

**Assessing the feasibility and scope
for Community Mobilization of Injecting Drug Users
in HIV-AIDS prevention:
A preliminary study in Manipur and Nagaland , North East India**

by

Priscilla C Ngaihte
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Approval

Name: Priscilla C Ngaihte

Degree: Master of Public Health

Title of Thesis: Assessing the feasibility and scope of Community Mobilisation of Injecting Drug Users in HIV/AIDS prevention: A preliminary study in two districts of North East India

Examining Committee:

Chair: Dr. Mark Lechner

Senior Supervisor: Dr. John O’Neil
Professor and Dean
Faculty of Health Sciences

Supervisor: Dr. Malcolm Steinberg
Adjunct Professor Clinical Practice
Faculty of Health Sciences
Simon Fraser University

External Examiner: Nicole S. Berry
Assistant Professor
Faculty of Health Sciences

Date Defended/Approved: 17THAUGUST 2010

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Abstract

In India and elsewhere community mobilization has increasingly become a key strategy and continues to be a proven success to HIV prevention in the realm of sex workers, men having sex with men and transgender who by a presence of intrinsic factors have enormous benefits and gains in terms of legal recognition, protection, health and human rights by being mobilized as a community. Injecting drug users (IDU), on the other hand are yet to exhibit the same levels of enthusiasm and success in the community mobilization approach of the national HIV intervention program. This study is an attempt to review the feasibility of mobilizing the IDU community and assess the contextual and structural factors that could act as facilitators or barriers to which the community could be mobilized in two areas in the northeast of India which are classified as high prevalence districts for HIV, and where intravenous drug use is an important route of transmission. This study is a result of a qualitative thematic analysis of data collected through in-depth interviews and focus group discussions.

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Sincerely,

Priscilla C Ngaihte

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Introduction

HIV/AIDS has become a major public health issue in India. Though the estimated adult HIV/AIDS prevalence rate in India is low- at 0.36% (NFHS-3, 2007) – it has the world's fourth largest population suffering from AIDS (UNGASS, 2008). Given the size of its population, if the present rate of transmission continues unchecked, the sheer number of infected could be overwhelming. According to the latest UNAIDS reports there is an estimated 2 million to 3.1 million people living with HIV in the country (UNAIDS, AIDS epidemic update, 2007)

Not everyone in the population has the same risk of acquiring or transmitting HIV. Much of the HIV transmission in India occurs within groups or networks of individuals known as 'high risk groups' who have higher levels of risk due to a higher number of sexual partners or the sharing of injecting drug equipment. The epidemic in the country is unique in the sense that though heterosexual transmission accounts for 85% of the spread, in some areas like in the north-eastern part of the country, injecting drug use drives the spread. In a grouping done by Chandrasekaran et.al (2006) of Indian states by data availability, epidemic stage and response, the two north-eastern states of Manipur and Nagaland have over one percent antenatal prevalence and transmission is largely through injecting drug use. Other states like Maharashtra, Karnataka, Andhra Pradesh and Tamil Nadu also have over one percent antenatal prevalence but the route of transmission is largely heterosexual. "The rest of India has less than one percent antenatal HIV prevalence with transmission in these states most likely to be heterosexual, although mapping of high-risk groups is not comprehensive" (Chandrasekaran et.al, 2006). In 2007 the average HIV prevalence among women attending antenatal clinics in India stood at 0.48% while much higher rates were found among people attending STD clinics (3.61%), female sex workers (5.06%) injecting drug users (7.23%) men who have sex with men (7.41%) (NACO, October 2008) The findings reveal that across India HIV prevalence still appeared to be low among the general population, but disproportionately high among high-risk groups, such as IDUs, female sex workers, men who have sex with men (MSM) and STD clinic attendees.

Purpose of the Paper

The success of community mobilization to prevent HIV among high risk groups such as sex workers and transgender(s) has often been highlighted in literature (Merzel and D’Afflitti, 2003). Mobilizing at risk communities is based on recognition of social vulnerability and concepts of empowerment and human rights. “In Santo Domingo, interventions combining support for sex worker solidarity and changes in government policy are showing positive effects” (Kerrigan, 2005). In Paris, the PAST project has mobilized sex workers and transgender to claim their rights and obtain services (Spire, 2008). In India, the Sonagachi project run by and for sex workers, has resulted in impressive rates of coverage for HIV prevention and other services for sex workers in the state of West Bengal, and, many have argued that Sonagachi’s actions have resulted in HIV prevalence rates remaining low in these communities.

In India, to combat the enormous HIV threat, the National AIDS Control Program (NACP III) recommends a peer led intervention and community mobilization approach whereby high-risk communities themselves take ownership and leadership in HIV prevention. These high risk groups are commercial sex workers, injecting drug users, men having sex with men and transgender (NACO operational guidelines, TI under NACP –III 2007-2012).

Project ORCHID, one of the lead partners in Bill and Melinda Gates funded HIV interventions in India, began institutionalizing community mobilization into its harm reduction intervention projects amongst injecting drug users by late 2007. During the months of January and April, 2010, exploratory research was conducted by project ORCHID and the author as part of her practicum, a requirement of the Master of Public Health (MPH) at Simon Fraser University. She was assigned the task of conducting an exploratory assessment by Project ORCHID amongst the clients of ORCHID NGOs to determine the feasibility and relevance of a community mobilization approach to the injecting drug users’ community.

Aim

This paper is an exploratory review of community mobilization in an HIV prevention program among IDUs in two sites in North East India.

Objectives of the Study

- To explore the degree of sense of ownership and membership to the community organization.
- To describe identified needs of IDUs around which the community can be organized
- To identify the barriers and opportunities to community mobilization among IDUs

Critical Review of Recent Literature

HIV Risks and Structural Factors

There has been recognition that earlier literature on HIV/AIDS failed to identify the context in which HIV is transmitted: high levels of preventable disease, inadequate health resources, and a background of poverty, rapid urbanization, commercial sex, social upheaval, and community marginalization (Zwi and Cabral, 1991). Rhodes et.al (2005) identified the following factors as “critical in the social structural production of HIV risk associated with drug injecting: cross- border trade and transport links; population movement and mixing; urban or neighbourhood deprivation and disadvantage; specific injecting environments; the role of peer groups and social networks; the relevance of ‘social capital’ at the level of networks, communities and neighbourhoods; the role of macro-social change and political or economic transition; political, social and economic inequities in relation to ethnicity, gender and sexuality; the role of social stigma and discrimination in reproducing inequity and vulnerability; the role of policies, laws and policing; and the role of complex emergencies such as armed conflict and natural disasters.”

The HIV/AIDS and drugs problem in Manipur and Nagaland can be understood within the context of the structural constraints that prevail.

Overview of Manipur and Nagaland: Economy and Politics

Geographically, the states of Manipur and Nagaland lie on the easternmost border of India sharing a common international border with Myanmar, the world’s second largest illicit opium producing country. Various ethnic communities, tribes and sub-tribes, recognized by the Government on the basis of languages and dialects, comprise the general population in these two states. Isolated from the rest of the mainland, and with poor connectivity, these states have been starved of basic infrastructure and services resulting in the absence of any sustainable economic activity (Nayak, 1999) . Both states have depended essentially on central funding for any development work. There continues to be an increasing number of educated unemployed in the two states, a factor contributing to the political instability in the region.



Figure 1: Map of North-East India

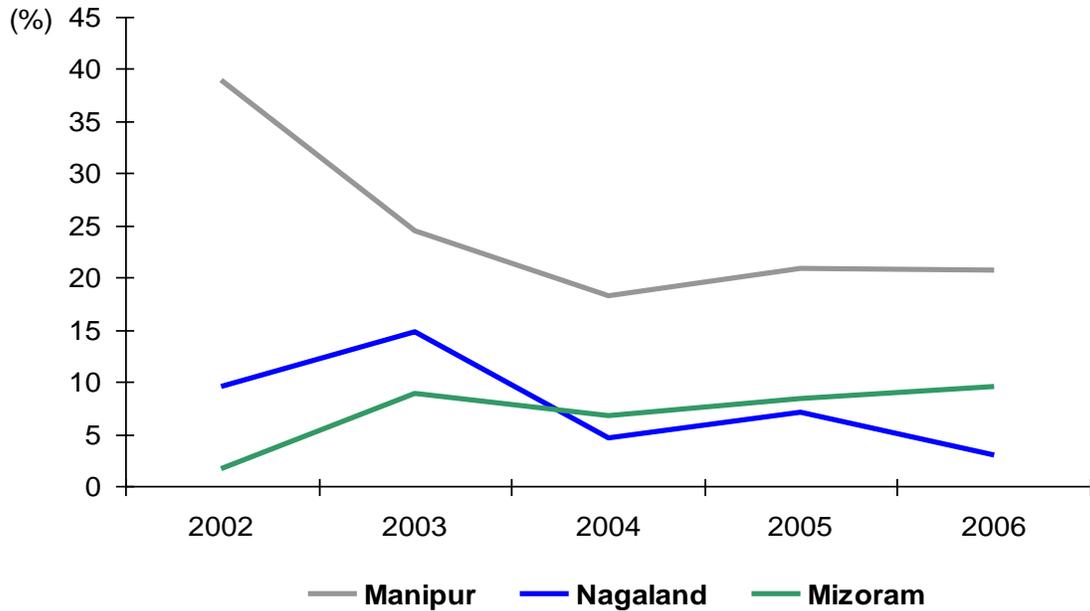
The North east states comprise a myriad number of tribes and ethnic communities, each with their own distinctive identity and culture amidst them . The varied languages, dialects, arts and culture has appeared to be fast eroding in the new socio-political framework of independent India , with the creation of new states , districts and ‘independent ‘and ‘autonomous’ regions. For many ethnic communities, a constant fear of losing their identity, their inheritance, their pride in their ethnicity, has accumulated over the years often resulting in tension with the Indian government as well as between communities.

