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An Outreach Intervention Among Injecting Drug Users and Their Sexual Partners in Manipur, India

Åsa Andersson-Singh, Swedish Embassy, New Delhi
asa.andersson-singh@foreign.ministry.se

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Executive Summary

The seven northeastern states of India, among the nation’s poorest and least developed, have long been affected by the high prevalence of drug use and HIV/AIDS. The worst affected is Manipur, which has less than 0.2 percent of the Indian population but accounts for nearly 8 percent of people living with HIV/AIDS, with as much as 72 percent of infection being transmitted by injecting drug users. Spread over 22,327 sq. km, Manipur shares a long border with Myanmar, and almost 67 percent of its geographical area comprises of hills and forests. Its urban areas straddle a national highway that originates in Myanmar and continues on to Nagaland. The quantities of drugs transported via this highway to other parts of the world are small, but they affect the young men who, for want of jobs, interact with the smuggling business along this highway.

Through perseverance, three grassroots organizations, using innovative and unprecedented interventions, have arrested drug use and the transmission of HIV/AIDS, developing an organic and informed leadership of ex-drug users, grassroots organizations, and development experts. They have mainstreamed the initiative by making it an official initiative of the Manipur State AIDS Control Society. And they have scaled up their interventions, geographically across the northeastern states and thematically across all affected and vulnerable sections of society.

By the early 1980s communities and NGOs alike had realized that the drug problem had reached a critical stage and that the issue could be tackled only if communities accepted ownership of the problem and induced behavior change among intravenous drug users (IVUs) and their sexual partners. What was also obvious was the need for awareness and sensitization programs among young people, who were seen as particularly vulnerable to substance abuse. By then there were an estimated 30–40,000 IDUs in the state. Mild tranquilizers and methaqualone were giving way to injectable morphine and pethidine. By the 1980s heroin, locally known as ‘Number 4’, was the drug of choice of young drug users.

Just one year after the first case of HIV/AIDS in the state was reported on December 1989, HIV prevalence rate among IDUs in Manipur rose from 0 to 50 percent, reaching 80 percent by 1997. Despite growing drug use among women there were virtually no treatment facilities for women. Social sanction against women drug users was so strong that they had been forced into self-denial and a marginalized existence.

By 1990, international agencies and the Manipur government had also realized the gravity of the problem, but efforts to mobilize were hindered by the growing insurgency in the state, its difficult terrain, and lack of governance mechanisms. In this vacuum, grassroots initiatives were launched by ex-addicts and others.

- One of the earliest was the initiative by the Centre for Social Development (CSD). With financial support from the Ministry of Social Welfare, CAPART, and the government of India, CSD had initiated development activities in 15 villages. The focus was on providing services to
enable terrace cultivation, tractors on low rent, low cost housing and latrines, but CSD workers soon realized that the debilitating role of drugs was repeatedly hampering the developmental efforts.

- Meanwhile, Dr. Jayanto Kumar, a practicing doctor, was prompted to launch the Institute for Social Disease (ISD). His community, adjacent to the highway, was becoming extremely susceptible to drug intake and use. Kumar believed that a community-centered response was vital because "unless affected people had a say in the matter, no sustainable solutions would emerge."

- About the same time, a group of seven ex-drug users formed a support group called Lifeline Foundation and began to collectively search for a humane and inclusive process of de-addiction and rehabilitation.

In 1993 a situational assessment done by two consultants for the Swedish International Development Agency (SIDA) noted that the state had not developed any kind of response to HIV/AIDS, that it was unaware of the concept of community centered work, and that it lacked financial resources for development. The assessment also concluded that NGOs involved in the initiative would need to “unlearn before learning” and that the effective training of all organizational staff would help in transforming the way drug users are dealt with in the region.

Subsequent to this report, five NGOs were selected as partners for SIDA’s interventions in the region. Only three—Lifeline, the Institute for Social Disease, and the Centre for Social Development—finally underwent training and participated in the intervention. SIDA and the NGOs decided that the harm-reduction, rather than the prevalent abstinence model, was better oriented toward intervening and preventing the further spread of HIV/AIDS.

By 1995 all three organizations had entered a decisive phase in their interventions. Having identified and witnessed the relentless march of HIV/AIDS in the lives of injecting drug-users, the harm-reduction approach became an indispensable strategy to arrest the transmission of HIV/AIDS. With their intentions clear on why they were using this approach, the three organizations demonstrated its usefulness in intercepting the transmission of the virus. Much of their success can be attributed to the fact that the three organizations had realized that the principal components of the program must be implemented simultaneously. These included:

- Developing a quality outreach program for injecting drug users by gaining their confidence and providing them integrated and need-based service.

- Educating and sensitizing the community on the linkage between harm-reduction therapy and preventing HIV/AIDS transmission.

- Sensitizing key agencies such as law enforcement personnel and healthcare professionals to engage with the issue in a more informed and sustainable manner.

Perhaps the most difficult task before the three organizations was that of gaining the absolute and total confidence of the injecting drug users. It involved reaching out to and sustaining the interactions with them, which in turn depended on the range of service they were able to offer and deliver to meet the many types of needs and demands of different individuals. When the clients faced problems or a personal crisis the workers did not abandon them.
Given this highly labor-intensive commitment, outreach workers often found themselves drained. Their fatigue and feelings of being overwhelmed by the problem were overcome by facilitating constant interactions among outreach workers and periodically withdrawing them from the field to enable them to interact with each other, revisit the ground situation, and assess their own performance in the field.

