

## 2. INTRODUCTION

At present, there are more than 13 million injecting drug users (IDUs) worldwide, and in some regions more than 50 per cent of them are infected with HIV (UNAIDS, 2004). The shift from traditional psychotropic substance use of opium and cannabis to non-traditional use in Asian countries has been characterised over the last three decades by the introduction of injecting use of heroin and/or synthetic pharmaceuticals such as buprenorphine or dextropropoxyphene. Sometimes, a mixture of drugs such as buprenorphine, antihistaminic preparations and sedatives is also injected.

Drug injecting with contaminated equipment and injection paraphernalia has now become the major HIV transmission mode in many parts of the world. Among the seven member-countries of SAARC<sup>2</sup>, the four which have recorded injecting drug use to a considerable degree are Pakistan, India, Nepal and Bangladesh. The remaining three (Sri Lanka, Bhutan and Maldives) have documented just a few cases. Injecting drug use in these countries is characterised by heterogeneity – both in the course taken by the HIV epidemic among IDUs and the types of drugs used. Despite this heterogeneity, what is nonetheless common among IDUs here is the self-reported high rates of injecting equipment sharing, which have given rise to alarmingly high Hepatitis C prevalence in these countries and high HIV prevalence in some places. The cost of syringes in the region is significantly higher in real terms than in several high income countries. This negatively impacts on the ability of IDUs to acquire needles and syringes as many of them come from poor economic backgrounds and leads to greater sharing of injecting equipment by IDUs in South Asia (Pandas and Sharma, 2005). Moreover, the fear of being punished if apprehended by the police (who can use possession of syringe and needles on person as an indirect evidence of drug use) has also forced many drug users in South Asia to share injecting equipment.

While it is logical and easy to appreciate, against this backdrop, that making sterile syringe and needles available to IDUs-as part of a package of comprehensive services–will go a long way in preventing several health and social consequences in relation to injecting drug use, the appropriateness of such an approach has been questioned. Some of the arguments put forward against the provision of sterile syringes and needles to IDUs in exchange for old and used ones are:

- Programmes promoting Safer Practices will encourage non-injecting drug users to start using drugs by injecting and will also increase drug use in general in a community.

<sup>2</sup> SAARC member-countries are Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.

- A Safer Practices programme will send a wrong message that the government's commitment to 'fight drugs' has softened and attention is being diverted away from abstinence-oriented programmes.
- The HIV epidemic related to injecting -drug -use is an independent and isolated epidemic. It is, therefore, not going to impact in any significant way on the heterosexually-driven epidemic, which is the major epidemic of concern. Thus, no special programme such as Safer Practices for IDUs is necessary.
- Why spend money on Safer Practices for IDUs when there are more important health issues such as inadequate supply of sterile syringes and needles for expanded programme of immunisation?

None of the above-mentioned concerns is, however, well founded. Increased access to sterile syringes and needles has been shown to effectively curb the spread of HIV infection among IDUs (Hurley *et al*, 1997; Hartgers *et al*, 1989) around the world and have served as referral sources for health related issues (Dolan *et al*, 1993). Programmes promoting 'Safer Practices' have also been found not to lead to an increase in drug use or an increase in HIV risk behaviours. It is also true that an HIV epidemic in IDUs has the potential to fuel a heterosexually-driven HIV epidemic as witnessed in South Asia (Panda, 2003) and averting HIV infections among IDUs would help the health system of a country from being overwhelmed by waves of HIV disease-related morbidity and mortality that would appear 5 to 10 years later. Finally, a government can still go strong on drug demand and supply reduction as well as abstinence-oriented programmes while endorsing Safer Practices, as these approaches are complementary rather than conflicting public health approaches. While one (drug supply and demand reduction) deals with primary prevention of drug use, the other deals with consequences of drug use and attempts to reduce resulting harms (areas under secondary and tertiary prevention).

In the South Asian context, Nepal provides an interesting case study in this regard. The sudden increase in HIV prevalence in 1997 from zero to 50 per cent among IDUs led conservative elements within the country to question supply of sterile syringe and needles and its effectiveness in preventing HIV epidemics. Even more worryingly, some individuals suggested that it was the existence of such projects that had led to the explosive HIV epidemic among IDUs. However, a retrospective study conducted among 200 IDUs in 1998-1999 suggested otherwise. Those IDUs who had at any stage been clients of the Safer Practices programme operated by a local NGO (Life Giving And Life Saving Society), which also supplied sterile syringes and needles, were 40 per cent less likely to contract HIV than those who were not. While the findings of this study are by no means conclusive, they are consistent with findings elsewhere in the world about the health benefits and protection offered against blood-borne viruses by programmes that ensure supply of sterile syringes and needles to IDUs (Reynolds, 2000).

Bangladesh, through a National Assessment of Situation and Responses to Opioid/Opiate use in the country (NASROB), provides additional compelling evidence on the benefits of Safer Practices (Panda *et al*, 2002). Direct and indirect sharing of injecting equipment reported by IDUs in this assessment was found to be significantly higher in sites and districts that did not have any outreach intervention (67 per cent and 62 per cent, respectively) when compared with sites having outreach-based programmes promoting Safer Practices (19 per cent and 23 per cent, respectively).