For the many and varied tribes that inhabit the region the pride that goes with their own distinctiveness or identities in the form of dialects, arts and culture, and geographical dominions are fast eroding in the new socio-political framework with the creation of new dwellings, blocks, districts, states and ‘independent’ regions. Ethnic groups from the better known to the ‘recently’ recognized tribes are struggling for preservation and promotion of their respective identities. A sense of insecurity and fear of being undermined result in the formation of ‘armed groups’ – the stronger ones challenging the might of Indian army and the smallest ones protecting their own interests and communities. In the absence of any sustainable economic activity in the state, a large

number of youth get drawn into the insurgent movement. Insurgency has become, in many ways, the only sustainable, expanding industry in the northeast. Conversation with locals gives the impression that states like Manipur and Nagaland have two governmental setups: the insurgent and the state.

The states lie next door to the Golden Triangle — the border areas of Thailand, Myanmar and Laos — and the purest grade of heroin, locally known as No. 4, is supplied to North America and Europe through Moreh, a town on the India-Myanmar border. Drug trafficking across this common border occurs with ease. The population on both sides of the Myanmar /India border is largely from the same ethnic group(s), speaking the same language(s) and sharing the same culture in most cases. As a result, it is an arduous task for the state to maintain a strict vigil along the border and there is continuous migration across the international border. Drug smuggling has devastated the society, creating destitute women and AIDS orphans, apart from infecting thousands of men and women.

Heroin from Myanmar started to appear Manipur in 1982-84 . It did not take long before availability of heroin shot up rapidly . Case studies of older IDUs reported the introduction of this ‘white powder’ to youths smoking marijuana at that time . Heroin trafficking reached a peak after 1990, which was mirrored by a startling increase in HIV prevalence in the state. IDUs form the majority of HIV/AIDS victims in Manipur, and the north-east in general Sarkar *et al* (1993) reported that there was a sharp rise of HIV infection among the IDUs in Manipur from 8.6% to 67.2% from 1989 to 1992. By 1997, prevalence among IDUs was as high as 80%. (Manipur State AIDS control society, 2007). However this rate came down from 80.7% in 1997 to 56.7% in 2001 and at 17.9 in 2008. This massive fall in the prevalence rate among the IDUs in Manipur could be attributed to the harm reduction program, a multi-pronged strategy for HIV intervention among IDUs introduced in 1993-94 with elements such as community sensitization, outreach work, risk reduction education, needle syringe exchange programme, drug substitution programme, continuum of care of PLWHA, condom promotion and referral services.



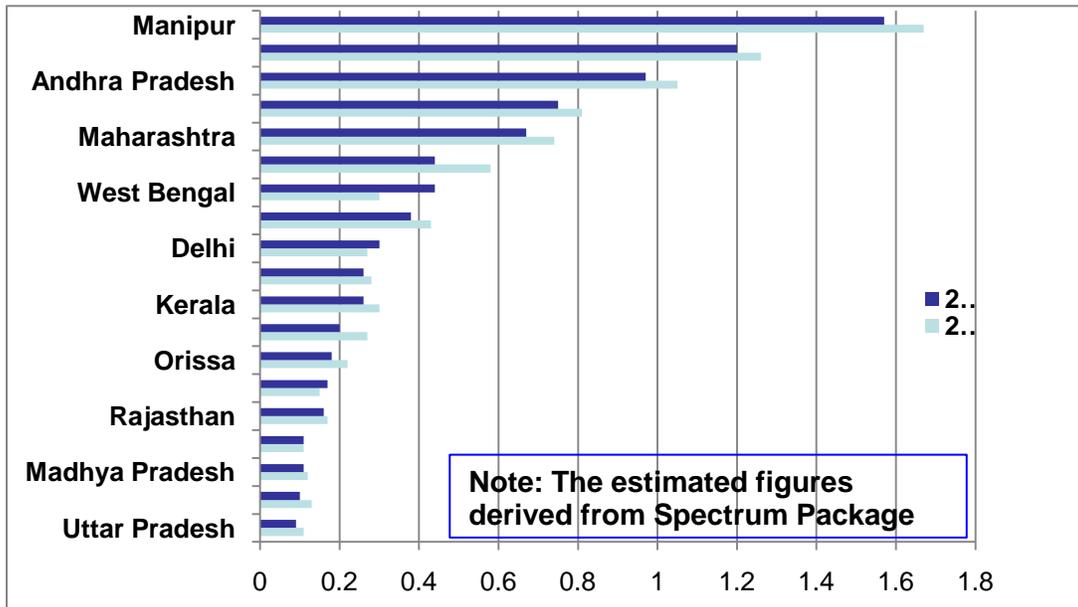
**Includes only those sites from which there was consistent data available for 2002 to 2006
 Number of consistent sites considered in Manipur=3, Nagaland=3 and Mizoram=1.
 Source: National Institute of Health and Family Welfare, NACO, Annual HIV Sentinel Surveillance [Country Report, 2006](#)*

Figure 2: HIV prevalence among IDUs in selected North-eastern states, 2002-2006*

Drug Use and HIV

Evidence shows that HIV transmission is linked to poverty, social and economic inequities related to gender, race, cultural differences, migration in and between countries and social turbulence. Many studies have been done to understand the influence of the environment on the risk of HIV transmission, whether among IDUs or among other populations at risk (Parker, Easton, & Klein, 2000; Singer, 2001; Aral, 2002; Galea & Vlahov, 2002; Friedman & Reid, 2002; Poundstone, et.al, 2004; Burris et al., 2005, Knowlton, & Sherman, 2003). Injecting drug use is a major driver of the HIV/AIDS epidemic in the two states. The twin problem associated with drug abuse and HIV/AIDS appears to be well intertwined within the socio- economic and political situation. It can be argued that the lack of employment avenues is one important contributing factor for the massive drug abuse among the youth and the climate of increasing political violence in the states. In a region where drugs are easily available, it does not take unemployed youth too long to start experimenting with them, and they are hooked before they know it. “The influence of illicit drugs continue to grow, drawing an ever larger number of people into a perpetual state of dependence, physiological as well as financial i.e. the influence reaches far beyond the heroin addict”(Drug and Development , 1994) . Recent data show that injecting drug users could constitute 1.9 – 2.7% of the adult population in

Manipur and Nagaland. Manipur, a small state with a population of only 2.4 million has the highest concentration of HIV infection in the country. ‘Despite being home to only 0.2% of the national population, Manipur currently accounts for nearly 17% of India’s total known HIV cases’(Beyrer, et. al, 2000).



Source: HIV Sentinel Surveillance and HIV estimation in India, 2007-2008: A technical Brief

Figure 3: State-wise estimated adult HIV prevalence, 2006 & 2007

The use of economics as a powerful way to understand the patterns of the spread of the HIV epidemic has been acknowledged in literature (Bloom & Mahal, 1995)Firstly economic deprivation and HIV/AIDS incidence are interlinked. Poverty may force many young girls, refugees from ethnic clashes, female intravenous drug users (IDUs), to resort to commercial sex and dictate their ability to negotiate the use of condom. Secondly, any inequality in economic development between the rural and urban areas may encourage migration and consequently its risky implications. There are also instances of sudden increase in disposable cash leading to increased possibilities for risk behaviors.

In the present economic and social circumstances there are many features of the north-east that may add to the probability of the epidemic becoming widespread in the general population. The states remain one of the most underdeveloped and poorest in India; a place where jobs are very hard to come by, where drug addiction is rampant, and insurgency, all pervasive.

