.

This in turn meant having the capacity to communicate with specific groups such as youth, community leaders and even parents. It must be stated here that the community was not homogenous and often they belonged to diverse ethnic groups. This is where the networking with other organisations as well as the training workshops on harm reduction, which brought all the three NGO-Lifeline, ISD and CSD-together assumed great relevance.

CSD organised 20 community meetings, community leadership training workshops and peer educator trainings reaching out to nearly 450 people in the first two years of the project.

By the last phase of the project in 2000, sensensitisation and leadership programmes were also being organised for SHGs and other community groups.

Participating in an integrated training process

Peer Educators Training

The on-going spread over nearly three years helped everyone associated with the programme to make a transition from the earlier model of institutional rehabilitation aimed at total withdrawal and abstinence to a more client-centred harm reduction approach.

It also helped them to develop the capacity to manage other processes like pre and post-test counselling and monitoring of the initiative. It was for all these reasons that the training combined processes like capacity building, stock-

taking, reviewing the intervention and if necessary re-strategising. Says Somorjit the project manager at CSD, "We were having capacity building training every six months. We used to have five days of training after which we work in the field. We then came back with our queries and re-planned our strategies if necessary."

Since much of the re-strategising stemmed from the need to mount an effective and workable client-centred response, the organisation partnered with different institutions, including the government. In 1993, they collaborated with the Ministry of Social Welfare to strengthen clinical services such as detoxification and rehabilitation. Soon they also found themselves reaching out to a cross-section of people and building their awareness on an understanding of the issue. Alongside, the members of the organisation took advantage of every training opportunity to hone their skill and capability to address such a complex behavioural issue. By the end of 1994 the organisation had a team of seven trained professionals who were giving shape to this initiative and providing the much-needed leadership.

CSD began its project in 8 areas of Imphal East district – Old Checkon, Tribal Colony, Maring Lane, Ngamthangpung, Angom Leikai, Nongmeibung, Mission Lane, Purana Rajbari. By the end of December 1995, two more localities in Imphal east – Chasat Avenue and Lampel Sakeithel were added.

By 1998–1999 CSD was able to scale up its activities to extend services to Moirang in Bishnupur district.

Lifeline Foundation – Seeking an image change of IDU

Lifeline Foundation on the other hand did not have to deal with the problem of changing gear. Having been founded by ex-drug users their greater concern at this time was to change the image of IDUs. Speaking of the initial uncertainty that existed amongst the members even as they were undergoing training and beginning their outreach work, Raghumani said that their *"problem was that of regaining the confidence of people as well as official agencies."* In fact, given the hostility towards drug-users, agencies such as the police was not only repressive towards drug-users but was also suspicious of the intentions of the outreach workers involved in interventions such as educating the user about the need to use clean syringes and needles. In fact, many of the skills that they had learnt at the training workshop could not be put to use "because the police was arresting our workers and clients". So whatever support they got from the people was undermined by the hostile attitude of the law enforcement agency.

In the initial period of the project in 1994–1995, LLF implemented in Yaiskul, Loklaobung, Chingmakha, Singjamei and Babupevia – within Imphal district.

By 1997–98 the project reach was extended to Keishampat, Keishamthong and Kwakeithel in Imphal. Additionally, services were also extended to 8 areas within Thoubal district including the Thoubal Bazar area.

During the last phase of the project from 2000–2002 care and support and networking of PWHAs was also being extended to Bishnupur and Churachandpur districts.

Harm reduction – organisational dilemma

Meanwhile at another level many members of the organisation felt uneasy with the newfound approach of harm reduction. Having internalised the goal of total abstinence, the change in emphasis towards harm reduction without insisting on abstinence and total withdrawal from drugs, seemed more like an appeasement of the drug-user and a compromise with the existing situation rather than a genuine alternative or an effort to eliminate the problem.

While their conscience was uneasy, *they also found themselves constantly learning about the inexorable relationship between injecting drug use and HIV/AIDS.* In 1993 members of the Lifeline Foundation collaborated with ICMR, to prevent HIV/AIDS amongst the high-risk group by creating awareness. This experience, according to Raghumani, provided them with a firsthand experience of the growing complexity of the problem that they were seeking to tackle. "We came to know firsthand that HIV can be transmitted through injecting drug use, if it is not intervened in time," he

stated. *Tempered by this realism they decided to be a part of the harm reduction intervention and publicly justified this approach on the grounds that it could make a great difference to HIV/AIDS prevention and help them to motivate the drug-user to move towards abstinence in a phased and friendly manner.*

From a support group to a development organisation

Meanwhile the organisation also faced the challenge of transforming itself from a self-help and support group to an organisation dedicated to a client-based rehabilitation programme. They also needed to raise funds and establish their credentials as a development organisation. So in collaboration with NACO they initiated an awareness campaign and used the training provided by Sida to evolve a highly creative IEC campaign.

Organisationally, Lifeline Foundation set up LIFE AID and began to recruit members to carry out harm reduction intervention. Four ex-users and a co-dependent were identified for carrying out the behaviour intervention project amongst the IDUs and their sexual partners. A needs assessment was then conducted and the newly inducted members received training in IEC, counselling, evaluation and monitoring.

On September 14, 1993 a community outreach program was initiated closely followed by the opening of a drop-in-centre for the stakeholders at Loklaobung. By this time the Foundation had identified a primary target audience of 300 IDUs and were maintaining regular contact with 75 of them.

In the initial phase of the project ISD began implementation in four areas within Imphal district – Singjamei, Yaiskal, Langthabal and Thongju. Covering a population of 1.5 lakhs, ISD estimated that there were over 2000 IDUs in these areas, Lying on either side of the Indo-Myanmar Road (NH-39)

By 2000, the programme had been consolidated in six areas of Imphal East and West, with Uripok and Sagolband and Keishamthong being the added areas along NH 53.

Institute for Social Disease – Building an organisational response

In the case of the Institute for Social Disease, set up by Dr. Jayanto, the challenge was one of transforming individual capabilities and expertise into an appropriate organisational response. The need for it arose "when the problem of HIV/AIDS was beginning to manifest in Manipur", according to Dr. Jayanto. He found that this was one more concern that needed to get addressed while dealing with the issue of drug use. "We were working in Singjamei and there were over 2000–3000 users there. *When the problem of HIV came we realised that to address the drug problem along with programme components such as de-addiction and detoxification, it was equally important to address the issue of HIV/AIDS".*

By 1995–1996 ISD initiated the Community Participatory Programme to encourage individuals to develop ownership of the issue. 3 workshops reaching out to over 75 participants was organised in 1996–97.