Consolidation of the rapport with the community also depended on the capacity to deliver service and more vitally, to motivate the affected individuals to use the service. In the first year of the program, CSD reached over 300 users; ISD worked with over 200 users. This activity was complemented by other initiatives such as bleach distribution, which educated IDUs in the use of bleach sterilization techniques and supplied them with bleach to clean their injecting equipment.

To sustain contacts with injecting drug users, it soon became necessary to provide an environment, free of any form of reprisal, condemnation and pressure, where clients could reinforce their resolve to break free from drugs and obtain services that would minimize the harm of injecting. The CSD, ISD, and Lifeline drop-in-centers enabled users to stay inside, out of harm’s way, and to get the information they needed. It also enabled CSD workers to spend time with their clients, to bring about behavioral changes, and persuade them to use safe practices. The IDUs often spoke of how other spaces, such as home, often drove them to acts of desperation.

Mainstreaming the initiative—an official response

So successful were the NGO initiatives that in 1998 the Manipur State AIDS Control Society (MSACS), a state agency, endorsed the harm-reduction approach (the first Indian state to do so), formulated a policy to mandate its statewide implementation, and offered much-needed leadership and commitment from the government. The state’s decision confronted MSACS and the three organizations with the challenge of scaling up and mainstreaming.

MSACS launched the Rapid Intervention and Care (RIAC) project on November 7, 1998, in order to use partnerships to cover large areas and respond more effectively in a state-wide initiative. CSD, ISD, and Lifeline, having created a model of intervention that could be replicated and scaled up across the region, participated in this partnership by providing their skills and training to the other NGO partners to implement this approach. This enabled a scaling up of the project from an initial target of 6,000 users to 18,000 by the end of 2002.

Realizing that communities’ apprehensions about the harm-reduction approach were hampering the impact of outreach workers, ISD devised measures to convince the community of the benefits of harm reduction. In the process, ISD's approach to information dissemination was altered dramatically. Training programs were designed for community leaders in which just 20 percent focused on information and the rest on development of outreach skills. They hoped thus to transfer the skills of outreach work into the community to ensure sustainability. ISD trained nearly 150 leaders, some of whom later functioned as volunteers and reached out to the community through their youth clubs.

In keeping with this thrust, CSD set up a Forum of People for Co-ordination and Development in 1997 to consolidate local initiatives through 24 member groups representing the
community, widow’s groups, local groups and community-based organizations, and various people’s organizations. Representatives of member organizations underwent an extensive sensitization process on issues of drug use, community responsibility, communication, referrals, and so on. By 2001 the Forum had gained increasing recognition at the village level.

Meanwhile, Lifeline Foundation set up a network for empowering people living with and affected by HIV/AIDS to negotiate for their rights and concerns. The Manipur Network of Positive People (MNP+) set up in 1997 was the first state-level network of people living with HIV/AIDS. Given the stigma attached to HIV/AIDS this network was responsible for providing confidence to many Manipuri youth to “come out in the open” about their status.

In 1998 the North East Network—comprising organizations from Nagaland, Assam Manipur and Arunachal Pradesh—was created to bring the states together on a common platform to address the issues of drug use, HIV/AIDS and other developmental problems that were hindering their progress.

**Lessons learned**

With ground realities becoming more complex and the community of injecting drug users becoming more vulnerable to the HIV virus, organizations involved in the intervention recognized the need for a strong paradigm shift in strategies. A sharp increase in the incidence of HIV among IDUs and the growing incidence of stigma and discrimination being experienced by them led to the realization among these organizations that these issues needed to be addressed in a concerted manner with the active support of communities and key stakeholders. A key lesson was that the issue of HIV/AIDS was not a stand-alone problem. It had to be situated in the paradigm of development. Intervention should be designed to deal with the root causes of the problem rather than its many manifestations. Effective networking and convergence of organizations with varied backgrounds, track records, skills, and core strengths can provide synergies for a meaningful qualitative response.
Introduction

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

To understand Manipur's problem with substance abuse it is important to take into account its geographical situation. Spread over 22,327 sq. km, it shares a 350 km border with Myanmar and almost 67 percent of its geographical area comprises of hills and forests. So much of its urban areas straddle the national highway - NH 39 that originates in Myanmar and continues on to Nagaland. The quantities of drugs that are smuggled and transported via this highway to other parts of the world are small but they suffice to impact the young men who for want of jobs are forced to interact with allied business along this highway. Because constant ethnic strife and insurgency as also governmental apathy and its failure to mainstream the north eastern states had made development well nigh impossible. In fact, much of the allocations made towards development remain unspent. So unemployment and poverty are widespread. A predominantly agrarian society, it is estimated that 80 - 90 percent of its cultivable land remains unused for nearly six months in the year due to poor agricultural methods. So a large segment of the population is forced to live at subsistence levels. The states feeble industrial sector has also not been able to provide a stable source of employment. Small wonder then that in 1999-2000 nearly 61 percent of job seekers were in the 15 - 34 age group of whom 67 percent had a minimum matriculation qualification or that increasing numbers of young people were becoming vulnerable to substance abuse. In fact, Manipur is being increasingly cited in studies as an example of how injecting drug use spreads in areas close to drug production areas or along drug trafficking routes.