The risk of being infected with HIV is particularly high among the poor and less educated due to

1. the socially determined knowledge and learning skills of the poor being inadequate to measure up to durable prevention of HIV infection e.g. for a given level of prevalence of drug abuse, a greater shared use of needles and syringes among poor drug users results in greater transmission of HIV.
2. Their limited access to higher quality public health services which reinforces the positive impact that social inequalities (based on class, caste, race, gender and nationality) have on the extent of prevalence and transmission of HIV.

Drug Use and Sex Work Interface

An individual's vulnerability, risk upon exposure to HIV and consequent prevention behaviour is directly influenced by the environment factors. These factors can be "direct or indirect barriers, or even facilitators of an individual's HIV risk and prevention behaviour" (Rhodes et al , 2005) Sacks also highlighted in his paper that poverty and unemployment are the two main reasons for most women deciding to work in the commercial sex trade (Sacks, 1997) According to an unpublished report by one NGO, in the northeast India, almost all female IDUs practice commercial sex work at one time or another, because it is seen as lucrative and a source of easy money. Poverty and the lack of knowledge and lack of access to means of protection can indirectly result in unsafe sexual practices. This unsafe practice can also be due to women's inability to negotiate condom use with sexual partners because of the established gender roles and power relations. In other words "there exist the contextually embedded cultural beliefs and socio-cultural as well as economic constraints to condom use" (Whiteside, 2002) and therefore the risks.

A study from Manipur, conducted in 1997, recruited female sex workers operating from the streets of Imphal, the capital city, and revealed that while 20 % of those who had never injected drugs were HIV positive, 57% of female injection drug users involved in sex work had HIV. About one-third of the female IDUs involved in sex work in this study had male IDUs as their regular sex partners. (Panda et al.2001)" Mapping exercises of the three north-eastern states of Manipur, Nagaland and Mizoram show substantial numbers of female sex workers in urban/valley areas where injecting drug users are also in higher numbers" (Chandrasekaran et al , 2006) Data from one voluntary HIV counselling and testing centre shows an increase in HIV prevalence amongst female sex workers in Manipur. In the North eastern part of India , population mobility is limited and most goods are transported by means of road hence more understanding is needed of the sexual networks of truckers, female sex workers, and injecting drug users in the northeast as a potential driver of the spread of HIV to other parts of the country (Tellis , 2008) .

Community Mobilization

Concept and meaning

Donahue and Williamson (1999) described “community mobilisation as a mechanism to define and put into action the collective will of the community” (Donahue and Williamson,(1999). In mobilizing the community- where the aim is to improve well being of the collective community-the process begins with a dialogue among members of the community to determine who, what, and how issues affecting their lives are decided, through an attempt to provide an avenue for everyone to participate in decisions making. The issues could be around ‘health, about water, security and basic human rights and entitlements’ (Bracht, 1999). The process is initiated by the community members and the planning, implementing and evaluating is done on a participatory and sustained basis by the community for the community(Valdiserri et al, 1995)

Process of community mobilization

The concept of community mobilization is based on the fundamental principle that the “impetus for action emerges from the community level and the community formulates its agenda around community priorities, concerns, capacities and commitments” (Donahue 2006). According to Merzel (2003) ‘key elements of community- based health promotion programs include the following: mobilizing communities to actively participate in achieving program goals; implementing interventions in multiple community settings; using multiple individual level intervention strategies; and developing environmental interventions by incorporating strategies to create policy and environmental changes’.

The process of mobilization starts with the community identifying and recognizing its own concerns. Once the concerns are identified, the community feel a ‘sense of responsibility and ownership’ which is a ‘starting point for identifying what responses will enable the most efficient and accountable outcome’ (Donahue and Williamson, 1999).

Community mobilization in public health

The role which community-based approach can play in health promotion and disease prevention has been increasingly emphasized by contemporary public health. Community-based approach to health promotion is today considered essential firstly to generate or garner support from the community itself and secondly, capacity for engaging in prevention activities. Community based approach represents a conceptual framework emphasizing community participation and ownership (Merzel, 2003)

Use of community mobilization in the context of HIV prevention

“International efforts for HIV/AIDS prevention and lessening of the AIDS pandemic through community mobilization strategies based on recognition of social

vulnerability and concepts of empowerment have emerged at the forefront and have increasingly replaced a focus on individual risk” (Busza and Schunter, 2001).

Community mobilization as an HIV prevention approach among high-risk communities can work to strengthen their individual and collective agency so that they can adopt and sustain safer behaviours. Effective mobilization of communities instils in the participants ‘a sense of empowerment, a genuine sense or feeling that their decisions’ can affect, and in most cases ‘alter the circumstances of their lives’ (Donahue and Williamson, 1999) In the field of HIV prevention, this empowerment is understood to increase receptivity to adopting behaviours that reduce the risk of HIV.

Among sex workers community mobilization is today recognized as an important HIV/STI prevention strategy. Examples from community based programs have found that there is a dynamic relationship between collective identity and participation.. A qualitative study on the relationship between social identity and participation among sex workers in Brazil, Murray et.al.(2010) found that participation in project clinic and community-based activities was motivated by three overlapping strategies. These were - ‘participation for psycho-social and health benefits; participation to improve individual status; and participation to change group status’.

In India, the Sonagachi sex workers organization has shown these same motivations behind participation in the community organization. Various studies done with Sonagachi sex workers organization showcase the importance of community mobilization and development as a process for HIV prevention and a force for empowerment of high risk and marginalized communities (D Kerrigan 2008, Cornish, 2008).

In the context of IDUs, community mobilization as an HIV prevention approach can be understood as a peer led intervention. It is primarily an outreach based approach designed for IDUs to reach their peers and other vulnerable populations at risk of HIV infection . A typical outreach based approach relies on indigenous members of the community which in this case may be IDU’s to access out of treatment IDUs/ peers establish trust and rapport, and initiate risk reduction activities including behaviour change communication and referral to other services such as clinics, voluntary counselling and testing centres etc which are available within access to the same. These outreach strategy has now been expanded to include sexual partners of IDUs, and other vulnerable populations such as female injectors and at risk youth (Needle et al , 2005)

Based on recognition of social vulnerability and concepts of empowerment, community mobilization strategy includes further what is today understood as creating an enabling environment. Rhodes et.al (2005) report the existence of a number of findings over the past decade that underline “the effectiveness of strategies focussing on creating local environment conducive to, and supportive of individual and community level behaviour change for HIV prevention and intervention”. These strategies involve

bringing about ‘changes in the physical, social, economic, legal and policy environments influencing HIV risk and prevention’ (Rhodes, 2002; Singer & Clair, 2003).

Community Mobilization under Project ORCHID

Project ORCHID an acronym for ‘Organised Response for Comprehensive HIV Interventions in the Districts of Nagaland and Manipur’ is an HIV prevention initiative funded by the Bill & Melinda Gates Foundation, and is a collaboration between the Emmanuel Hospital Association (EHA) and the Nossal Institute for Global Health, University of Melbourne. Since 2004, it has been working to reduce the transmission of HIV and STIs among the high risk populations - injecting Drug Users (IDUs), sex workers (SWs), men who have sex with men (MSM) and their sexual partners. Project ORCHID works in seven of nine districts in the state of Manipur, and six of eleven districts in the state of Nagaland in north-east India. It supports local partner non-government organisations (NGOs) to deliver a range of harm reduction interventions in rural and urban settings including the provision of new needles and syringes, treatment of sexually transmitted infections (STIs) and abscesses, condom distribution, counselling for behaviour change, opioid substitution therapy (OST) and community mobilization.

Project ORCHID’s community mobilization approach aims to foster the involvement of injecting drug users in the program, which leads to ownership of interventions and empowers groups and individuals to take responsibility for their lives. Community mobilization is also essential to the long-term sustainability of the program(From Hills to Valleys : Avahan’s HIV Prevention Program among Injecting Drug Users in Northeast India , 2009)

Project ORCHID began institutionalizing community mobilization in Manipur and Nagaland from November 2007 onwards, once outreach was well established. Project ORCHID formed a community mobilization advancement team to provide technical and managerial support to both injecting drug users and NGO staff, through classroom training and onsite visits. The team facilitated a series of exposure visits for community members to other states to witness strong community mobilization in action, among successful sex worker organisations as there were none in the country for the IDUs. Collaboration in the planning of community mobilization gave the staff of the NGOs and the injecting drug users confidence in the community's potential.

More than 50 community committees have been formed at the implementing NGO sites to oversee program implementation at the site level across the program, including drop-in centers, clinics, referrals, and program monitoring. More than 30 informal community groups have been developed, and two registered community-based organizations (CBOs) have been formed, one of which is Hope United in Churachandpur, the site for this study.