In 2000 during the last phase of the project 44 awareness meeting were conducted for people in the age group 14–37 years.

HIV/AIDS-Disseminating prevention messages

Sharat, a member of the Service Recreation and Organisation of the Youth, a local club in Singjamei which underwent sensitisation programmes with ISD, spoke of how, "when ISD began to alert us about HIV/AIDS and give us information, because we had no knowledge of HIV/AIDS, we thought we would also get HIV/AIDS from the users. We began to isolate them and there was a lot of fear. People started throwing them out of localities. These awareness programmes give us some idea of this problem". *In fact, by the end of 1994 a substantial number of local clubs had undergone basic information training sessions and though there was initial reluctance, in time people began to attend these sessions.* It was at this time, when people were approaching Dr Jayanto to conduct community

awareness programmes that he decided to register an organisation along with some people "who were involved in these activities and were also part of the same locality where I was working".

Meanwhile in the process of conducting these awareness-raising programme Dr. Jayanto's approach towards information dissemination also began to change. It became clear to him that along with disseminating information and creating awareness, it was also important to impart life skills and the capacity to cope with different challenges. So he began to develop tools necessary to disseminate behavioural change communication.

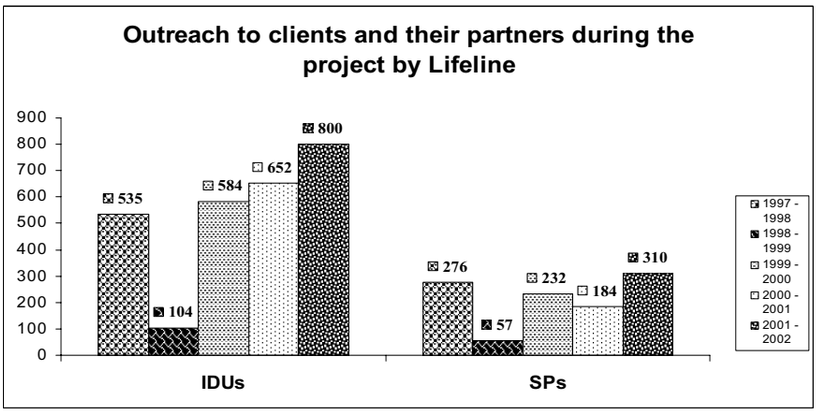
Tackling resistance

Dialogue with chemists for sale of needle and syringe

Like the other organisations ISD's theoretical understanding was put to test when they began to work with the community and set up Helpline to implement the intervention. They also faced resistance like the other organisations and were conscious of the fact that they were pioneering a harm reduction intervention. Promot Chand, who was amongst the first counsellors with ISD and currently their Project Manager recalled how, "when we started working in the community there was a very strong reaction from the community. We couldn't distribute needles and syringes and the IDUs would not come to the centre. The police and the community used to harass them if they were caught with these syringes. Though I had experience of working with IDUs the focus was new. I was working for the first time on a harm reduction intervention."

Looking back on those early days, Dr Jayanto admitted that they were extremely difficult days for them because their "credibility after undertaking the project was much lower" than when they were just rehabilitating drug users. This, he stated left many of them "confused about this approach and its viability." However at the end of two years ISD was able to develop a professional rapport and there was some understanding in the community of the work they were doing.

8. Going beyond implementing project on harm reduction, making it a mainstream programme



All three organisations *entered a decisive phase* in 1995. Having identified and witnessed the relentless march of HIV/AIDS in the lives of injecting drug-users, the harm reduction approach became an indispensable strategy to arrest the transmission of HIV/AIDS. With their intentions clear on why they were using this approach, *the three organisations gave a qualitative shape to the approach over the next two years and clearly demonstrated its usefulness in intercepting the transmission of the virus.* Consequently, the official programme in 1997–98 was compelled to adopt the intervention and endorse it with a clear policy formulation on it. Quite clearly, the harm reduction approach was no longer just another option. *In the context of HIV/AIDS these three organisations had proved that it was a logical and rational way of addressing the goals of abstinence as well as reducing the incidence of HIV/AIDS.*

Strategic focus

It was clear to the three organisations that a piece-meal approach would not work and that they had to ensure that the various components of the programme were implemented simultaneously and in tandem with each other.

The three programmatic components were:

- Developing a quality outreach programme for injecting drug users by providing them integrated and need-based service.

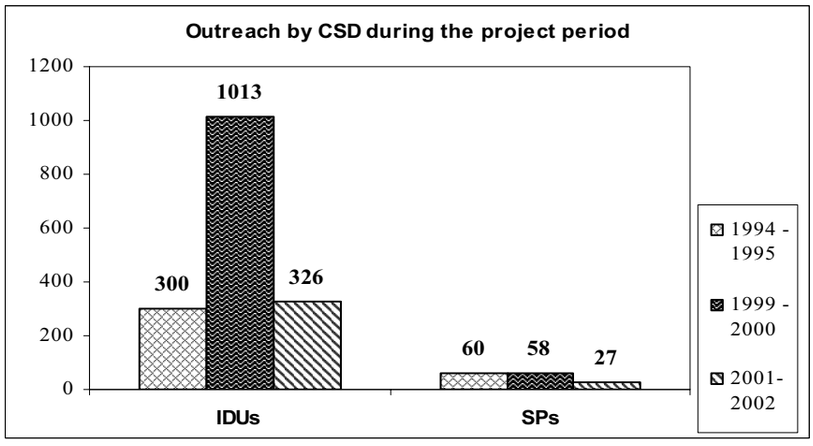
- Educating and sensitising the community on the linkage between harm reduction therapy and preventing HIV/AIDS transmission.
- Sensitising key agencies such as law enforcement personnel, health-care professionals to engage with the issue in a more informed and sustainable manner.

Community Workers Training

Making the outreach worker the key pillar of the initiative

The three organisations had realised early on that to implement these three components of the programme, they would have to gain the absolute and total confidence of the injecting drug users. This, they also realised was not going to be easy. It involved reaching out to and sustaining the interactions with them, which in turn depended on the range of service they were able to offer and deliver to meet the many types of needs and demands of different individuals.

Tarun Roy recalls *the constant process of review that took place, often through observations of the outreach workers, which served as a process for learning even for the trainers.* "We (the trainers) had extensive experience of community outreach and drug use but the Manipur situation was different. The environment was hostile. There were times when the outreach workers were unable to meet their clients for a month because of the law and order situation. They used to lose contact. Sometimes as a protective mechanism the outreach workers used to go in groups to the houses. We had to explain to them, 'you may be comfortable but you are violating the basic principle of confidentiality by drawing unnecessary attention of the community to your work'".