Objective

Though Manipur, was showing a significant increase in drug use by the last 70s, the issue remained neglected and marginalized because communities, barring a few individuals, took a very negative stand and chose to ignore it. This study will attempt to document the innovative and unprecedented interventions launched by three grassroots organisations to address a complex behavioral concern like substance abuse. For by persevering, often against great odds, they succeeded in:

- Translating a felt need into an effective and large scale intervention to arrest drug use and the transmission of HIV/AIDS.

\(^1\) National AIDS Control Programme. 2001 – 2002, Status Report, Manipur AIDS Control Society
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- Developing an organic and informed leadership provided by a collective of ex-drug users, grassroots organisations and development experts.
- Strengthening the individual and collective capacities of the organizational team and enabling them to use multiple strategies.
- Mainstreaming the initiative and making it an official initiative of the government’s focal point- the Manipur State AIDS Control society.
- And also in scaling-up interventions, geographically across the north eastern states and thematically across all affected and vulnerable sections of society like young people and widows.

Context

By the early 80s communities and NGOs alike had realized that the drug problem had reached a critical stage and that the issue could be tackled only if communities accepted ownership of the problem and if behaviour change processes were initiated among IDUs and their sexual partners. What was also obvious was the need for awareness and sensitisation programs among young people who were seen as particularly vulnerable to substance abuse. By then there were an estimated 30-40,000 IDUs in the state and what was also alarming was that addiction which in the early years was in the form of mild tranquilizers and methaqualone was giving way to injectable morphine and pethidine. So by the 80s heroin, locally known as ‘Number 4’, was the most popular drug of choice amongst the youth drug users combined with other pharmaceutical combinations like phensydyle, spasmoproxyvon, buprenorphine, cough syrup, nitrazepam and substances like opium, alcohol and ganja.

Even as efforts were being made to combat the challenge of drugs the first case of HIV/AIDS was reported on December 1989 indicating quite clearly that the link that had emerged world wide of unsafe injecting practices and HIV/AIDS was also beginning to manifest in Manipur. This was also obvious from the fact that in just one year (1990-91) HIV prevalence rate among IDUs in Manipur went up from 0 to 50 percent. By 1994, it was 60 percent and by 1997 it had touched 80 per cent. Moreover, from early 1992, evidence was also pointing to an increase in drug use among women with an unlinked, anonymous screening of antenatal women showing one percent of HIV infection. This led to the realisation that there were virtually no treatment facilities for women and that social sanction against women drug users was so strong that they had been forced into self-denial and a marginalized existence.

But by 1990, international agencies and the Manipur government had also realised the gravity of the problem. A meet held in 1991 of representatives of the State Government and various agencies including DFID (Department for International Development), UNDP (United Nations Development Programme, ODA (Overseas Development Agency), Sida, WHO and Aus

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3 All HIV/AIDS incidence and prevalence figures - National AIDS Control Organisation, 2003
4 Sarkar et al. (1993)
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Aid, called for a concerted response given the magnitude of the problem. It was also felt that given the experience of many countries the harm reduction approach would be more effective in controlling the spread of HIV/AIDS among drug users. In fact, Nobo Kishore recalls that, “our efforts grew out of this mandate.

But, despite the urgency of the situation, not all donor agencies at that point of time were willing to take it forward because of the growing insurgency in the state, its difficult terrain and lack of governance mechanisms. Nevertheless, voluntary organisations like CSD persisted. “We sent proposals to many of the donors who had attended the meeting but they deferred on one ground or the other”, remembers Nobo Kishore while Yasmin Zaveri Roy, Programme Manager, Sida recalls how, “Nine project proposals came out of that meeting. But there were no takers for those proposals”.

Tracing the Origins

Though donor agencies and even the state government were reluctant to deal with the problem a few grassroots initiatives were launched by ex-addicts and others. Among the earliest was the initiative by the Centre for Social Development that was set up in 1986 by individuals from such divergent professional backgrounds as law, education and social work. It was a time when food, health care, safe drinking water were constant casualties to civil strife and insurgency. The government was also finding it difficult to respond, so with financial support from the Ministry of Social Welfare, CAPART and Government of India, CSD initiated activities in fifteen villages. The focus, Nobo Kishore says, was on “providing services to enable terrace cultivation, tractors on low rent, low cost housing and latrines” but CSD workers soon realised that the debilitating role of drugs was repeatedly hampering the developmental efforts. "We soon realised that substance abuse would harm productivity in the long run and the development of the state". It was this realisation that enhanced CSD's resolve to address the problem of drugs.

Meanwhile, Dr. Jayanto Kumar, a practising doctor, was prompted to launch the Institute for Social Disease. His close association with the community in Singjamei, on NH 39, had made him realise that it was becoming extremely susceptible to drug intake and use. Initially, he responded as a clinician and assisted local clubs to conduct detoxification camps. But he soon realised that a community-centred response was vital because "unless affected people had a say in the matter, no sustainable solutions would emerge". Moreover, "the camps were subscribing to a coercive approach and treating the drug-users in a highly inhuman fashion that did not take into account the social dimensions of the problem." The murder of a young child in 1986 by a drug-user who pawned her jewellery to sustain his habit had evoked deep distrust of all drug-users and forced detoxification was seen as the most appropriate solution. The focus being on keeping people away from drugs with scant attention being paid to the reasons why people were in fact turning to drugs. It was this realisation that prompted him to institutionalise his work in 1991.