Oral substitution therapy has been seen to significantly accelerate the process of community mobilization, mostly by offering community members the stability needed to focus on activities other than looking for their next dose of drugs.

Methods

Selection Criteria

Selection of area

This study was conducted in two Project ORCHID districts, one urban and one rural town in Churachandpur district and one semi-urban town in Ukhrul district. Churachandpur district was selected for several reasons. Firstly, it remains one of the highest IDU and HIV prevalent districts in the country. Secondly, out of a total 29 implementing partners of Project ORCHID distributed within two neighbouring states, Churachandpur district offered perhaps the most ideal setting for studying IDU community mobilization with a ‘developing’ IDU community based organization namely Hope United and a comparatively vibrant and larger membership from the IDUs. Ukhrul district was selected as it offered a similar tribal setting to Churachandpur, albeit a more difficult terrain, less vibrant IDUs and a slower progress in terms of community mobilization.

Selection of sample

The sampling framework was purposive. In Churachandpur town, respondents were beneficiaries of the three existing Harm reduction NGOs, namely SHALOM, LRRC and the IDU Community Based Organization, Hope United. And this permitted in-depth interviews and focus group discussions with the same at these sites. However, in Singngat, a rural town about 20 kms from Churachandpur, without any service provider or Drop-in-centre for IDUs at the time of the study, respondents were chosen with the help of NGO workers during a health awareness and treatment camp organized by the NGOs and the Border Security Force of the Indian Army. In Ukhrul town, respondents were beneficiaries of another Harm Reduction NGO, CARE Ramungo and therefore permitted the use of focus groups and in-depth interviews at the centre.

Source of Data, Collection and Analysis

Data for this study was collected during an exploratory needs assessment from IDU beneficiaries of existing harm reduction ORCHID NGOs working in the two districts of Churachandpur and Ukhrul by a Project ORCHID staff and the author between the months of January 2010 till April 2010 as part of the author’s practicum field work and exposure. The data collected during the site visits and field observations, through focus group discussions and in-depth interviews were done to enable this report. A secondary analysis of this data was conducted for this project report.

This study primarily includes in depth interviews and focus group discussions with the IDUs, NGO workers and community leaders working in the two Project ORCHID Districts. Thirty in-depth interviews were conducted with injecting drug users in three different settings, two in Churachandpur district at an urban and rural town and another in Ukhrul, a semi-urban town in Manipur. Following the in-depth interview seven focus group discussions were held with key informants from staff and members including a Community based Organization (CBO Hope United). Interviews lasted 45-90 minutes and FGDs lasted approximately 90 minutes. Although FGD and interview guides were utilized, consisting of 26 questions, the interviews and FGDs were semi-structured and facilitated by a Project ORCHID staff. The guides were based upon a literature review and developed with inputs from Project ORCHID staffs and key informant IDUs.

Analysis of the secondary data was done using qualitative thematic content analysis technique. The data collected was first transcribed and read to identify themes and meanings. Once all the meaning units were identified, theme statements were generated. Then a table or matrix was created for each theme, showing all the related meaning units which exemplify the themes. Finally evaluation of each meaning unit was done to ensure that the theme adequately and accurately captures its meaning.

Results

Community Ownership and Membership

At present the community based organization (CBO) in Churachandpur has about 500 registered members out of an estimated IDU population of 2000 in the district. Ukhrul District, with a similar estimate of IDU population, at present has a smaller support groups (SGs) made up of IDU beneficiaries at each NGO. The progression of these small support groups into a full-fledged CBO for the district is a part of the community mobilization strategy. The support groups in Ukhrul have at most 10 - 50 members.

Membership in the community organization (CBO) is limited to registration and a right to vote. Most of the members are those who remain in frequent contact with the harm reduction projects in the headquarter town and IDUs from the surrounding areas such as Lamjang, Singngat, within 5 to 30 kms from the town, are yet to have heard of the existence of an IDU community organisation for the district. Membership drives were the main instrument for getting IDUs to register, and in most instances, IDU members registered without much awareness or interest in active participation.

Some of the respondents however are very clear with why they registered as a member. As one respondent shared –

‘I like the idea of an organization solely for IDUs of the district, this in itself is a big achievement and I want it to progress, this is why I became a member’

There are however several cases of IDUs opting to stay away for personal reasons. As one respondent shared –

‘I don’t enjoy being with crowds and going to all these IDU community events and showing my face, I prefer this invisible life’

Membership to the support groups in Ukhrul is however, automatic in nature i.e. by being a beneficiary of the NGO where the support group is initiated. And IDUs and NGO key informants alike share the difficulties in improving attendance, interest and unity in these smaller groups. At present, monthly meetings are organised at each NGO for the support group members.

The majority of the IDUs reported limited active participation in terms of voicing opinions and attendance at meetings. For all respondents, membership is limited to registration and does not necessarily translate to attending the meetings and voicing their opinions. They are all aware that by being a member, they can voice their suggestions occasionally but it appears that there is very low interest in attending and voicing

opinions in the meetings. Above all, holding regular meetings for both CBO and SG remains a challenge.

The main reasons cited for lack of participation in the meetings are foregone expenses, difficulty in travelling to and fro, lack of belief in a positive outcome which arises from a lack of resources in the hands of CBO executives, and lack of information alerting all members to the meetings

At this stage, the CBO Hope United itself is reported to have had just two to three meetings with limited attendance from non-executive committee members.

Needs

In this section, the respondents were asked to describe their own list of needs, in their daily lives as an injecting drug user, based on their own understanding of immediacy and importance. Next, the respondents were given a hypothetical situation where the Community Based Organization was at an ideal state - standing strong with elected executives, good membership and access to resources. The respondents were again asked which out of the identified needs in their first list did they feel could be taken up by the IDU community collectively through the CBO.

Identified needs

All respondents reported that in the daily life of an individual with an addiction to drugs, getting his/her regular fix was the most urgent and important need. However, this would apply to only those with an addiction problem amongst a more general injecting drug users' community which may include ex-users, regular and occasional users as well as those currently under treatment such as detoxification or opioid substitution therapy.

Next on the list of needs was some form of wage earning opportunity. Suggestions ranged from income generating activities to facilities and provisions for manual work such as carpentry, apprenticeships or other forms of skill development such as driving lessons. This need, the respondents suggested, if realized, would have a two-fold benefit. Firstly, some form of daily wage would reduce the need for petty thefts to pay for drugs. Secondly, a drug user who does not create any nuisance has a chance to automatically re-integrate himself into the general society. As one respondent explained,

“If we don't steal, then we don't disturb the stores and the society, therefore they don't do anything to us. But when one drug user steals, the brunt is on all of us, they immediately suspect the drug addicts. So it is like if you are a drug user but can supply yourself, then nobody will look down or discriminate you”.

Another suggestion was to develop and integrate music classes and sports as part of overall project or Drop-in-centre activities. The respondents shared that incorporation

of music classes and sports activities would go a long way towards dispelling prejudice and discriminatory attitudes against drug users and the drop-in-centers. Further, it will serve to build self esteem and image and aid towards rehabilitation by providing healthy recreation and participation and a support system in their peers.

Another important point listed was the need to hold trainings and classes for the IDU community on community mobilization. This need was felt by all respondents as the majority of the IDU community were yet to grasp the basic concept and scope of a mobilized community. Further, the staff of the CBO project including the members of executive leaders desired more understanding on the scope, extent and future direction for the IDU community in the district.

Night shelter for injecting drug users afraid to go home on particular days was also listed by several respondents. The respondents shared that a night shelter would be highly beneficial for those injecting drug users who have to spend the night at the DIC verandah or on the streets. Even though the exact numbers are not yet known, the respondents shared there were few cases here and there and once a night shelter is put in place, the shelter would fill up soon enough.

Another important need listed out was to have a separate program for IDUSW, female injecting drug users who are also involved in sex work. The respondents shared that this was greatly needed because at the moment they are unable to access services from the male-oriented program. Female IDU are also much more hidden as compared to the male injecting drug users. The respondents shared that various factors compelled these females to stay hidden and decline from accessing services. They felt that an entirely separate program would greatly benefit these particular communities.

Another identified need was for setting up more project DICs and sub-DICs in peripheral locations and far flung villages such as Singngat, Tipaimukh and along the Guite road in Churachandpur district. The respondents shared that HIV intervention in any form was not reaching these far flung areas. The awareness levels were very low, amongst the general public as well and there was the danger of HIV transmission through the sexual route as well. The respondents indicated that raw opium was taken through the oral route amongst the villagers and the poppy plant was also to be found in the nearby fields. The respondents believe that DIC set-ups in these areas would benefit in two main ways. Firstly, a DIC would be the base from where any form of awareness, prevention and clinical services could be provided. Secondly, new DICs in unreached areas would create new posts including peer educators and outreach workers. And employment opportunities in a context such as Manipur goes a long way in assisting a drug user's rehabilitation and integration into the mainstream community.

