

INDIA

ADVOCACY

BRIEF

PART 1

In collaboration
with Indian
Harm
Reduction
Network and
Lawyers
Collective HIV/
AIDS Unit,
supported by
Open Society
Foundation



A Time for Better Laws, Policies & Practices to Ensure Quality Services for People-Who-use-Drugs, their Families & Communities

By **ASIAN, HARM REDUCTION NETWORK & Partners**

People who inject drugs (PWID) in India represent a core group most at risk of contracting HIV, hepatitis C and other blood borne pathogens. Though a minority amongst four (4) classified most-at-risk populations in the country, the injecting drug use population is rapidly increasing, affecting new areas and populations including the younger generation and women. According to recent estimates there are roughly 177,000 PWID in India¹, accounting for at least 2.2% of all new HIV transmissions.² Interventions critical to manage HIV transmission in PWID sub-populations include scaling up needle and syringe exchange programs (NSP), expanding opioid substitution therapy

(OST), and ensuring PWUD (people who use drugs) living with HIV receive antiretroviral treatment (ARV).³

Over the past year, drug treatment centers throughout Asia have been heavily criticized and scrutinized by various organizations due to its inhumane and unconstitutional modality of treatment. This has led to modifications up-to some extent (e.g. Conversion of CCDUs to CBTx in Cambodia)⁴ but these are still deemed substandard and lack quality. In India, the Ministry of Health and Family Welfare (MoH) and the Ministry of Social Justice and Empowerment (MSJE) sponsor both state government and voluntary organization

¹National AIDS Control Organization. (2011). Department of AIDS Control, Ministry of Health and Family Welfare: Annual Report 2010-2011: Delhi.

² National AIDS Control Organization. (2012). Department of AIDS Control, Ministry of Health and Family Welfare: Annual Report 2011-2012: Delhi.

³ Conversion of Compulsory Centres for Drug Users - CCDUs to Community-Based Drug-Treatment (CBTx) program in Cambodia in 2011 lead: <http://www.unodc.org/eastasian/pacific/en/2012/02/cbt-x-cambodia/story.html>

⁴5.Tripathi, B. M., Ambekar, A. (2009). Minimum standards of care for the government de-addiction centres. National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi.

INDIA

ADVOCACY

BRIEF

PART 1

AHRN Advocacy Brief India

⁶Personal communication with various stakeholders and AHRN partners from India, 2011 & 2012, this includes personnel from various departments of state and central governments.
⁷Ministry of Social Justice and Empowerment. (2009). Alcohol and Drug Demand Reduction and Preventative Policies. Retrieved from <http://www.socialjustice.nic.in/add.php#a6>.

⁸Rajesh Kumar, President SYPM, personal communication, 12 June 2012.

⁹Personal communication with various stakeholders and AHRN partners from India, 2011 & 2012, this includes personnel from various departments of state and central governments.

¹⁰Rajesh Kumar, President SYPM, personal communication, 12 June 2012. (SYPM is currently RRTC/Regional Resource Training Center for DDTRCs/Drug Dependence Treatment & Rehabilitation Centers under MOHFW)

run de-addiction centers.⁵ Despite decades of involvement by these ministries, infrastructure for drug treatment in India remains poor and woefully inadequate. While the Ministry of Health, for example, has supported the establishment of 122 treatment centers, the results of the two evaluations conducted in 2002 and 2008 were discouraging and revealed a large amount of variability in the functioning of Government de-addiction centers⁶. In general many are of the opinion that very few treatment centers in India are actually operational.⁷ In partnership with local nongovernmental organizations, the MSJE claims to currently operate 376 de-addiction and rehabilitation centers.⁸ Those working in harm reduction, however, assert that many of these centers are neither functional nor effectively operate, and that there is an extreme diversity in the quality of programs between those operated under the government health care settings and voluntary or non-governmental run treatment and rehabilitation centers. Both these settings have its own merits and demerits, but both lack clear deliverables, established minimum standards of care and robust monitoring and evaluation mechanisms⁹