About the same time, a group of seven ex-drug users led by Vikram Singh and Raghumani. formed a support group called Lifeline Foundation and began to collectively search for a more humane and inclusive process of de-addiction and rehabilitation. They founded a commune and developed a fishery and pig-rearing farm. Alongside they made a “kuchha”
(temporary) building to provide space for current drug users. “Our idea”, Raghumani recalls, "was to be part of a self-help group to support ourselves”. The activities of this commune inspired others to join and contribute to the many tasks within it. Many in the community also began to feel that if the drug user in their family was exposed to this sort of environment there was the possibility of getting him to get rid of his habit. Soon the efforts of this group began to take the shape of an initiative. As the number of inmates increased, the challenges of managing such a response also grew and appropriate partnerships, technical assistance, adequate funding and effective leadership also became vital. Happily, this coincided with the advent of Sida.

**Developing a Mandate**

In 1993 a situational assessment done by two consultants for Sida noted that the State had not developed any kind of response to HIV/AIDS, that the concept of community centred work was totally alien to them and also that it lacked financial resources for any development or community-based work. Calling for a paradigm, the assessment also opined that NGOs involved in the initiative would need to 'unlearn before learning' and that the effective training of all organisational staff would help in transforming the way drug users are dealt with in the region. Moreover, it would reinforce the efforts being made by the pilot project to establish a broader message of safe drug use to a larger population of IDUs and motivate IDUs to seek and demand help for detoxification and residential treatment services.

**The Entry of SIDA**

Subsequent to this report and following a series of workshops in the North Eastern states, Sida in 1993 decided to step in and check the transmission of HIV/AIDS among IDUs using the harm reduction approach. Initially five NGOs were selected as partners for interventions in the region. However only three - Lifeline Foundation, Institute for Social disease and the Centre for Social Development - finally underwent training and participated in the intervention.

In a strategic shift Sida and the NGOs decided that the targeted interventions among drug users would use the harm reduction approach rather than the abstinence model that was being used. They felt that it was better oriented towards intervening and preventing the further spread of HIV/AIDS. And that it had taken into account the complicated processes necessary for complete rehabilitation, the high rate of relapse amongst users and the need for an interim solution to the growing instances of HIV amongst users.

It was also decided that the interventions would:

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5 Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of interventions from safer use, to managed use to abstinence. Harm reduction strategies meet drug users “where they’re at,” addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction. [www.harmreduction.org](http://www.harmreduction.org).

6 However, only the three organisations documented in this study undertook the initiative. AIDS prevention society, Assam and Prodigal’s Home, Nagaland did not continue beyond the initial training period.
Encourage the use of clean needles and motivate IDUs to stop sharing equipment.

Increase awareness levels of the community to undertake their social responsibility to participate actively in preventing the further spread of HIV.

The strengthening and linking of training to the actual implementation of the activities.⁷

Consequent to this decision, Sida supported a series of training workshops to build capacities of NGOs and resource people between April 1993 and December 1996. The specific objective of this training project was to support the participating NGOs so as to ensure the optimal implementation of activities that would reduce the risk of HIV transmission among injecting drug users and their sexual partners.

Creating Capacities

Sida’s role in creating capacities was a critical component that shaped the course that these three organisations took in refining their approach to implement the intervention. This was possible because the trainers went beyond the modular pattern of imparting training and sought to understand the needs of the three organisations and the environment within which they were undertaking the intervention. According to Tarun Roy, who was associated with the , understanding these differences was an important part of the manner in which the training proceeded. “We realised that the three organisations would take total different perspectives when looking at the issue because they were different. CSD had a development background and could therefore look beyond the perspective of service provision. Lifeline, an organisation of ex-users would be involved in the day-to-day issues of care. Jayanto from ISD, though he had undergone medical training later began to realise the necessity of community empowerment and the importance of building local partnerships”.

By 1995 all three organisations had entered a decisive phase in their interventions. Having identified and witnessed the relentless march of HIV/AIDS in the lives of injectingdrug-users, the harm reduction approach became an indispensable strategy to arrest the transmission of HIV/AIDS. With their intentions clear on why they were using this approach, the three organisations successfully translated a felt need by giving qualitative shape to the approach over the next two years and thereby demonstrating its usefulness in intercepting the transmission of the virus.

In fact, much of the success of their initiatives can be attributed to the fact that from the outset the three organisations had also realised that a piece-meal approach would not work and that the principle components of the programme must be implemented simultaneously and in tandem with each other. These included:

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

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⁷ May 30, 1993, Memo, SIDA
• Educating and sensitising the community on the linkage between harm reduction therapy and preventing HIV/AIDS transmission.
• Sensitising key agencies such as law enforcement personnel, health-care professionals to engage with the issue in a more informed and sustainable manner.

**Institutional Innovation**

**Making the Outreach Worker the Key Pillar of the Initiative**

Perhaps the most difficult task before the three organisations was that of gaining the absolute and total confidence of the injecting drug users. It involved reaching out to and sustaining the interactions with them, which in turn depended on the range of service they were able to offer and deliver to meet the many types of needs and demands of different individuals.