Another identified need was the provision of general health care. The respondents indicated that the existing services were not enough. The care and support services were restricted to HIV positive persons while the medicines at the DIC clinics were oriented to

STIs and abscess treatment. The respondents felt that if more general medicines and nutritional support could be provided at the DIC clinics, this would greatly benefit the IDU community in the districts. A hospice specifically for the IDU community, run by and as part of the community based organization would be ideal as per the respondents.

Stigma and discrimination remains an interesting topic in the context of the places such as Churachandpur and Ukhrul. According to most respondents in Churachandpur, they are resigned to accepting stigma and discrimination as part of life for a person with drug addiction and consider it a lesser problem to other needs. In Churachandpur, there are cases of random physical abuse by individuals identified as belonging to militant organizations. However, the same abuser does not necessarily mistreat all drug users in this manner, but has friends and often spends time amongst other known drug users as well. Such cases are more likely when alcohol is involved and targets were more likely random and dependent on how far away from the social network the possible victim is from the abuser. These cases are more of assault and physical abuse by individuals and not necessarily endorsed by the organization they belong to. The respondents feel that due to certain individual drug users who are engaged in petty thefts now and then, the general community has a prejudice towards them all. They are also more vulnerable and more likely to be physically assaulted by any rogue looking for a fight.

Stigma also exists where parents do not want their daughters to get involved with known drug users.

Another form of stigma is where families have a prejudiced fear of petty thefts occurring anytime a known drug user visits their homes, shops or locality. This can put a huge pressure on the reformed drug users to prove themselves, which can be mentally agonizing in itself.

A point worth mentioning here is that Ukhrul District respondents report a more severe problem with regards to stigma and discrimination. According to a respondent,

'IDUs in Ukhrul are treated as if our mental state is distorted and as if we are inferior to others'

Stigma and discrimination is reported to occur everywhere even in the health sector, where the nurses and the doctors still display some resentment purely because they are drug users.

Also here in Ukhrul, because of the fear of the society and community, IDUs are comparatively more reluctant to reveal their identity as a drug user. According to the respondents the armed insurgents (UGs) are the main problem as their local town commanders keeps on changing. Advocacy is often done with the local commanders, but the insurgent outfits also follow a system of rotation and transfers. Before one realizes it, the new town commander and his cadres, yet to be sensitised, have already assaulted an

IDU. And the respondents reported that not so long ago, the armed insurgents knocked down a budding IDU community group thinking that it would cause them to stop using drugs.

‘In Ukhurul, the difficulty is that though there may be some who understand our situation, there will always be another section of the society who do not understand , so the problems will continue’ - a respondent

For the majority of the respondents the church setting is seen as the main place of discrimination. Thus active involvement of the institution of the church whether in lessening stigma, rehabilitating or initiating the process of community mobilization would go a long way in containing the drug use problem. As one of the respondents said

“if the church begins to believe in IDUs and has no problems in using them / this will be a big factor towards their rehabilitation”.

As much of social life in both the districts, with a majority Christian population, is centered around the Church, the respondents indicated that the institution of the Church remains in the most privileged position to turn things around for the injecting drug users. By making an effort to believe and encourage IDUs to take active part in church activities with minor roles and responsibilities, respondents indicated that this could go a long way to change stigma and social exclusion. And through a non-judgmental approach and nurturing, IDUs would be encouraged to rehabilitate with support from the Church and families.

Availability of clean syringes and condoms supply, according to majority of respondents were not difficult to obtain. There is apparently an abundance of supply in the form of DICs, Chemists and outreach work. Peer educators indicated that injecting drug users utilize one needle syringe a couple of times without sharing in cases where immediate access to a peer educator or DIC is not possible.

Felt needs

A major felt need of the IDUs was the provision of having a drop- in centre with the clinics open on Sundays. At the moment, only one drop-in centre, that of Hope United is open on Sundays. The respondents shared that this offered them a place to spend their Sundays whereas earlier they would roam about the town without any particular place to go to and in most cases ended up giving way to temptation, thefts and drugs. The need therefore was to have all DICs open on Sundays in the district, as one lone sub-DIC was not accessible to all.

As one respondent put it- *‘injecting drugs does not halt on a Sunday’*

Another felt need, was for more treatment places for opioid substitution therapy (OST). The respondents shared that there was a rush for admission into the OST program, and many had to wait for over a year to be allotted a place into the program.

Another felt need was for a rehabilitation program for IDUs completing treatment under OST or detoxification. The respondents felt that this was a gap and many of the OST clients had relapsed due to the absence of any opportunity post- OST for healthy rehabilitation into the society.

Awareness of Rights

On the topic of rights, the respondents shared that though awareness of rights exist, exercising it is difficult as there is no empowerment as a community. In a context like Churachandpur, the respondents indicate it would take maybe few more years for them to exercise and enjoy the benefits that come with those rights. For example, an IDU member is randomly harassed by the militant outfits for the occurrence of a theft in the locality, even if he is not the one committing the theft, he has to comply to the punishment meted out to him for the mere reason that he happens to be carrying syringes or drugs with him at that time. They are aware that this is a rights violation but they cannot voice their rights because they feel they have no one to support them , as even the CBO is not strong or bold enough to stand up for them. As one respondent put it -

‘If the issue became too big, I might probably go to the CBO but whether or not CBO will or can effectively support me is a matter that is questionable.’

Another respondent shared –

‘First the CBO has to show interest to come to my aid, to take up my rights violation case and to fight on my behalf and on behalf of the community, at the moment, they the leaders themselves are showing no interest’

Majority of the respondents reported being conscious about their basic rights. However, all respondents admit they do not bother about their rights.

A respondent stated *‘as long as drug addiction exists, some form of harassment will continue to exist’*.

Some of the IDUs do not even care about their rights , they prefer to ignore it because they know nothing will come out of it even if they voice their rights , they are aware that they might be beaten up and harassed if they try to voice such rights.

A respondent explained it this way –

'I have wrongfully been accused of theft and been kicked by some people, I was angry at that time, I could have gone back and fought them, but who will listen to me, so maybe I just mention it to my family that I was not the thief, my family needs to know I did not do it, If I happen to go to the DIC, then I share my anger to my friends, they understand, but there is no use in dwelling too long on it'

At present, there exists a crisis response team operating within the community mobilization process and through this team, any sort of harassment or violation of rights is to be reported to the Crisis Response Team. However, at the moment there is a very low interest in reporting such cases. This is because the Crisis Response Team is yet to prove its efficacy beyond reporting and documentation at the project offices. The elected leaders of the CBO are also yet to show interest in day to day harassment issues. As per the respondents, they are also yet to take any stand or exert any influence amongst the pressure groups in the district. Respondents also feel that because of the strong presence of factors like armed insurgents and communal mistrust amongst various ethnic groups, legal remedy cannot take place as desired, and rights-seeking behavior can even become a dangerous venture.

With regards to rights abuse and legal action, most IDUs shared they would not go about reporting to the CBO and when they face harassment, they do not normally go to the NGOs. They share their experience with close friends if at all.

The respondents believe that harassment or cases of rights violations should be taken up by higher level authorities such as NGOs with participation from IDU community leaders. At present, the respondents share that the CBO by itself is not influential enough or respected enough to be able to tackle the issues of rights violations. Advocacy committees must have members from the injecting drug users community, supported by NGOs and influential authorities in the district. Perhaps several years down the line, the community organization would have the capacity to take up this task on their own. The respondents therefore feel that advocacy is an area where long-term support from other agencies can exist.

Democracy and Sustainability

The respondents indicate that in a community based organization for IDUs, there exists a possibility of abuse of democratic processes as seen in mainstream democracy. However, members believe that representative seats allotted to different tribes in the executive leadership and bi-yearly rotation of office location and even setting up sub-offices and clusters would benefit the democratic process. It would also greatly enhance the mobilization processes.

‘rotation of office location or cluster wise set-ups will not eliminate abuses but it will control to a great extent’ – an FGD respondent

Members do not trust current users or ex-users with fewer than 10 years of sobriety to lead the organization, and a majority of respondents would prefer a role model ex-user or a non-user to lead the process. And to bring accountability further members feel the need for a monitoring presence in the form of NGOs or influential board members from the mainstream community.