With the entire process dependent on the organisational link provided by outreach workers, much of the effectiveness of the initiative hinged on the capacity of the workers to develop a steadfast and client-based relationship with the injecting drug

Outreach workers in a planning meeting

users. This meant that when the clients faced any kind of problem or a personal crisis the workers could not abandon them. Even if the problem was not related to the concern he was dealing with, the worker had to respond to the needs of the clients and see them through their various problems. Often in the case of drug related problems, *the outreach worker not only had to provide a ready referral for the client but they also had to accompany them to the doctors and ensure that the clients were given all the necessary psychosocial support they required.*

Given this highly labour-intensive commitment, the outreach worker often found himself, physically, emotionally and even financially drained. The business of building a rapport with and gaining the confidence of the community also took a heavy toll on them. Bhanu, one of the founding members of Lifeline spoke of how, "we used to spend our money to buy children gifts and since women used to come to us and take rice and clothes because they felt that they could trust us, we had to meet their individual needs".

So they had to also deal with their own periodic fatigue and in extreme cases even burn out and a feeling of being overwhelmed by the problem. According to Somorjit, by facilitating constant interactions among the workers they were able to overcome this sense of isolation that the workers felt in the field. This was done by periodically withdrawing outreach workers from the field to enable them to interact with each other, revisit the ground situation and assess their own performance in the field. *At the conclusion of such an exercise they were encouraged to re-work strategy, question the assumptions that were made or learning that were drawn by the programme staff.* It was found that all this helped them to stay connected with the problem, renew their commitment to the work and experience a sense of moving ahead.

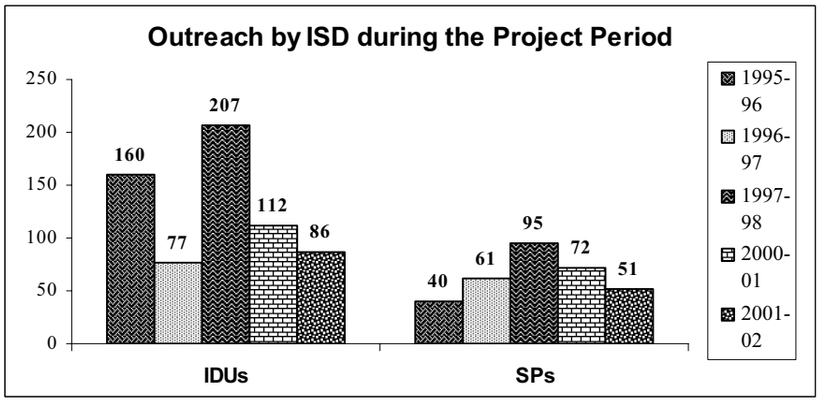
Peer Educators training

What made the strategy possible?

It must be stressed that *much of the success of this intervention was because of the kind of sustained support Sida gave to capacity building, not as a top-down process but as a way of catalysing a leadership that was rooted in the issue* and aware of its stake in creating long-term solutions and alternatives. The objective of the training process was to not to create efficient func-

tionaries and organisations but to unleash their potential to creatively shape and take forward not just a run-of–the–mill intervention but one that brings about a distinct paradigm shift with people's consent and participation. One in which the affected community played a central role.

It was realised that to achieve this *it was necessary to motivate current and recovering users to become peer educators and assist the intervention in locating and educating the injecting drug users. Promot Chand, explained how, "The recovering addicts had the advantage of knowing the community of drug users" and were able to disseminate to them the basic information about harm reduction therapy and the hazards of HIV/AIDS.* Although the peer educators were trained to impart and communicate to the IDU the basic information on the programme and HIV/AIDS in as accurate a manner as possible, demonstrate safer injecting practices and motivate their peers to trust the outreach workers, they could not be made the main frontline workers. They were at best a supportive group of people, drawn from the community but not necessarily capable of systematically executing such a multi-layered initiative. This was because many of them despite temporary cessation of the drug habit often relapsed into it and had to be constantly monitored by the outreach workers. Anil (name changed), a relapsed user at the CSD drop-in-centre recalls how as a peer educator he used to visit his friends and "they used to try and convince me to share with them. I could avoid them for some days but not always. I felt that taking a little bit would not get me hooked again". To prevent instances of relapse, Raghumani, spoke of how "we tried to keep them in the field as peer educators only for limited periods of time and the outreach workers would closely monitoring them. If they relapsed then we took care of the person and made sure he that he did not go to the field for a month".



Building the confidence of the community through delivery of quality service

However, the consolidation of the rapport with the community depended on the capacity to deliver service and more vitally, to motivate the affected

individuals to use the service. These services included condom promotion, basic health care services, home detoxification, referral services, pre and post counselling related to HIV/AIDS testing and the needle and syringe exchange programme. Each area of service delivery was equally complex with distinct requirements, capabilities and organisational imperatives. For instance a service such like home-based detoxification could only work if there was provision for "minute and consistent monitoring".


Home care service

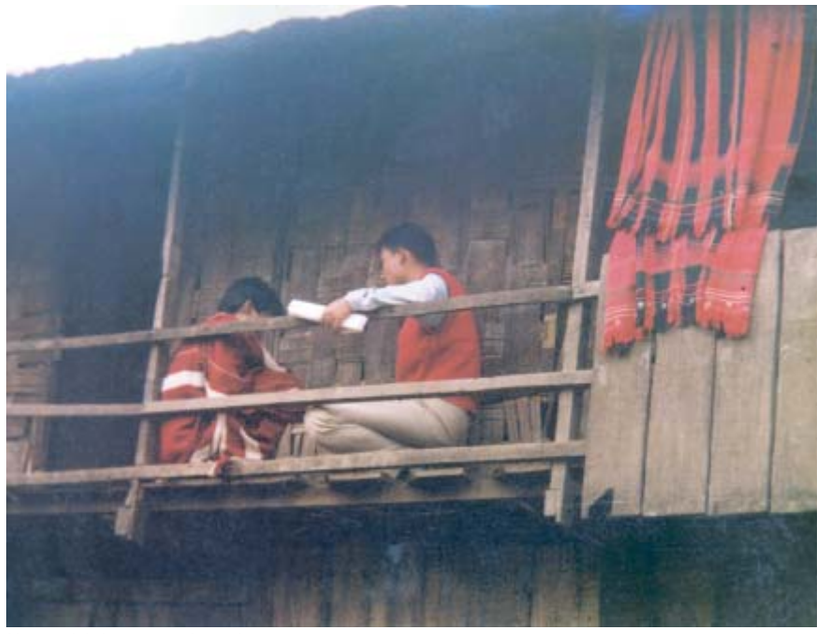
So organisations such as Lifeline, who work in close association with the affected community, have admitted that till the end of 1997 they were dependent on referral networks provided by organisations like CSD to service their clients with home-based detoxification. However *some services like needle and syringe distribution and exchange programme were essential strategies that needed to be promoted on a decisive scale so as to ensure the effective prevention of transmission of HIV/AIDS.* Therefore they had to be implemented in a strategic manner to extensively cover populations that inhabit the main route of drug trafficking. Moreover, it was important that they also succeed in a qualitative manner by educating and training injecting drug users about safer injecting practices and inculcating in them the habit of using clean injecting equipment.