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

With the entire process dependent on the organisational link provided by outreach workers, much of the effectiveness of the initiative hinged on the capacity of the workers to develop a steadfast and client-based relationship with the injecting drug users. This meant that when the clients faced any kind of problem or a personal crisis the workers could not abandon them. Even if the problem was not related to the concern he was dealing with, the worker had to respond to the needs of the clients and see them through their various problems. And if the problems related to drug use, the worker not only had to provide a ready referral for the client but they also had to accompany them to the doctors and ensure that the clients were given all the necessary psychosocial support they required.
Given this highly labor-intensive commitment, the outreach worker often found himself, physically, emotionally and even financially drained. The business of building a rapport with and gaining the confidence of the community also took a heavy toll on them. Bhanu, one of the founding members of Lifeline spoke of how, “we used to spend our money to buy children gifts and since women used to come to us and take rice and clothes because they felt that they could trust us, we had to meet their individual needs”.

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

The objective at all times was to develop an informed leadership that was rooted in the issue and aware of its stake in creating long-term solutions and alternatives. And also to use their potential as ex-drug users, development experts and grassroots organisations to shape and take forward an intervention that would brings about a distinct paradigm shift with people’s consent and participation. One in which the affected community played a central role. To achieve this it became necessary to motivate current and recovering users to become peer educators and assist the intervention in locating and educating the injecting drug users. Recovering addicts not only had the advantage of knowing the community of drug users but with adequate training they could communicate basic information on the programme and HIV/AIDS in as accurate a manner as possible, demonstrate safer injecting practices and motivate their peers to trust the outreach workers.

But, they were at best a supportive group of people drawn from the community and were not necessarily capable of systematically executing such a multi-layered initiative. This was because many of them despite temporary cessation of the drug habit often relapsed into it and had to be constantly monitored by the outreach workers. Anil (name changed), a relapsed user at the CSD drop -in -centre recalls how as a peer educator with he used to visit his friends and “they
used to try and convince me to share with them. I could avoid them for some days but not always. I felt that taking a little bit would not get me hooked again”. To prevent instances of relapse, Raghumani, spoke of how “we tried to keep them in the field as peer educators only for limited periods of time and the outreach workers would closely monitoring them. If they relapsed then we took care of the person and made sure he that he did not go to the field for a month”.

Building the Confidence of the Community through Delivery of Quality Service

Consolidation of the rapport with the community also depended on the capacity to deliver service and more vitally, to motivate the affected individuals to use the service. But this again was far from easy given the fact that each area of service delivery was equally complex with distinct requirements, capabilities and organisational imperatives. For instance, a service such like home-based detoxification could only work if there was provision for “minute and consistent monitoring”. So organisations such as Lifeline, who work in close association with the affected community, have admitted that till the end of 1997 they were dependent on referral networks provided by organisations like CSD to service their clients with home-based detoxification.

However, some services like needle and syringe distribution and exchange programme were essential strategies that needed to be promoted on a decisive scale so as to ensure the effective prevention of transmission of HIV/AIDS. Therefore it was crucial that they be implemented in a strategic manner to extensively cover populations that inhabit the main route of drug trafficking. Moreover, it was important that they also succeed in a qualitative manner by educating and training injecting drug users about safer injecting practices, providing them pre and post test counselling and inculcating in them the habit of using clean injecting equipment.

In keeping with these practical goals, the three organisations virtually fanned out the message across the different parts of the State. While CSD succeeded in implementing the initiative in Imphal East, ISD concentrated its efforts in four localities of Imphal that lie on either side of National Highway 39 and Lifeline focussed on parts of Imphal as well as Thoubal district.

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

Providing Friendly Spaces
To sustain contacts with injecting drug users, it soon became necessary to provide an environment, free of any form of reprisal, condemnation and pressure. CSD's drop-in-centre was for instance seen as a place where medical psychosocial support was available for those who were undergoing rehabilitation. And as a place where clients could reinforce their resolve to break free from drugs and avail of services that would facilitate in minimising the potential harm that an injecting drug could cause.

The other obvious advantage was that the harm that was caused in the street or at home was reduced. The CSD drop-in-centre for instance enabled them to stay inside, watch TV, read magazines and get the information they needed. More importantly, it enabled CSD workers to spend quality time with their clients, to bring about behavioral changes and persuade them to use safe practices. The IDUs often spoke of how other spaces such as home often drove them into acts of desperation. For instance, after a fight with the family they would might lock themselves up in a toilet, use unsafe water and inject with a used syringe. The idea of the center was therefore to reduce all such provocation's and as a first step encourage them to have an informed relationship with drugs and other substances. According to Nobo Kishore, “Our idea was that until and unless they come out of the drugs let them do it in a manner, which is less harmful”. Initially families had problems with such a concept and the organization even found it difficult to start drop-in-centres in communities but over the years the situation changed for the better, because the impact was becoming evident”.

Endorsing this Sushil, (name changed) a peer educator and a client spoke about how the centre helped them. “Here we got treatment when we were in pain. Initially, we used to meet in groups of two and three and take the shots. They came and told us not to do that. After the needle and syringe program they provided us with syringes so sharing has been reduced.” Nirmal, (name changed) another peer educator said, "When we come here the doctor understands the problem. They know what we are going through".
By 1994 Lifeline like CSD had opened its centre in Csingamaks, which was within the community area. It had facilities for indoor games and was also next to a basket-ball court and billiards facility. This attracted more users to come there and spend their time”. ISD however set up its drop-in-centre ‘Help-Line-Centre’, outside the community area of Sinjamei in 1994. This was done because of the intense reaction from the community. Promot recalled how, “They were very hostile so we decided to open the centre within our office itself.” However, by 1996, the community had begun to accept the efficacy of the harm minimisation services that were being offered and ISD was consequently able to open its first drop-in-centre within the community area.