As one respondent put it,

‘drug users, some of them have limitations, and some just do drugs depending on whatever amount they come across. I believe that there has to be a guardian sort of, because even when we loosen the strings so much and give them freedom, there is always a danger again. When I get 500 rupees, I do drugs for 500 rupees worth’

While another responded said -

‘I cannot be trusted yet because I cannot trust myself either’

As regards the question of sustainability, there appears to be no intrinsic foundations for community mobilization to build on, even without funding or policy as is seen in the area of sex workers where legal reforms supporting sex work as a profession or decriminalization of homosexual activity amongst men having sex with men can be cited as an example. This may be indicative of the weak foundation in terms of understanding the true concept and benefits of community mobilization. On the other hand it may also indicate that in the context of IDU, community mobilization (community led intervention) makes good sense only as far as the community taking ownership of HIV prevention, as in peer outreach and in micro-planning or in program planning, upholding the wisdom that ‘community knows their needs and their peers better than any other’

The common needs identified by the respondents here appear more to be in terms of reducing stigma, creating wage earning opportunities, post-OST programs which will lead to economic and social re-integration into the society. The needs identified by the IDU respondents lean more towards a longer term objective or goal of rehabilitation and getting themselves back into the general society.

“OST has been successful, but what after OST ? If there is nothing to occupy the IDU after OST, then he will relapse again but to even incorporate him into the project as a staff, say an outreach worker, we don’t have the resource. What will they do after OST program ? They need to be re in-corporated into the society by making themselves busy or with some kind of vocational training”- a respondent

“ In Lamka for example, once we become an ex-user there is a tendency to stay away from all things ‘IDU’ and go for , say Bible school , and completely ignore and stop talking to old friends who are current users. Why should we go be a member of an organization made up of unmanageable current users is often the attitude with successful ex-users”

‘Each person may have their own reasons, it could be fear of relapse, but in general the trend is possible role model ex-users have no interest in the Community organization, they are afraid to lose their prestige’ – a respondent

As indicated by the respondents, the next step for an IDU coming clean is usually to step away from the drug users’ scene and look for employment, start a family and merge into the general population, away from the stigma and the pro-activist role provided by community mobilization. Of those few ex-users who do remain in touch with the IDUs, the primary incentive is economic or employment opportunities available at harm reduction projects and their interest limited to this factor. Coupled with a lack of intrinsic foundations as mentioned above, these points indicate the possibility that community mobilization amongst drug users may be only as strong and sustainable as the funding or the national policy.

Barriers to Community Mobilization

The focus group discussion with staff of the existing organization cited the difficulty in mobilizing the IDU community without some form of compensation or immediate gain for the members. Since attending community meetings would involve taking some time off from work and therefore forgoing earnings, unless some incentive is given, it does not make sense to the IDU to voluntarily participate in the meetings or even to be a member. This could be because the larger benefits which membership to a community might entail are poorly understood.

As reported by a member,

‘IDUs do like the idea of gathering together, but to hold any event , there has to be a stimulus, for example, a community feast or afternoon tea and snacks. Usually it is money that provides the stimulus. IDUs are still at a very initial stage in terms of understanding the benefits of active participation in community mobilization. IDUs are quite scattered across the district, and if invited for a meeting, the first thing on their mind is what profit will they get for attending. So, suppose we provide travel reimbursements for coming to a meeting then they will say great, there is money for my next dose.’

And the benefits to be had from the community organization are seen simply in terms of tangible and material benefits like OST, condoms, NSEP, places of recreation etc. Therefore ‘contributing one’s time and commitment’ is a challenge. Oral Substitution Therapy (OST) has been seen to promote participation and active involvement in the community groups/support groups or activities because OST acts as the incentive.

Another reason cited for lack of interest in membership is abuse of democratic processes by sections within IDU community. Since the areas are torn throughout history by ethnic clashes and political unrest, everything is seen from the perspective of one tribe against another. This is more prominent in Churachandpur where different tribes with minor linguistic differences live and are in constant conflict. Therefore real democracy and sustainability is questioned of the IDU community organization because ‘‘if a majority tribe has too much say, for instance by getting more representations through elections with the help of sheer majority numbers, then other tribes will find it uncomfortable to come and actively access and participate in it’’. This problem is cited to exist in the society not just for the drug users but also for most anything happening in the society.

The respondents also shared some more likely barriers within the community themselves-

‘If drug users become so powerful, it might become a platform to disrespect parents or the community. An addict’s life is very selfish, and if growth of the organisation does not go hand in hand with proper counselling, there might come a time when these same drug users, fuelled by their new status or posts at the organisation, get back at their parents, their families and even the society for the memories of stigma faced at their hands’.

‘If at all there is a strong functioning CBO, standing alone, then it is most likely that the drug user community would misuse the power given to them’

The likelihood of misuse of power by the CBO, once the hand-holding support is let go has been echoed by several respondents during the interviews.

The focus group discussions also brought out some more possible barriers -

‘Also the community themselves cannot trust one another. Besides lack of trust amongst themselves, IDUs are very competitive and some specifically want to be in the limelight so that there is constant confusion and fights amongst the community. Jealousy could play a big part in the success and failure of the community empowerment process’.

Another reason which acts as a barrier to membership was the lack of role models as “ex-users who have come clean from drugs would rather stay away from drug users and disassociate themselves for fear of losing their newly gained reputations’. The respondents shared that with more interest and support from role model ex-users, the IDU community members would be greatly encouraged to reform as well. Their involvement would also take the community based organization to great lengths. In the IDU scenario, there are ex-users, current drug users as well as those on Oral Substitution therapy. For the purposes of harm reduction, the current users have to be in the forefront. However, for the purposes of a strong community organization or leadership, all respondents feel that ex-users with several years of sobriety are the only people qualified to take on these roles.

Related to the role model concept is the ‘issue of trust’ and its role in the sustainability of the community. Some respondents mention the non-existence of trust whether in self or other IDU members to carry out the work assigned. Even for the ex-users, there is always the chance of relapse whereby many ex-users find it difficult to trust themselves. The respondents therefore indicated that role model ex-users would mean ex-users with proven sobriety of not less than 8 - 10 years.

Abuse of democratic processes is also indicated to be present amongst the IDUs themselves with regards to community funds, power and responsibilities. The respondents point out that such cases are far too common as the injecting drug users are themselves not willing to trust themselves with regards to money.

Another responded explained -

‘addicts are sometimes very manipulative, when seeing big money, they will start playing games and all sorts of ideas will come up and they will start scheming things, they are not ready to take complete responsibility as they are very sensitive and very manipulative’

Several of the respondents indicated time and again during the interviews their inability to trust their peers with any amount of money. This could be a big problem in future in a possible community organization of 2000 plus members in the district.

‘The moment any amount of money comes into the picture, everything else falls apart. Any money incentive in the form of salary for posts created by the community organisation, incentives for any work, travel, etc, often creates jealousy and back-biting amongst the community members’

Also community mobilization as a concept is yet to be properly understood by the majority of injecting drug users, and even some active members of the CBO. A majority of the respondents expressed their desire to understand the scope and future direction for community mobilization of drug users. There remains a real confusion as to the definition of ‘community’ with regards to IDUs and mobilization. The lack of any proven model or

literature elsewhere also becomes a barrier. There are also difficulties and questions for and against mobilizing ex-drug users and current drug users and those on OST under a single community organization with a shared purpose, there will have to be different roles to each set of IDUs in any community organization if the definition of ‘community’ encompasses all. This is possibly difficult to achieve without a proven model or strong leadership. Even as the CBO members appreciated the advantages of mobilizing as a community, they felt that there was no clear cut direction and their future lay in the hands of funders and policy makers. One of the barriers cited by the CBO members is because much control over program design and resource still lies in the hands of the State Lead Partner, namely Project ORCHID who is responsible for hand-holding the developing CBOs under its fold. Another reason indicated by the respondents is that in the existing set up between parent NGO and CBO, there is no stable organizational structure. It remains a bit vague when and where the community organization’s responsibility begins and ends. They feel that the onus lies much on the State Lead Partner /parent NGO at the moment.

Again, any ‘meeting’ to discuss issues with regards to injecting drugs users, HIV/AIDS, or the benefits of the IDU community has a stigma attached to it, being dubbed as “ a drug users gathering place/event” and so adjacent residential areas or people being warned of the possibility of ‘their things being stolen’. This also highlights the case of IDUs being marginalized as ‘petty thieves’. The society being a predominantly tribal society, the sense of belongingness, not being ostracized or seen as an outcast is very important. The concept of community as practiced by the philanthropic organizations like Young Mizo Association (YMA), Paite Students Welfare Association (SSPP) etc which function simply to benefit the community is easily understood. However coming together as a community of injecting drug users is a big step, even though it might work for their benefit, as one respondent said he was ‘not willing to expose his identity’.