In keeping with these practical goals, the three organisations virtually fanned out the message across the different parts of the State by 1995. While CSD succeeded in implementing the initiative in Imphal East, ISD concentrated its efforts in four localities of Imphal that lie on either side of National Highway 39 covering an estimated population of 1.5 lakhs and reaching out to nearly 400 IDUs and their sexual partners in the first phase. Lifeline focussed on parts of Imphal as well as Thoubal district. However, unlike the Centre for Social Development, both ISD and Lifeline initiated only needle and syringe distribution during this phase. The process of needle and syringe exchange was commenced in 1998.

Motivating users to adopt safe practices

In an intervention of this kind *what finally counts is the organisation's ability to persuade people to adopt a new practice.* Niranjan Singh, Project Manager recalled how outreach workers from CSD," used to go door to door to give new syringes and collect the old ones". In the first year of the programme, CSD reached over 300 users and ISD worked with over 200 users. This activity was complemented by other initiatives such as bleach distribution, which educated IDUs in the use of bleach sterilization techniques and supplied them with bleach to clean their injecting equipment.

A critical part of this strategy, according to Dr. Jayanto was "counselling". Jatin, a former outreach worker with ISD, recalls how as outreach workers they were provided training in counselling and in particular on "pre and post test counselling on HIV/AIDS".



Home visit by outreach worker

Providing friendly spaces

To *sustain contacts with injecting drug users, it became necessary to provide an environment, free of any form of reprisal, condemnation and pressure.* CSD's drop-in-centre set up in 1994 was for instance seen as a place where psychosocial support was available for those who were undergoing rehabilitation. And where clients could reinforce their resolve to break free from drugs and avail of services that would facilitate in minimising the potential harm that an injecting drug could cause. Therefore it also had multiple utilities such as counselling, clinical services and recreation centres.

The other obvious advantage was that the harm that was caused in the street or at home was reduced. Earlier, according to Nobo Kishore, "they would hang out on the street where they would fight. Or at home where there would get into tension with the family and take recourse to unsafe practices or get into problems with law enforcers, the CSD drop-in-centre enabled them to stay inside, watch TV, read magazines and get the information they needed".

Playing carrom board at the drop-in centre

But the *biggest advantage of having a centre was that it enabled CSD workers to persuade the drug users to use safe practices. The IDU often spoke of how other spaces such as home often drove them into acts of desperation.* After a fight with the family they would often lock themselves up in a toilet, use unsafe water and inject with a used needle and syringe. The idea of the center was therefore to reduce all such provocations and as a first step encourage them to have an informed relationship with drugs and other substances. According to Nobo Kishore, *"Our idea was that until and unless they come out of the drugs let them do it in a manner, which is less harmful".*

Capacity Building workshop with women

These spaces also encouraged the members to increase their sense of self worth and self esteem. In December 1996, an SHG "Citizen's Circle" was set up in the drop-in center run by ISD. According to Jayanto, "members of the group were mostly HIV positive and were receiving home based care from ISD and they came together to share their experiences". They actively visited de-addiction centers to motivate inmates apart from visiting families of the SHG members. "These visits were started by the members themselves with an aim to build closer relationships within the families" says Promot.


Community meeting

Creating trust and confidence

Meanwhile, what proved rewarding for people managing the centre was the quality time that the staff was able to spend with their clients. Niranjan spoke of how during this time, "the staff would try to facilitate behaviour change among the clients. *Initially families had problems with such a concept and the organisation even found it difficult to start drop-in-centres in communities but over the years the situation changed for the better, because the impact was becoming evident".*

Endorsing this Sushil, *(name changed)* a peer educator and a client spoke about how the centre helped them. "Here we got treatment when we were in pain. Initially, we used to meet in groups of two and three and take the shots. They came and told us not to do that. After the needle and syringe program they provided us with needles and syringes so sharing has been reduced." Nirmal, *(name changed)* another peer educator said, "When we come here the doctor understands the problem. They know what we are going through".

By 1994 Lifeline had opened its centre in Csingamaks, which was within the community area. Moindero spoke of how "the centre had facilities of indoor games. It was also next to a basket-ball court and billiards facility. This attracted more users to come there and spend their time". While CSD and Lifeline set up centres within communities, ISD set up its drop-in-centre 'Help-Line-Centre', outside the community area of Sinjamei in 1994. Promot said this was done because of the intense reaction from the community. "They were very hostile so we decided to

open the centre within our office itself." By 1996, the community had begun to accept the efficacy of the harm minimisation services that were being offered and ISD was consequently able to open its first drop-in-centre within the community area.

Educating and involving the community

The initial hostility of communities convinced these three organisations that community sensitisation would need to be a major part of their strategy. Therefore as part of their initial advocacy strategy, community meetings and leadership training programmes were organised. *The objective was to create awareness about HIV/AIDS while stressing on the importance of the harm minimisation philosophy, so as to effect a change in the community perception towards IDUs and their partners.*

Meeting with parents

Ten such meetings were held in the project area by CSD between 1995 and 1996 enabling them to reach out to nearly 200 members of the community. Most of these meetings were held with youth clubs and women's welfare associations.

Similarly, ISD also decided to involve local clubs and women's groups. They realised that their clients were unable to carry the needles and equipment for fear of harassment by their own community and others. This prompted them "to move from client oriented services to community based initiatives, especially in tight knit communities where the apprehending of a user became an issue".


Health care training with housewives

The process required interaction with local Community Based Organisations (CBO) and negotiating with influential stakeholders like Women's group-the Meira Paibies and Nasha Bandi (the Anti Drug Group). Two major community organisations United Club Organisation and Thongju Kendra Coordinating Committee were identified as potential groups that could generate a response from the citizens. The other mechanism used was that of motivating local groups like Luhongba and Phanek Marup, involved in diverse activities such as promoting local culture and even managing chit funds.

However, *it became increasingly clear to the organisations that the sensitisation would work only if it took into account people's reservations and apprehensions about the harm reduction approach.* Therefore, one technique that was adopted was to make these interventions interactive and far more educational.