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**Commitment for Change**

**Mainstreaming the Initiative—An Official Response**

In fact, so successful were their initiatives that in 1998 the official agency of the State Government, the Manipur State AIDS Control Society (MSACS) was compelled to adopt the intervention and endorse it with a clear policy formulation on it. By doing so they gave harm reduction the status of a programmatic response and formulated a clear-cut policy to mandate its state wide implementation and provide the much-needed leadership and commitment from the government. With the State having decided to make the harm reduction intervention as the flagship programme of the official focal point - MSACS and these three organisations found that they were supporting an equally challenging process of scaling up and mainstreaming.

What is significant about this development is not the scale of the intervention but the fact that the State had adopted the harm reduction approach as a policy objective, thereby signalling a clear break from the past. And by legitimising this approach the State for the first time enunciated a public health perspective shaped by human rights and development imperatives. The policy in fact clearly mentioned that harm reduction measures like “drug maintenance therapy”, needle syringe exchange programme (NSEP), bleach and teach programme needed to be introduced to minimise the risk of spread of HIV infection in the population.

With the adoption of this policy Manipur became the first Indian State to officially adopt the harm reduction approach as an intervention measure to prevent transmission of AIDS amongst injected drug users and their partners. It must be noted that such a radical shift would not have been possible, without the path-breaking efforts of these three organisations. They had demonstrated that despite harm reduction being potentially a double-edged approach, it could be successfully harnessed as an instrument to prevent transmission of HIV/AID, build a response that was participatory and create a socially accepted alternative. This helped the State to justify its unswerving commitment to such a programme. This shift in policy was an important milestone for Manipur because to quote the Project Director MSACS, Dr. Sukumar Singh, it created a
public-private partnership and paved the way for decisive measures and the launch of a response to the spiralling epidemic on a war footing.

Developing Sustainability—Sowing Seeds for the Future
Having adopted this policy, MSACS launched the Rapid Intervention and Care (RIAC) project on November 7, 1998 in order to use partnerships to cover large areas and respond more effectively in a state-wide initiative. CSD, ISD and Lifeline having created a model of intervention that could be replicated and scaled up across the region participated in this partnership by providing their skills and training to the other NGO partners to implement this approach. This enabled a scaling up of the project from an initial target of 6000 users to 18,000 by the end of 2002.

Modelled on the harm reduction approach the RIAC project included community sensitisation and mobilisation, NSEP, bleach and teach, condom promotion, drug substitution, STI treatment, home detoxification, referral services, formation of self help groups amongst its primary services. And it involved organisations that had a track-record in implementing the harm reduction interventions as well as new organisations.

An interesting outcome of the mainstreaming of the harm reduction approach was that it provided CSD, ISD and Lifeline with an opportunity to share their valuable experiences, skill and knowledge of harm reduction interventions with RIAC partners during training and field-work. It also enabled them to branch out into key associated activities and consolidate earlier achievements with a greater degree of comfort and support. Working in partnership with the Integrated Women and Children Development Centre, Manipur Voluntary Health Association, SASO and Shalom these organisations were able to provide a variety of support services including legal aid, care and support and economic empowerment.

According to Raghumani this facet of their work grew out of the realisation that “the clients needed more than just education about HIV/AIDS prevention and syringe and needles”. Various day-to-day issues concerning care and support of children and widows emerged. After three or four years we were seeing that people were becoming ill and beginning to die from AIDS. When they fell sick their condition became pathetic and given their impoverished conditions even visiting hospitals and accessing care became difficult”. It was then that Lifeline convinced Sida that in the changing environment a programme that integrated care and support was a vital service that needed to be offered to the users and their families. Consequently, by 1999 Lifeline was offering care and support services which included free treatment, free medicines for opportunistic infections and transportation to the affected.

Similarly, ISD’s in partnership with the Direct Observation and Treatment Short course (DOTS) programme under the National TB Control Programme, technical centre of the Regional Institute of Medical Sciences and Public Health Centers by 1997. ISD, for example, was able to successfully establish a large network of referrals with major hospitals, de-addiction centres and pharmacies. It was also able to facilitate a rapport between the users and service providers by organising interactions between them.
**Sensitising Stakeholders**

The initial hostility they had encountered with communities and the principle stakeholders had convinced these three organisations early on that community sensitisation would need to be part of their strategy. And that the success of the intervention depended on sensitising the stakeholders and ensuring that the rights of injecting drug-users were not violated. This they realised was essential to ensure that the intervention could shift from being micro, defensive, piece-meal to becoming pro-active, holistic, integrated and visible. So, as part of their initial advocacy strategy, community meetings and leadership training programmes were organised. The objective was to create awareness about HIV/AIDS while stressing on the importance of the harm minimisation philosophy, so as to effect a change in the community perception towards IDUs and their partners.