The greatest barrier is they are unable to come together, whether for lack of time or due to the stigma attached or because the opportunity cost of foregone income is too high or even due to lack of awareness of the advantages. The general feeling among those to whom the concept is clear can be summed up by one member’s words-

“once we come together, and have discussion, there is a chance of evolving certain ideas, common ideas but frequent meeting remains a great challenge ”.

Discussion & Conclusions

Discussion

This paper aims to contribute to our understanding of the challenges involved for community mobilization amongst IDUs, particularly in Northeast India, a complex setting where injecting drug use and a consequent HIV epidemic present substantial public health challenges. There is still an absence of literature specific to community mobilization with injecting drug users, and whereby structural and contextual factors are examined hand in hand with the feasibility and efficacy of policies and interventions.

Community awareness and participation

A varied level of awareness of community mobilization exists amongst the IDUs in the districts. In both the districts, most of the IDUs are aware that there is a term called 'community mobilization' frequently used amongst the drug using community. But it is reported that the majority of them do not really understand the meaning or the concept of community mobilization. The minority who report to understand the concept of community mobilization are the ones who have worked or are in touch with the CBO office and have been exposed to the community trainings conducted by the NGOs. Few awareness drives had been initiated by the CBO in the early days which led to an increase in membership but this has not been sustained and has not translated into grasping or understanding 'community mobilization'. Other ways of hearing about community mobilization are from general conversations amongst a peer circle of injecting drug users.

Active participation is limited to attending events such as World AIDs Day or observance of International Day against Drug abuse. Respondents report a certain stigma attached with such community events.

Community needs- a multi-sectoral intervention

The collective needs of the community relate to income- generating opportunities, basic health care, reduction of stigma and rehabilitation avenues for the IDUs post oral substitution and detoxification. A majority of IDU needs support the need for a multi-pronged intervention, whereby there is close co-ordination between different agencies which is not seen in the present situation. The efficacy or lack thereof in IDU community organization in areas such as reducing stigma, or improvements in health, rehabilitation can be linked to the weakness in other agencies primarily set up for these purposes. This study indicates the need for multiple agencies such as the primary health centre, community health centres, other referral links and hospitals, Ministry of Health and Family Welfare, the Ministry of Social Justice and empowerment etc to work in tandem together with organizations that provide harm reduction.

Rights-seeking Behaviour

It is evident from the interviews that there is very little rights seeking interest amongst the IDUs in the districts. The main forms of rights violation reported are in the form of stigma, physical assault and the labelling as thieves accorded to IDUs in general. Most IDUs are reported to share such cases only to their close friends or peers at the Drop-in-Centre if at all. There are many factors behind the low levels of interest in seeking justice. As mentioned by the respondents, they basically have no one to go to and they have become used to it. The CBO is yet to exert any influence in the district. The parent NGOs do offer assistance, but it appears the IDUs themselves are not so keen to report each and every harassment they face on the streets. The respondents also share that in a multi-ethnic population, with a history of mistrust amongst each other, legal remedy is not always achievable. Further, the presence of multiple armed insurgents makes rights –seeking a dangerous venture.

As pointed out by the respondents, advocacy is better placed in the hands of higher authorities such as NGOs and influential leaders of the society.

Democratic Organization and Sustainability

One of the greatest barriers to community mobilization identified by the respondents is the difficulty in coming together, due to varied reasons including foregone income or expenses. Democratic functioning of the community organization is reported to be a lesser barrier once the primary difficulty in collecting together or gaining a consensus exists. And according to the respondents, though there is always a possibility of abuse of democratic process by certain individuals or segments of the IDUs, there can be checks and balances to enforce accountability.

Sustainability of the community organization and community mobilization depends very much on how united the community members are on common issues that they feel important for their community. This is difficult to ascertain at this stage and will need the test of time provided the CBO is allowed to progress at its own pace and through its own efforts.

Findings from this study indicate a lack of intrinsic foundations that can be the basis on which community mobilization of IDUs is built. Therefore this study also supports the need for identifying needs intrinsic to IDUs upon which real community mobilization and empowerment can be built to last.

Conclusion

The question which emerged from the study with regards to the feasibility and scope of community mobilization amongst IDUs is whether lack of awareness of the benefits of community mobilization is behind the slow progress or whether the barriers to being mobilized stem from the structural issues which exist in the particular context. The

problems of drug availability, stigma, participation and mobilisation of injecting drug users are woven within the socio- economic, cultural and political constraints which exist. Projects and programs are often introduced on the basis of similar initiatives being ‘successful ‘elsewhere or in other contexts. There can be a myriad of contextual factors that need to be taken into consideration in different locations while projects and programs are being designed and implemented .

Contextual Factors

As the latest behavioural studies and KAPs indicate, awareness and education levels are high now amongst both high risk as well as the general population, but in the present socio-political state of affairs, intervention programs are also compromised. Both the interviews and FGDs reveal certain structural and environmental factors that may define the success and failure of community mobilization in the northeast. Unemployment, poverty, social disruption due to militancy, increases the vulnerability and limits the ability to actively participate in a community organization or to integrate as a community- the case of individual needs being greater than the collective needs of a community. Awareness of rights exist, exercising it is difficult as there is no empowerment as a community. Blockades and curfews hamper real intervention work and increase the risk and vulnerability situations. Structural violence exists in all forms of economic opportunities, in employment opportunities, businesses and contracts, often shuffling between the government offices and the insurgent groups. Success of the programs depends a lot on how well they can be managed inside this web of entanglement. This means dealing with insurgent groups, government officials, corruption, uninspired NGOs and political instability.

Community Mobilisation: a new process

One major factor brought out by this study is the need to understand the context of community groups with regards to the feasibility and scope of community mobilization. According to this study, there appears to be no intrinsic foundations for community mobilization to build on, even without funding or policy as is seen in the area of sex workers where legalization of sex work as a profession can be cited as an example. The common needs identified by the IDUs appear more in terms of wage earning opportunity, reducing stigma, post-OST or detoxification programs which will lead to economic and social re-integration into the mainstream society. The needs of IDUs lean more towards a longer term desire or objective of rehabilitation, and getting themselves back into the general society. In-spite of a sizeable number of reformed ex-users in the district of Churachandpur, the lack of role model ex-users to motivate or support the CBO indicates a trend where the next step for an IDU coming clean is to step away from the drug scene altogether in search of employment, a family and re-integration into the mainstream society.

Addressing the multi- sectoral needs

The respondents in this study identified their most basic need as ‘some form of income generating activity’ or daily wage opportunity. Most of the IDUs in earlier studies have also cited lack of employment and therefore abundance of spare time as one of the main reason for resorting to drug use and describe how they were socially and economically marginalized.. There is thus evidence of the link between poverty and inability to relate to the message of behavioural change which is an essential part of prevention and control strategies across the country. Again, some of the other needs identified in this study are provisions for general health care and nutritional support, rehabilitation avenues for drug users. The multidimensionality of the drug use and HIV issues which is seen from the many identified needs and the broader contextual issues provides a clear argument for multiple agencies to work in tandem. For instance the centres providing either rehabilitation services, harm reduction or even a those centers providing vocational training and micro finance may work in coordination with each other and may also be capacitated so that an IDU accessing a needle syringe exchange program may also have provisions for his general health ailments or a drug rehabilitation centre take in drug users post- opioid substitution therapy or drug users who come out of detoxification camps and help them in all aspects of rehabilitation.

Issues within the community

Another major factor shaping the feasibility of community mobilization among the IDUs in the particular context could be the difference in goals and priorities frequently found between individuals of different linguistic communities, and individual concerns being greater than other pressing community concerns. Such differences in priorities and values often lead to struggles over power and control of programs and reflect the need to build trust and mutual respect to foster true partnership. Community collaborations are hard to develop and sustain, given the volunteer nature of community participation, the enormity of the task, and the natural conflict between groups with differing agendas and priorities and among which some level of distrust already exist.

Implications and Recommendations

It has been argued that ‘empowerment is essential for any successful community program to be effective in reducing HIV risk behaviors’ (Latkin, 1998). Through empowerment process people are given opportunities to create or control their own destiny and influence decisions that affect their lives. This paper describes a situation where limited interest and participation in the community mobilization process can be seen as a lack of empowerment stemming from structural issues.

Policy makers and program planners need to understand that the future of HIV prevention among IDUs to a large extent depends upon the extent to which environmental change interventions are promoted. HIV prevention and harm reduction needs to be nested within programmes to alleviate social and economic inequality among this marginalized population more generally. Once the empowerment issues are resolved, opportunities for greater mobilization exist which will lead to increased empowerment again. More importantly, community mobilisation should not only be as a mechanism for IDU empowerment or mobilisation, but also as an important mechanism to address social issues.