According to Nobo Kishore, these interactive meetings would often go on for four to six hours. "The community would accuse us of encouraging drug users. So along with giving them knowledge of HIV/AIDS we explained to them about the work we were doing. Their complaint was that the drug-users were stealing and that they were breaking doors of shops etc. We refused to get drawn into such issues. Instead we posed the challenge whether in such circumstances the enforcement of legal action was the best possible option? We further asked them whether the government had space to jail all of them? Moreover if the community wanted to kill of all them, would it prove to be a viable solution? We then extended the argument that though their intention was to help the drug-users to come out of the habit they were not ready to be part of the prolonged struggle. We convinced them that it was also necessary to keep them free of HIV/AIDS while helping them towards abstinence. We asked them to treat them as human beings, accompany them and help them to get out of this habit through counseling and ensure that they do not fall victim to HIV/AIDS". The community, according to him did listen to them, "but only after a lot of persuasion and sensitization".

They hoped thus to "transfer the skills of outreach work into the community to ensure sustainability. Nearly 150 leaders were trained in the process", says Somorjit, Programme Manager, CSD. Some of the participants later functioned as volunteers and reached out to the community through their youth clubs. Commenting on the process of identifying these individuals, Niranjan said, "We approached CBOs, community leaders and ex drug-users who were capable of contacting and organising programs in the community." The training thereafter provided participants with information on preventing the spread of HIV/AIDS, safe injecting practices and help them decide how they could contribute to the intervention. *Confidence in the process was built slowly and gradually, creating as wide a consensus and as much social acceptance as possible.*

Similarly, when ISD realised that the community continued to harbour reservations about the harm reduction approach and this was hampering the impact that outreach workers could have on people, they decided to address three dimensions of the issue. These were to:

- Enhance the community's appreciation of the work being done by outreach workers.
- Explain to the community the concept of harm reduction.
- Persuade the pharmacists to sell syringes and condoms readily.

The community questioned the contention that harm reduction could lead to abstinence In fact, they feared that the boys would misuse needles and syringes and it would encourage the habit. Says Jayanto, *"It took ISD all of three years to convince the community that harm reduction was a process that was likely to lead to a more responsible relationship with drugs".*

In the process, ISD's approach to information dissemination also altered dramatically. Earlier they used to give people information related to HIV/AIDS and transmission. But they soon realised that "it is equally important to focus on skill development programs, contribute to social mobilisation, enhance motivation and increase capacity to negotiate in situations of risk". Hence, they designed training programs for community leaders in which 20 per cent focussed on information and the remaining 80 percent on the development of skills.

Mainstreaming the initiative – An official response

So decisive was the impact of the intervention that the official agency of the State Government, the Manipur State AIDS Control Society (MSACS) decided in 1998 to adopt the approach and take ownership of it. They raised harm reduction to the status of programmatic response, formulated a clear-cut policy to mandate its state-wide implementation and provide the much-needed leadership and commitment from the government.

With the *State having decided to make the harm reduction intervention as the flagship programme of the official focal point – MSACS and these three organisations found that they were supporting an equally challenging process of scaling up and mainstreaming.* What is significant about this development is not the scale of the intervention but the fact that the State had adopted the harm reduction approach as a policy objective, thereby signalling a clear break from the past. *It legitimised this approach and perhaps more importantly the State for the first time enunciated a public health perspective shaped by human rights and development imperatives.* It must be noted that such a radical shift would not have been possible, without the path-breaking efforts of these three organisations. They had demonstrated that despite harm reduction being potentially a double-edged approach, it could be successfully harnessed as an instrument to prevent transmission of HIV/AID, build a response that was participatory and create a socially accepted alternative. This helped the State to justify its unswerving commitment to such a programme.

Policy enunciation

In 1998, MSACS introduced the State AIDS policy. A critical element of the policy was the recognition that, harm reduction measures needed to be put into operation to halt the spread of HIV/AIDS in Manipur. The policy clearly mentioned that harm reduction measures like "drug maintenance therapy", needle syringe exchange programme (NSEP), bleach and teach programme needed to be introduced to minimise the risk of spread of HIV infection in the population. *With the adoption of this policy Manipur became the first Indian State to officially adopt the harm reduction approach as an intervention measure to prevent transmission of HIV amongst injected drug users and their partners.*

The policy was an important milestone for Manipur. *According to the Project Director of the Manipur State AIDS Control Society, Dr. Sukumar Singh, it created a public-private partnership and paved the way for decisive measures and the launch of a response to the spiralling epidemic on a war footing.*

Public private partnerships for a unified response
The Rapid Intervention And Care project (RIAC)

The Manipur State AIDS Control Society launched the Rapid Intervention and Care (RIAC) project on November 7, 1998. According to Abhi Ram, the NGO Advisor of MSACS, the main objective of the RIAC project was to enable MSACS to respond on scale and "use partnerships to cover large areas and respond more effectively". *Modelled on the harm reduction approach the project included community sensitisation and mobilisation, NSEP, bleach and teach, condom promotion, drug substitution, STI treatment, home detoxification, referral services, formation of self help groups amongst its primary services.*

Given this continuity of approach it included organisations that had a track-record in implementing the harm reduction interventions. However to enhance coverage, new organisations were involved in a state-wide initiative. These organisations provided a variety of support services including legal aid, care and support and economic empowerment. Some of the initial partners included the Integrated Women and Children Development Centre, Manipur Voluntary Health Association, SASO and Shalom. In addition CSD, ISD and Lifeline also participated in this partnership by providing their skills and training to the other NGO partners to implement this approach. An initial target of 6000 users set for the project, was scaled up to 18,000 by the end of 2002.

Leveraging RIAC to enhance groundswell – Consolidating community support

By 1997–98, all the organisations involved in the RIAC project were sensitising the community on the issue. According to Nobo Kishore, the environment had become more open, at least as far as the state machinery was concerned. "We were still facing some instances of resistance within the communities but the problems we had with the Army, the police and pharmacists began to reduce drastically". The outreach staff was able to reach a total of 1351 IDUs in 1999 alone.

In keeping with this thrust, CSD decided to set up a Forum of People for Co-ordination and Development in 1997. The Forum which currently has 24 members groups representing the community, widow's groups, local groups and community-based organisations and various people's organisations was essentially envisaged as a group that could be used to consolidate local initiatives.