For harm reduction activists, support for such centers, particularly short-term ‘de-addiction’ or ‘detoxification’ facilities, is fraught with controversy. Compulsory treatment and abhorrent living conditions are clear violations of the rights of PWUD, and are linked to custodial treatment referrals as prescribed by the law. It is clear that demand for such short-term services is enormous, particularly in countries such as India, where propaganda related to drug consumption coupled with family ties and social pressure influence policy and treatment choices.¹⁰ It must be recognized that as long as such demand exists, services will arise to meet it, regardless of its quality, affordability or effectiveness. Those who opt for treatment, for whatever reason, deserve services, which are evidence-based and respectful of their rights. Within this context, it is thus imperative that facilities,

which *do* exist, are subjected to various quality assurance measures and government rules and regulations, be they private or government-run. Indian law, particularly the NDPS (Narcotic Drugs and Psychotropic Substances) Act, is badly in need of amendments, which reflect the pressing issues such as consent to treatment, minimum standards of treatment and alternative treatment options like harm reduction services.

At present, the NDPS Act gives the government the power to “establish centers for identification, treatment, etc. of addicts (Read: PWUD) and for supply of narcotic drugs and psychotropic substances.”¹¹ The law goes on to say that the government “may make rules consistent with this Act providing for the establishment, appointment, maintenance, management, and superintendence of...the centers referred to in sub-section (1) and for the appointment, training, powers; duties and persons employed in such centers.”¹² Importantly, the law governing regulation of treatment and de-addiction centers covers only those established by the government. In the absence of an adequate number of government-run or sponsored facilities, private institutions claiming to offer treatment and de-addiction services have sprung up rapidly. Such programs are overwhelmingly unregulated, a fact that is reflected in the abhorrent conditions offered by many ‘treatment centers.’ The horrific physical abuse, torture, and inhumane living conditions are often used as means to control the patients and costs in many of these centers, thus subjecting patients to an utter disregard of human rights and scientific medical standards. Patients have been kept in cramped quarters or had their legs chained together for weeks, such actions justified by the need to keep drug users away from drugs.^{13,14} There are cases of patients being beaten to death in the course of treatment or while attempting to escape from the treatment center.¹⁵ Such outright violation of human rights did also occur in government sponsored drug dependence treatment and rehabilitation

INDIA

ADVOCACY

BRIEF

PART 1

AHRN Advocacy Brief India

10.11. NDPS/Narcotic Drugs and Psychotropic Substances Act (1985), s. 71.
 12 "Chaining of drug users in rehabs still prevalent in Churachandpur" - Hueiyen News Service, Imphal, July 29, 2011 - <http://new.ahrn.net/chaining-of-drug-users-in-rehabs-still-prevalent-in-cepur>
 13 HRI, IHRN, and ANPUD. (2012). *Human rights violations associated with India's anti-drug laws: Delhi, Imphal, Manipur*.
 14 Ibid & Also "Drug user beaten to death" - Hueiyen News Service, Imphal, Manipur, July 25, 2011 (<http://new.ahrn.net/drug-user-beaten-to-death>) & "De-addiction centre doc beats patient to death" - May 09, 2011, New Delhi - NDTV (<http://www.ndtv.com/article/cities/de-addiction-centre-doc-beats-patient-to-death-104401?op>)
 15 Personal communication with stakeholders during India visit, June 2012.
 16 Aditya Singh, Program Officer, NACO and Sonia Khumukcham, Technical Officer, NACO, personal communication, 13 June 2012.

centers, but these were never brought out to the limelight.