Between 1995 and 1996 CSD organised ten meetings to reach out to nearly 200 members of the community. Most of these meetings were held with youth clubs and women’s welfare associations. Meanwhile, ISD realising that their clients were unable to carry the needles and equipment for fear of harassment by their own community and others decided “to move from client oriented services to community based initiatives, especially in tight knit communities where the apprehending of a user became an issue”. So interactions and negotiations commenced with influential stakeholders like Women’s group- the Meira Paibies and Nasha Bandi (the Anti Drug Group) and with two major community organisations United Club Organisation and Thongju Kendra Coordinating Committee to sensitise citizens and generate a positive response towards IDUs. The other mechanism used was that of motivating local groups like Luhongba and Phanek Marup, involved in diverse activities such as promoting local culture and even managing chit funds. However, these organisations soon realised that sensitisation would work only if it took into account people’s reservations and apprehensions about the harm reduction approach. Therefore, one technique that was adopted was to make these interventions interactive and far more educational.

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

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

According to Jayanto, "It took ISD all of three years to convince the community that harm reduction was a process that was likely to lead to a more responsible relationship with drugs".

But in the process, ISD's approach to information dissemination also altered dramatically. Earlier they used to give people information related to HIV/AIDS and transmission. But they soon realised that “it is equally important to focus on skill development programs, contribute to social mobilisation, enhance motivation and increase capacity to negotiate in situations of risk”. So training programs were designed for community leaders in which 20 per cent focussed on information and the rest of the training on development of skills. They hoped thus to transfer the skills of outreach work into the community to ensure sustainability. Having done that they trained nearly 150 leaders some of whom later functioned as volunteers and reached out to the community through their youth clubs. Commenting on the process of identifying these individuals, Niranjan said, “We approached CBOs, community leaders and ex drug-users who were capable of contacting and organising programs in the community.” The training thereafter provided participants with information on preventing the spread of HIV/AIDS, safe injecting practices and help them decide how they could contribute to the intervention. Confidence in the process was built slowly and gradually, creating as wide a consensus and as much social acceptance as possible.

Leveraging RIAC to Enhance Groundswell—Consolidating Community Support

In fact by 1997-98, all the organisations involved in the RIAC project were sensitising the community on the issue. As Nobo Kishore, pointed out, the environment become much more open, at least as far as the state machinery was concerned and “the problems we had with the Army, the police and pharmacists also began to reduce drastically”.

In keeping with this thrust, CSD decided to set up a Forum of People for Co-ordination and Development in 1997. The Forum which currently has 24 members groups representing the community, widow’s groups, local groups and community -based organisations and various people’s organisations was essentially envisaged as a group that could be used to consolidate local initiatives. It was felt that membership organisations that emerge from the community-centred Forum would be able to respond more sensitively to the user’s situation and needs rather than outside organisations. Members of these organisations underwent an extensive sensitisation process on issues of drug use, community responsibility, communication, referrals, etc. By 2001 the Forum had gained increasing recognition at the village level. Today, according to Niranjan, "the groundwork has been laid for these people’s organisations to take forward and sustain the
initiatives" and the Forum is responsible for implementing and carrying out HIV/AIDS initiatives in coordination with the staff of CSD.

Meanwhile, Lifeline Foundation set up a network for empowering people living with and affected by HIV/AIDS to pro-actively negotiate for their rights and concerns. The Manipur Network of Positive People (MNP+) set up in 1997 was the first State level network of people living with HIV/AIDS. Given the stigma attached to HIV/AIDS this network was responsible for providing confidence to many Manipuri youth to “come out in the open” about their status. Coincidentally, many MNP+ members had been earlier associated with Lifeline. Consequently, three district Self-help groups consisting of positive people were formed and the members were given an opportunity to interact with other state-level networks and develop organisational skills.

Interestingly, amongst the stakeholders, it was the medical community and the law enforcement agencies that were the most difficult to convince. This was largely due to the fact that with the links between HIV/AIDS and drug use becoming more evident but the cause of drug-use still unclear, many misconceptions and rumours began to thrive making access to basic services more and more difficult. Doctors were refusing to treat people whom they suspected to be users. They were also not willing to disseminate information or provide counselling and care. The NGOs had to campaign for an extended period before doctors began to treat drug-users.

Similarly the law enforcement agencies were also extremely hostile to the injecting drug users. During the arrests of the clients and the outreach workers in 1995-96, the worker was often released but the client was retained in police custody. Due to this the field workers began to lose the confidence of their clients. According to Raghumani, “when we went back to a client after that we found we had not only lost his trust but we had also lost the confidence of other potential clients.” According to all the three organisations, convincing the law enforcement agencies took the longest time as “they were convinced that their own police model would be more successful in dealing with the problem rather than our approach”. Spurred by this, by 1996 the organisations decided to interact with officials responsible for law enforcement. Says Jayanto, “we realised the need for sensitising the police and the Army. The only problem was that by the time a rapport was built and they understood what we were doing they would get transferred. So we would have to start all over again.”

Another tactic used according to Nobo Kishore was to engage with the law enforcement machinery at the higher levels to gain acceptability, “when organising workshops with peer educators, we were often harassed by the beat constables. So we decided to invite the higher -ups to attend the meetings.” By 1998 this effort was scaled up with sensitisation processes that were customised to cater to their needs. For instance in the case of local leaders, exposure trips were organised. Nearly 70 leaders were sensitised during this process.
Organisational Scaling Up

North East Network
As this initiative grew there was a felt need among these organisations for NGO partnerships outside the State so as to provide a more co-ordinated response to the problem of drug use and HIV/AIDS. In 1998 the North East Network, comprising of organisations from Nagaland, Assam Manipur and Arunachal Pradesh was set up to bring the seven states together on a common platform to address the issues of drug use, HIV/AIDS and other developmental problems that were hindering the progress of these States.