It was felt that membership organisations that emerge from the community-centred Forum would be able to respond more sensitively to the user's situation and needs rather than outside organisations. Members of these organisations underwent an extensive sensitisation process on issues of drug use, community responsibility, communication, referrals, etc. By 2001 the Forum had gained increasing recognition at the village level. Today, according to Niranjan, "the groundwork has been laid for these people's organisations to take forward and sustain the initiatives" and the Forum is responsible for implementing and carrying out HIV/AIDS initiatives in coordination with the staff of CSD.

Meanwhile, Lifeline Foundation set up a network for empowering people living with and affected by HIV/AIDS to pro-actively negotiate for their rights and concerns. The Manipur Network of Positive People

(MNP+) set up in 1997 was the first State level network of people living with HIV/AIDS. *Given the stigma attached to HIV/AIDS this network was responsible for providing confidence to many Manipuri youth to "come out in the open" about their status.* Many MNP+ members had been earlier associated with Lifeline. Consequently, three district Self-help groups consisting of positive people were formed and the members were given an opportunity to interact with other state-level networks and develop organisational skills.

Developing sustainability – Sowing seeds for the future

Mainstreaming the harm reduction approach provided the three organisations with an opportunity to share their valuable experiences, skill and knowledge of harm reduction interventions to the RIAC partners during training and field-work. It also enabled them to branch out into key associated activities and consolidate earlier achievements with a greater degree of comfort and support.

Sensitising key stakeholders

By 1995 it was clear that the success of the intervention depended on sensitising the stakeholders and ensuring that the rights of injecting drug-users were not violated. This was essential to ensure that the intervention could shift from being micro, defensive, piece-meal to becoming pro-active, holistic, integrated and visible.

According to Raghumani, the sensitisation strategy of Lifeline Foundation was to a great extent shaped by the segments that they identified as critical to the strategy. This, according to him included elderly people, local municipality council members, elected representatives in the state legislature and women's associations such as Meira Paibi.

They decided that the best way to sensitise them was to "make them understand the dynamics of drug use, different approaches of rehabilitation and practices of harm reduction" It was felt that it was only after they understood the intervention that they would be able to support it. Therefore they were invited to the organisation and were "told that drug abuse was not a crime but a mental and social disease".

Interestingly, amongst the stakeholders, the medical community and the law enforcement agencies were the most difficult to convince.

With the links between HIV/AIDS and drug use becoming more evident but the cause of drug-use still unclear, many misconceptions and rumours began to thrive making access to basic services more and more difficult. Doctors were refusing to treat people whom they suspected to be users. They were also not willing to disseminate information or provide counselling and care. The NGOs had to campaign for an extended period before doctors began to treat drug-users.

Similarly the law enforcement agencies were also extremely hostile to the injecting drug users. During the arrests of the clients and the outreach workers in 1995-96, the worker was often released but the client was retained in police custody. Due to this the field workers began to lose the confidence of their clients. According to Raghumani, " when we went back to a client after that we found we had not only lost his trust but we had also lost the confidence of other potential clients." According to all the three organisations, convincing the law enforcement agencies took the longest time as "they were convinced that their own police model would

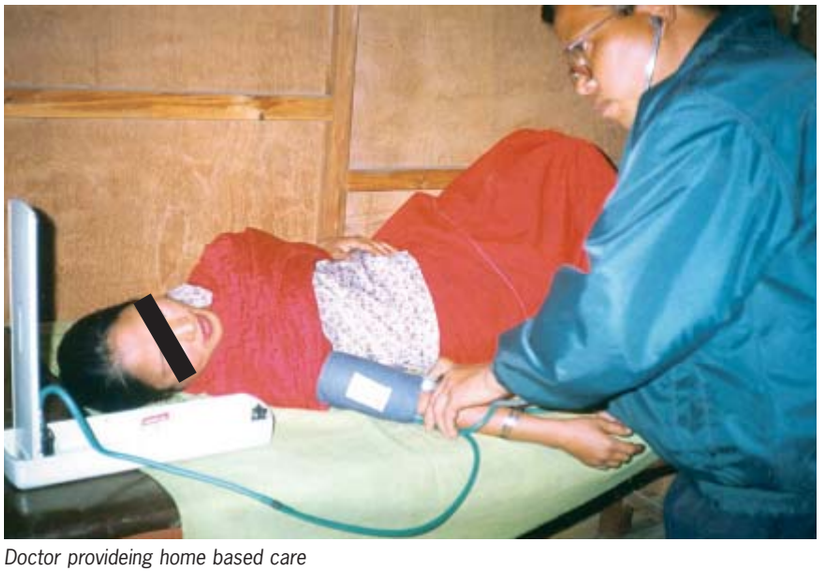
be more successful in dealing with the problem rather than our approach". Spurred by this, by 1996 the organisations decided to interact with officials responsible for law enforcement. Says Jayanto, " we realised the need for sensitising the police and the Army. The only problem was that by the time a rapport was built and they understood what we were doing they would get transferred. So we would have to start all over again."

Another tactic used according to Nobo Kishore was to engage with the law enforcement machinery at the higher levels to gain acceptability, "when organising workshops with peer educators, we were often harassed by the beat constables. So we decided to invite the higher-ups to attend the meetings."

By 1998 this effort was scaled up. *Depending on the target audience that was being addressed these organisations customised the sensitisation process to cater to their needs.* For instance in the case of local leaders, exposure trips were organised. Nearly 70 leaders were sensitised during this process.

Providing care and support

During the course of implementing the programme, Lifeline according to Raghumani "came across many instances when the clients needed more than just education about HIV/AIDS prevention and syringe and needles". Various day-to-day issues concerning care and support of children and widows emerged. After three or four years we were seeing that people were becoming ill and beginning to die from AIDS. When they fell sick their condition became pathetic and given their impoverished conditions even visiting hospitals and accessing care became difficult".



Doctor provideing home based care

It was then that Lifeline convinced Sida that in the changing environment a programme that integrated care and support was a vital service that needed to be offered to the users and their families. Consequently, by 1999 Lifeline was offering care and support services which included free treatment, free medicines for opportunistic infections and transportation to the affected. The organisation also initiated community-based care and support to those with AIDS and their families.

Establishing referral networks

The problem of providing increased access to services for positive people having opportunistic infection led to ISD's partnership with the Direct Observation and Treatment Short course (DOTS) programme under the National Tuberculosis Control Programme, technical centre of the Regional Institute of Medical Sciences and Public Health Centers by 1997. ISD, for example, was able to successfully establish a large network of referrals with major hospitals, de-addiction centres and pharmacies. It was also able to facilitate a rapport between the users and service providers by organising interactions between them.