A further barrier to accessing quality treatment and care is cost. MSJE-run centers in Delhi charge at least 1500 INR per month, ostensibly to cover the cost of food. Most PWUD are isolated and often living on the streets, and have no way to cover the costs demanded by even public de-addiction and rehabilitation centers. At drop-in centers in Delhi, staff report recommending their clients go to jail, citing medical services for PWUD in Tihar Jail as "better than anything available outside."¹⁶

While there is still much to aim for, significant progress has been made in expanding many harm reduction services, such as needle and syringe exchange and opioid substitution therapy, to the communities that need them.¹⁷ Yet no similar achievements have taken place in the realm of treatment and rehabilitation. Detoxification and rehabilitation centers frequently ignore evidence-based treatment in favor of harsh tactics that have been proven time and again to be utterly ineffective. Such centers are arguably even counterproductive and destructive - both failing in effectiveness and creating traumatic experiences that can push PWUD further underground. In addition to the moral reprehensibility of abusive "treatment" programs in an era where extensive research points to what does work, it is reckless and dangerous to propagate failed approaches. The disparity between the number of 'official' and operational centers operated by the MSJE and Ministry of Health further indicates a diversion of resources away from what has proven to work. Funding, already so scarce for harm reduction and drug treatment, can hardly afford such inefficient and less cost-effective investments.

It is imperative that the regulation of de-addiction and rehabilitation centers is improved and expanded beyond that of public centers to include all facilities offering treatment for PWUD. The NDPS Act must be updated to reflect this change,

and expanded to mandate, rather than suggest, the creation of regulatory rules and policies. The central government must ensure the state government maintains facilities with minimum standards of operation in all existing centers and therefore, legislate a policy under which each state shall draft appropriate rules and regulations with stringent measures to ensure minimum standards of care and respect for the human rights of PWUD. The state and central government should make every effort to ensure adequate numbers of facilities are available, and that these are voluntary, free of cost, and easily accessible for every PWUD, including those affected by HIV and Hepatitis C, and women with children or in pregnancy.

Rehabilitation and de-addiction centers affect the lives of PWUD, their families and communities, and therefore wider society. It is therefore unconscionable and unconstitutional that facilities without standards or regulation continue to operate.

The state and central government must ensure greater and more meaningful involvement of the PWUD in providing oversight and hence, an independent evaluation system needs to be developed, where communities, particularly PWUD, alongside professional experts take center stage.

It is indeed time for India to adopt better laws, policies and practices to ensure adequate quality services for people-who-use-drugs, their families and communities, if the Millennium Development Goals (MDGs), particularly number 6, and the global target of getting to zero new infections are to be realized.

INDIA

ADVOCACY

BRIEF

PART 1



Our heartfelt gratitude to our partners, colleagues, friends and well wishers from India who have contributed their valuable time and shared priceless thoughts and opinion:

*DNP+ (Delhi Network of Positive People) – Loon Gangte , President;
EHA (Emmanuel Hospital Association) – Joy Ganguly, M & E Officer;
IHRN (Indian Harm Reduction Network) – Mr. Luke Samson; President & Chair AHRN;
LAWYERS COLLECTIVE - Anand Grover, Director & Special Rapporteur; UNHRC;
NACO (National AIDS Control Organization) - Dr. Dhingra, Deputy Director;
Subash Ghosh, Program Manager; Alok Agarwal, Program Officer;
Sophia Kh, Technical Officer; NACO
SANKALP - Eldred Tellis, Director;
SPYM - Rajesh Kumar - President;
NCB/CUSTOMS - Romesh Bhattacharji – Retired Director & Commissioner;
UNAIDS - Prasada Rao - Special Envoy to the Secy. General, UN;
UNAIDS India - Charles Gilks, Country Coordinator;
UNODC - Cristina Albertin, Representative South Asia; and
UNODC - Kunal Kishore, HIV/AIDS Program Manager.*

*AHRN
Federation
Secretariat,
405/5 Mahidol, Tha Sala,
Muang, Chiang Mai,
Thailand - 5000
+66 53 122332
www.new.ahrn.net*

HARM REDUCTION SAVES LIVES