Empowering Self-help Groups
Meanwhile ISD set up an SHG in its drop-in-centre “Citizen’s Circle’s” in December 1996 to help recovering and current users to increase their self worth and motivate visiting families of the members. Buoyed by this success another self-help-group was started in 1998 by recovering users. This group received training from various institutions to manage small-scale initiatives and enterprises. Though “You and I”, started-up with financial support from ISD, it is now operating on funds raised by the members. According to Jayanto, “the decision to support and train this group was consciously taken in order to motivate SHG members to find other sources of sustenance by themselves rather than becoming dependent on outside funding.” As Emanuel (name changed) a recovering user remarked, “We don’t earn a big amount from packaging masala (a spice mixture) but at least I have some money in my hand.” The SHG also acts as a DOTS centre in partnership with the National TB control.

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

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

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

**Reaching Out to Young People**

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

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

**Milestones and Lessons Learned from the Initiative**

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

- With ground realities becoming more complex and the community of injecting drug users becoming more vulnerable to the HIV virus, organisations involved in the intervention recognised the need for a strong paradigm shift in strategies.

- A sharp increase in the incidence of HIV among IDUs and the growing incidence of stigma and discrimination being experienced by them led to the realisation among these organisations that these issues needed to be addressed in a concerted manner with the active support of communities and key stakeholders.

- A key lesson learnt was that the issue of HIV/AIDS was not a stand-alone problem. It had to be located in the paradigm of development.

- The intervention should be designed to deal with the root cause of the problem rather than be diverted by its many manifestations and take recourse to stigmatising and discriminating against IDUs and their partners.

- That partners should be flexible and eclectic so as to allowing the exigencies of the situation rather than any dogma or belief to determine the quality of the response.

- More importantly, this issue needed to be mainstreamed.

- And that effective networking and convergence of organisations with varied backgrounds, track records, skills and core strengths could provide synergies for a more meaningful qualitative response.
Bibliography


Centre for Social development. (1999). Annual report. Imphal Manipur


Parliamentary Questions. Rajya Sabha Unstarred Question No. 5459, dated 17.05.2002.
## List of interviews conducted

<table>
<thead>
<tr>
<th>Category</th>
<th>Participants</th>
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| **Injecting Drug Users**  | ISD: Men SHG - 5 Drug Users
 GD                                                                                                        |
| **Recovering users**      | CSD: Rehab Centre - 1 male user, 1 female user
 LF: Men SHG: MNP+ GD                                                                                       |
| **Sexual partners of IDUs**| Rani (name changed), spouse of user                                                                                      |
| **Parents of IDUs**       | Nyan Kom, A.K Kom, Mother and Brother of user                                                                 |
| **Peer educators**        | Recovering drug user, IWCDC                                                                                                      |
| **Widows of IDUs**        | Hope - Women's SHG, Widows group – women                                                                                           |
| **Outreach Workers**      | Jatin, Former Outreach worker, Basanto, outreach worker                                                                               |
| **Organisation staff**    | Jayanto Kumar, Pramot Chand, Nutan, Jeevan Mala, Nobo Kishore, Somorjit, Saratchandra, Rebati Raman, Niranjan Singh, Sarat Chand, 
                          | Rehab centre – 3 Counsellors, ORW - Kimboi                                                                                         |
| **Partners**              | NSS, Manipur College - Teachers, Student Volunteers, Dr. Noren, Former PRAM, Manipur Driver’s Union – Secretary Sushil – lawyer |
| **NGOs**                  | IWCDC, Seiko, Local Club, People’s organisation – Forum for Coordination for Development, Vasu Diamond Club, Manda GD          |
| **State health**          | Dr. Bhrajachand, RIMS, Dr. Diamond                                                                                                   |
| **State AIDS Cell**       | Abhi Ram - NGO Advisor; Sukumar Singh – PD                                                                                          |
| **Pharmacists**           |                                                                                                                                        |
| **Media**                 | Roopa Chandra                                                                                                                        |
Politicians
Community Leaders
Opinion Leaders
Trainers

Local clubs
Tarun Roy
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CAPART</td>
<td>Council for Advancement of People’s Action and Rural Technology</td>
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<td>CSD</td>
<td>Centre for Social Development</td>
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<tr>
<td>DFID</td>
<td>UK Fund for International Development</td>
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<td>DIC</td>
<td>Drop-In-Centre</td>
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<tr>
<td>DOTS</td>
<td>Direct Observation and Treatment Short course</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immune Virus/ Acquired Immune Deficiency Syndrome</td>
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<td>ICMR</td>
<td>Indian Council for Medical Research</td>
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<td>IDU</td>
<td>Injecting Drug User</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>ISD</td>
<td>Institute for Social Disease</td>
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<td>LLF</td>
<td>Lifeline Foundation</td>
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<td>MNP+</td>
<td>Manipur Network of Positive People</td>
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<td>MSACS</td>
<td>Manipur State AIDS Control Society</td>
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<td>NACO</td>
<td>National AIDS Control Organisation</td>
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<td>NGO</td>
<td>Non Governmental Organisation</td>
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<td>NH</td>
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<td>Primary Health Centre</td>
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<td>Rapid Intervention and Care</td>
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<td>SHG</td>
<td>Self Help Group</td>
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<td>WORC</td>
<td>Women’s Organisation for Reintegration and Consolidation</td>
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