Organisational scaling up

Empowering self-help groups

ISD was able to successfully set up an SHG in its drop-in-centre "Citizen's Circle's" in December 1996, that helped recovering and current users to increase their self worth. Promot states that the members of the group came together to share their experiences and to motivate visiting families of the members. Buoyed by this success another self-help-group was started in 1998 by recovering users. This group received training from various institutions to manage small-scale initiatives and enterprises. Though "You and I" another SHG of recovering users, started-up with financial support from ISD, it is now operating on funds raised by the members.

According to Jayanto, *"the decision to support and train this group was consciously taken in order to motivate SHG members to find other sources of sustenance by themselves rather than becoming dependent on outside funding."* Rajesh, a twenty-year old recovering drug user says, "I come here almost every day. Once they know that I am at the DIC my parents are less anxious about me. One of my relative who is a counsellor at a rehabilitation centre suggested to us that I can spend time at the DIC." Emanuel *(name changed)* another recovering user added, We don't earn a big amount from packaging *masalas*[18] but at least I have some money in my hand." The SHG also acts as a DOTS centre in partnership with the National TB control.

Empowering women

Realising that there would be many more women in similar situations, ISD decided to start a program to form self-help groups for widows to enable them to sustain themselves. Resources were mobilised and services were started to address their problems. Outreach workers (ORW) helped to build a rapport with widows groups and organised informal group discussions to enable them to discuss their concerns. Two categories were identified-women at risk and sexual partners of IDUs. Three SHGs-HOPE, WEDA and MANGAL were subsequently set up involving 60 women. Their activities include condom promotion, literacy programmes, health check-ups and family meetings, skill training, vocational training and SHG management training.

Indira one of the founding members of the HOPE group was herself an outreach worker with ISD. Recalling her experiences she said, *"while doing the outreach I use to hear the problems of the women, and when I lost my husband I realised how similar our situation was."* This group also took the initiative and brought together seven self-help groups comprising of the sexual partners of IDUs and formed a union called Womens' Joint Self-Help Group in June 2000. But while doing so it also had to deal with constraints like the lack of clarity in the concept of SHG. Most of these organisations were influenced by the NGOs who had brought them together. Members of HOPE wanted the focus to be on empowerment and capacity building but the rest wanted monetary assistance. By 2001, this group developed strong linkages with the Department of Women and Children, Government of India and was able to secure monetary and capacity building assistance for a programme on food and nutrition.

18 Spice mixture

Similarly, in 1999 the Lifeline Women's Solidarity Project had identified over 140 widows in Imphal district and provided them with extensive skill building and awareness opportunities. The aim according to Moindero, a Counsellor with Lifeline Foundation was, "not only to provide them awareness on their legal rights as widows but also to improve their socio – economic and health status through income generation workshops, life skill training and exposure training". Lifeline also created strong links with their families to build rapport and ensure that these women were reintegrated. Says Kajal (name changed) a widow who found that she was positive in 2000, *"Being in this group I have been able to come out and live positively. I am able to enjoy my life, share my concerns and also do small things like collect clothes and distribute to other women who are positive".*

Women Organisation for Reintegration and Consolidation (WORC), which had been established by Lifeline by 1995 was also beginning to increasingly empower themselves and widows outside their group through various skills trainings. MSACS provided them support under the RIAC project to initiate small-scale enterprises and manage credit and thrift programmes.

Many of the women felt that such support groups had made a great difference to their lives and shaped their ability to cope with the situation. Mema, secretary of WORC recalls, "In 1995 I was in a very pathetic condition. I was in a state of shock and uncertain of my future at that time. I did not want to go out of my house. *If WORC had not been formed I would have been able to meet others in the same situation. It helps us to bond and work together for the common good."*

Prize distribution for essay writing in school awareness programme

Reaching out to young people

A network of twenty organisations represented by nominees of local Clubs, the NSS and Boys scouts was gradually formed by ISD from 1998 to advocate on reproductive and sexual health concerns of young people. *The network comprising of 15–20 boys and girls have been sensitising parents and elders on the need to talk to their wards about sex and sexuality and caution them about risky sexual behaviour.* The network also aims at strengthening the rapport between ISD and community based organisations. Stressing on the importance of this initiative Nutan, the project officer at ISD who undertook the Reproductive and Sexual Health (RSH) component of the project said, " Adolescent sexuality is a taboo in our society. The youth don't have access to information and the community cannot provide this on its own. Though we tapped only community volunteers initially, gradually we were able to involve NSS authorities directly by 2000–2001". A.K Sharma, former NSS liasoning officer, observed how this association has been able to create "a network of dedicated volunteers who are able to organise programs in their own colleges and even motivate their friends to participate and conduct programs. The program

has also been able to encourage the volunteer to do something on his own initiative".

By 2000, Lifeline Foundation had also realised the need to have a common platform where adolescent youth could share and discuss the issues of HIV/AIDS, STI and their general health. A Youth Forum was formed in Thoubal district and six peer educators were trained to organise training and participatory programs for young people. Four information centres were also established so that both the community and the youths can have access to information on HIV/AIDS, STI and other related issues. Peer educators reported various constraints, the most important being the preoccupation of the young with their education and careers.

North East Network – NEIHAN

Encountering numerous challenges and simultaneously gaining insights and experiences, the NGOs have learnt that targeting a small groups of IDU population will not have a major impact on the growing pandemic in the region. Recognising the need to respond collectively and increased momentum and vigour – between civil society, voluntary and government sectors- have a wider coverage to address vulnerabilities and also to enhance a consistent regional sharing of experiences and capacities amongst the neighbouring north-eastern states, a North East India HIV/AIDS Network (NEIHAN) was formed in May 2000 by the NGOs.

The objective was to bring the seven states together on a common platform to address the issues of drug use, HIV/AIDS and other developmental problems that were hindering the progress of these States.

Moreover, understanding the need to avoid a second Manipur like situation in terms of the spread of the virus, and that a few NGOs alone cannot tackle the situation, the need for a concerted and collective effort by various NGOs and the government with a wider coverage, is expected to improve the HIV/AIDS situation of the region.

9. Milestones and Lessons learnt from the initiative

In documenting an intervention that started as a nascent effort spearheaded by a few creative, dynamic, knowledgeable individuals and developed into state-wide mainstream programme, the challenge lay in capturing every bit of the experience that shaped the initiative. This included presenting the evidence, profiling all the people that steered the initiative, describing the process that helped to shape the initiative and more importantly to identify the major milestones of the initiative.