A participation strategy in community mobilization is essential for a successful community mobilization and address the issues of governance. The strategies for participation could include the following:-

- *Awareness drives and invitations to membership*
It has been seen that registration in membership was enhanced in the initial days of the CBO with membership drives and events held in the district for the community. However, this has not been sustained as per the respondents. There is a need therefore to continue such drives and campaigns covering all areas of the district to motivate all IDUs to voluntarily register as members in the community organization. As has been observed during this study, it is likely that awareness about community mobilization and the existence of a CBO for IDUs is yet to reach many in the near vicinity of the headquarter towns.
- *Equal and fair representation of all segments of IDUs*
As suggested by the respondents, particularly in Churachandpur district, with a myriad of tribes and ethnic communities, there is a need to ensure a fair representation of all segments of IDUs to ensure democratic functioning of the CBO.

One way of achieving this is to have rules that ensure fair representation of all ethnic communities in the executive committees of the CBO. Secondly, the location of the CBO office can be rotated at regular intervals to cover areas of different ethnic

communities. This is deemed necessary as the different ethnic tribes have had clashes, and a history of mistrust amongst them. Another suggestion is to set up smaller branch offices or clusters covering the different areas. These improvements, if taken

As one FGD respondent shared –

“if we put the CBO office in a particular tribe area for say, 6 months, immediately the IDUs in that area will take ownership, members will increase, it will serve as a good mobilization strategy also”

- *Stimulus for attendance at meetings*

One barrier to community mobilization has been the lack of interest in attending meetings. Another has been the forgone expenses. Therefore greater stimulus for attendance and participation has to be looked at by the community leaders itself. This is one area where community led discussions and consultations can be organised.

- *Hand-holding support in advocacy*

Advocacy has been an area where the respondents desired the active lead and support of higher authorities such as the NGOs. As is seen in this study, rights awareness and most importantly, rights seeking behaviour is lacking in the IDU community. And there are various reasons to this as reported by the respondents. Advocacy and creating of an enabling environment is one area where more studies, more impetus needs to be focussed on.

- *Support from external agencies such as the Church*

The two districts in this study, with tribal populations have a majority Christian population with only a small percentage from other religions. The institution of the Church therefore remains a big factor in the social life of the populations. At present the involvement of the Church has not gone beyond acquiescing to the concept of harm reduction. As suggested by the respondents, if the Church were to develop more interest in the welfare of IDUs and start believing in them, it would go a long way to reduce stigma and discrimination as well as motivate the IDUs to rehabilitation. As suggested by the IDUs, a small beginning could be in the form of visits to DICs from Church personnel, visits to the support groups and CBO, psycho-spiritual counselling for IDUs and PLWHAs.

This can move on to more formalised programmes with NGOs in aspects of rehabilitation, in advocacy with insurgent groups and other pressure groups, and active support and sanction in the community mobilization of IDUs. Again, the role of the institution of the Church in lessening stigma and discrimination of IDUs cannot be over-emphasized. Similarly, in the two districts with tribal populations,

there exist several social and cultural institutions who are understood to have social sanction in all matters pertaining to the collective welfare of the society. The possible role of these institutions in lessening stigma for IDUs and PLWHAs or in supporting the the welfare of drug users is an area which needs to be explored. Finally, effective advocacy will be realised when these institutions be it religious, social and cultural, take earnest steps to support the community mobilization of IDUs in HIV prevention, in their welfare and in their rehabilitation back into society.

- *Multi-sectoral, multi-agency interventions and linkages to provide effective linkages in health, rehabilitation opportunities/vocational training avenues*

The needs identified by the IDUs in this study point towards the needs for effective linkages across many agencies. For instance, it has been seen that rehabilitation centres providing detoxification and institution based counselling and support or centres that endorse a non-medical treatment through spiritual counselling and prayer have been in existence much before the concept of harm reduction was introduced. It appears that since the introduction of harm reduction and needle syringe exchange programs in the early 90s, interest in these rehabilitation centres have faltered and existing set-ups largely neglected across the state. A quick glance at these centres shows that they lag far behind, and are in no position to pick up for example clients that have just come out of OST treatment. There is therefore a need to revamp these rehabilitation centres, build up their capacities in terms of technical knowledge, staffing and resources to be at par with harm reduction providers. There is an opportunity here which can be explored. Similarly there is a need to have effective linkages with agencies that can provide vocational trainings, micro-finance or other income generating opportunities at the grass-roots level. Again, with respect to health care needs of IDUs, respondents share that one barrier is that primary health centre or community care centres in the rural and sub-district levels remain mostly non-functional, with absentee doctors and non-availability of medicine stocks. Not to mention the entire district has one single government hospital. These factors make referral from harm reduction providers also difficult. Even as this list is not exhaustive, the identified needs of IDUs argue for a multi-sectoral approach to the twin problem of drug abuse and HIV in the state.

Study Limitations

A number of limitations need to be considered when interpreting these study findings.

Data for this study was collected during an exploratory needs assessment from IDU beneficiaries of existing harm reduction ORCHID NGOs working in the two districts of Churachandpur and Ukhrul by a Project ORCHID staff and the author between the months of January 2010 till April 2010 as part of the author's practicum field work and exposure. This study therefore is a secondary analysis of the data collected

during the site visits and field observations, through focus group discussions and in-depth interviews.

- The community mobilization program for IDUs in the north-east is new, and limited the possible number of respondents and sites for a more concrete discussion and exploration on the objectives of this paper.
- Membership bias may have influenced the findings as majority of the respondents were members of the CBO
- Bias may occur in the interpretation of data as it was collected in the local languages, and the nuances of the language may not be effectively captured in the analysis of the data
- Social acceptability bias may have influenced the respondents to understate or overstate their feelings about Community mobilization and the CBO

Future Research Directions

A number of other studies would strengthen the evidence for the public health benefits or barriers of the community mobilization program amongst IDUs in Northeast India. These are described below:-

Policy studies on HIV intervention in the north-east would greatly benefit any community mobilization program in the northeast It has become clearer to interventionists and researchers the importance of understanding the geographical, political, social and ethno-cultural contexts of HIV risk environments and the relevance of these factors for effective intervention planning (Rhodes et al, 1999).

- Studies on self- identified needs of IDUs
- Studies on human rights and IDUs in the north-east
- Studies on structural interventions to prevent HIV/AIDS transmission and/or to enhance access/utilization of treatment and services

Personal Reflection

Between January 2010 to April 2010, I completed MPH practicum with Project ORCHID(Organized Response for Comprehensive HIV Interventions in the Districts of Nagaland and Manipur) , North East India. Under the guidance and supervision of Project ORCHID staffs , I was able to spend time with injecting drug users in two states and three districts and two sub divisions of the districts of North East India . It was a very enriching experience as I was able to put into practice the theories I learnt during my entire MPH course and apply the research methodologies for the same from literature reviews to conducting interviews and focus group discussions and I gained a greater understanding of the importance of collaborations among health organisations in the public health practice.

My experience with the people in the practicum has taught me about the practical issues of Injecting Drug Users in North East India. It has given me new resolve in my chosen career as a public health worker. It has given me insight into what a difference it makes to the lives of people when they are offered a willing ear to listen, a chance to speak, an opportunity to participate. I felt more like their little sister chatting away while they shared to me their stories, some funny, some sad and some deeply moving. The welcome I received at the DICs and into their lives will remain one of the most precious I will treasure in my life

Throughout my time here, I have observed a common resignation to discrimination that exists amongst the IDU community. It feels really sad to hear that families still don't understand that 'drug addiction' is a medical problem which can be treated just as much as diabetes through such programs as Oral substitution therapy. It is heartbreaking to know that these same friends go through stigma and discrimination, often ostracized as sinners or petty thieves in the society. Some of my older respondents have also been through drug rehabilitation centres where chains were used to ensure one was not able to escape from the premises. It feels sad to learn that much of the general population including the families still don't wish to understand about drug addiction so as to be able to help out their brothers or sons. Most of the time the families themselves just want to be rid of their IDU sons, ensuring that discrimination starts at home.

I also felt really moved by the simple things that the injecting drug users wished for when they identified their needs. Often times we forget that daily wage opportunity or some nutritional support, a mother's love, should not be taken for granted.

This exploratory study was one of the first investigations about the scope and feasibility or practicality of Community Mobilisation in the two states of North East India. I would be really happy if community mobilization would prove a success in the IDU community, and prove to be a vehicle through which stigma and discrimination against the same would be undone. I would also hope that there will be always be enough dedicated leaders and role models amongst my IDU friends so that programs that will benefit this community as well as the stigmatized and the marginalized amongst the society may continue.

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