- The initiative was able to intervene in an insurgent situation developing mechanisms and strategies to work in an hostile environment that was fraught with conflict and fear.
- With the ground realities becoming more complex and the community of injecting drug users becoming more vulnerable to the HIV virus, organisations involved in the intervention recognised the need for a strong paradigm shift in strategies.
- A sharp increase in the incidence of HIV among IDUs and the growing incidence of stigma and discrimination being experienced by them led to the realisation among these organisations that these issues needed to be addressed in a concerted manner with the active support of communities and key stakeholders.

A key lesson that they leant was that the issue of HIV/AIDS was not a stand-alone problem. It had to located in the paradigm of development. To deal with these challenges the organisations redesigned the intervention to deal with the root cause of the problem rather than be diverted by its many manifestations and take recourse to stigmatising and discriminating against IDUs and their partners.

- Since the organisations had varied and indepth experience of interacting with IDUs, the challenge during their training lay in helping them to develop their own responses to the situation. A critical and consciously developed component of the training strategy developed by Sida in partnership with the trainers and organisations was to work with the teams to define the problems and provide them with technical inputs and support. This strategy ensured that ownership of the process developed as the project evolved.
- A three-fold strategy was adopted to ensure social mobilisation that took into account the human rights of vulnerable groups such as women and young people affected by the problem. It provided for client-centred, need-based services for current and ex-drug users;

rehabilitation of IDUs to build their self-esteem and confidence and widespread public education to increase the circle of concerned people.

- All three organisations realised that they would have to address organizational challenges while undertaking effective outreach programmes in order to implement this intervention in a phased, constantly expanding manner, that provided different sections of society an opportunity to engage with the issue. Therefore, they first created a learning environment by providing hands-on training by a team of experts. This helped them to evolve winning strategies and processes to achieve their objectives. At the same time, they focused on creating a caring and nurturing environment, by making the outreach worker and peer educator the main pillars of the intervention.
- They also had to constantly demonstrate the efficacy of this approach and the workability of specific services to affected people and communities that harboured reservations on these interventions. This was done by adopting a behaviour change communication approach, which went beyond creating and building awareness, to taking different segments of concerned people into confidence and enhancing their understanding of the dynamics of the issue. This resulted in far more enduring response and genuine consent for the intervention.

As a catalyst, Sida played an extremely decisive role. They decided not to address the problem in a piecemeal manner. They strengthened the effort rooted in local experiences, expressions and needs by strengthening organisational depth and capability. A partnership was forged a partnership between grassroots organisations, concerned community, team of experts and an experienced donor agency. The most path-breaking decision taken, was to be flexible and eclectic, allowing the exigencies of the situation rather than any dogma or belief to determine the quality of the response. The process of building human resources went beyond the project and even the institution. People engaged in the response had to see themselves as change agents working for social transformation. The transition from the more conventional models of rehabilitation based on the conceptual framework of abstinence to the harm reduction approach needs to be implemented in a phased, need based and in a practical manner constantly educating people about its necessity helped to build public confidence in the intervention.

- They also had to sensitise key stakeholders, including law enforcement agencies and the administration, who were still adopting conventional and often inhuman demand reduction strategies to deal with IDUs. This was done by constantly proving to them that there were more humane ways of administering and addressing these problems.
- More importantly, this issue needed to be mainstreamed. The three organisations by proving the efficacy of the intervention succeeded in bringing about a policy shift by prompting the Manipur State AIDS Control Society to adopt harm reduction as one of the flagship programme of the HIV/AIDS prevention strategy.
- Having catalysed a state-wide response, the organisations are currently involved in building a greater response through regional networks spanning the seven North-East States as well as empowering other emerging and entrenched marginal groups such as positive

people, women and other communities caught in difficult circumstances like widows and the youth.

In the process of implementing these activities three significant outcomes were achieved. They were able to:

i. Increase the circle of concerned and sensitised people.
ii. Impact official structures and systems.
iii. Generate people-centered initiatives such as networks of positive people, self-help groups set up by women widowed by HIV/AIDS and drug use and forums of concerned citizens.

The intervention demonstrated that an effective networking and convergence of organizations with varied backgrounds, track records, skills and core strengths could provide synergies for a more meaningful qualitative response. Since the concerns, needs and aspirations of the target audience had to be understood, articulated and dealt with in many ways, a coalition of grassroots organizations found itself developing and demonstrating a more complex and multi-faceted response.

The three organizations worked towards a multi-pronged response. They responded to the constantly changing and expanding needs of the clients. In keeping with this core objective they developed many niche and complementary responses-some in the realm of service and others in the area of information, education and communication.

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11. List of interviews conducted

	ISD	CSD	LLF
Injecting Drug Users	Men SHG – 5 Drug Users GD	FGD with users	3 Male users
Recovering users	Men SHG – Recovering Drug User	Rehab Centre – 1 male user Female user	Men SHG – MNP+GD
Sexual partners of IDUs	Hope – women NGO GD		Rani *(name changed),* spouse of user
Parents of IDUs		Nyan Kom, A.K Kom, Mother and Brother of user	Subodh – founding member
Peer educators	Recovering drug user, IWCDC		
Widows of IDUs	Hope – Women's SHG	Widows group – women	WORC – Jamuna Devi, President, Mema – Secy, Sonia, Nirmala, Bishoni. GD
Outreach Workers	Jatin, Former Outreach worker Basanto, outreach worker	4 outreach workers	Moindero,
Organisation staff	Jayanto Kumar, Pramot Chand, Nutan, Jeevan Mala	Nobo Kishore, Somorjit, Saratchandra, Rebati Raman, Niranjan Singh, Rehab centre – 3 Counsellors ORW – Kimboi	Banu Devi – Former Secy, ORW, RIAC; Sharat – Founding member, Raghumani – Secretary, Ingocha – ORW, Project Coordinator; Zubeida – Coordinator; Anita *(name changed)* – Clients
Partners	NSS, Manipur College – Teachers, Student Volunteers IWDC – Anna, Ratan	Bankim – SASO.	Dr. Noren, Former PRAM, JN Hospital; Manipur Driver's Union – Secretary Sushil – lawyer

NGOs	IWCDC, Seiko, Local Club,	People's organisation – NEIHRN – Leela Banta, Forum for Coordination Basant Kumar for Development, Vasu GD Diamond Club, Manda Eastern student club

Others	
State health Department/private hospitals	Dr. Bhrajachand, RIMS,
State AIDS Cell	Dr. Diamond Abhi Ram – NGO Advisor; Sukumar Singh – PD
Media	Roopa Chandra
Community Leaders	Local clubs
Trainers	Tarun Roy Yasmin Zaveri Roy

Halving poverty by 2015 is one of the greatest challenges of our time, requiring cooperation and sustainability. The partner countries are responsible for their own development. Sida provides resources and develops knowledge and expertise, making the world a richer place.

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