GOVERNING HARM: THE POLITICS OF SURVIVAL IN THE ERA OF HARM REDUCTION IN INDIA

BY

GAYATRI MOORTHI

DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Social Work in the Graduate College of the University of Illinois at Urbana-Champaign, 2011

Urbana, Illinois

Doctoral Committee:

Associate Professor Barry Ackerson, Chair
Associate Professor Steve Anderson
Associate Professor Zsuzsa Gille
Associate Professor Jonathan Inda
ABSTRACT

My ethnographic project aimed to understand the policy context of the harm reduction paradigm in New Delhi, India and detail its implications for drug users on the ground. In order to do so, my research posed two key questions. How are the state, NGOs and international organizations interact, negotiate and construct harm reduction in neoliberal India? How does this new therapeutic regime shape the life of the recovering drug users- their recovery subjectivities, meanings and experiences? My project tries to establish the complex linkages between policy and ground level practices laying out the real activities, culturally embedded practices as well as the global-local understanding of health and values that shape this treatment paradigm. Over the course of eight months from August 2008- April 2009 I conducted this multi-sited project using methods such as participant observation, in depth interviews, life-history interviews and archival research to collect data from both policy and practice contexts.

In light of the spiraling rates of HIV, my research findings suggest that both grassroots organizations and global actors played a key role in bringing harm reduction to the forefront. Non-state stakeholders such as the NGOs, civic society organizations and bi-lateral agencies helped to shape policy, fund programs and provide expertise to the state. This research demonstrates the manner in which, the state adopted multiple ways of functioning, balancing the pressures and agendas of a complex web of local, regional and transnational actors. I detail how each stakeholder was involved in what I label as the “politics of survival”. They functioned in a highly charged atmosphere of competing economic stakes, fragile health politics and flexible stances on harm reduction.

Drug treatment, as my research shows, became the site for new innovations and controversies. Harm reductionists promoted pharmaceuticals and needle syringe exchange in lieu of traditional abstinence-based programs. Rather than eliminating drug use and improving
overall health, risk reduction became the main goal. These temporary prevention systems did not fully account for the endemic inequities and poor health infrastructure of the country. I show how health gets negotiated within such adhoc conditions and the new meanings given to recovery within drug treatment.

My project suggests that clients judiciously utilized these highly specialized services to forge their survival, while struggling to maintain their basic needs and escape the punitive justice system. The participation of these marginalized drug users in the harm reduction paradigm is both problematic and empowering. Injecting drug users were encouraged to become active and responsible managers of their recovery- a type of ‘biological citizenship’ laden with choices and rights. At the same time, they struggled to meet their basic needs in the absence of a strong public health infrastructure, an issue completely overlooked by the harm reduction model.

My project also addresses the tense dynamics between the clients and peer workers. Unlike other peer driven models, this treatment paradigm recruits both active drug users and recipients of harm reduction treatment. My research documents that the boundaries between the provider and receiver were severely challenged, as each tried to outline his/her numerous roles as clients, peers, models and experts. My dissertation highlights how this “mutant” worker juggles these identities and shapes a new type of recovery. I ultimately raise important questions about the feasibility of harm reduction within resource poor settings, issues of social justice for the drug user and the larger community as well as the ethics of this public health endeavor.
ACKNOWLEDGEMENTS

To my committee, this research grew from small ideas into a project of cogent arguments and endless possibilities. Your guidance, creativity, openness and encouragement became the backbone of this project. Dr. Ackerson, thank you for shepherding me through a sea of ideas and bringing me to the other side. Dr. Anderson I will always be indebted to your dedication and unwavering commitment to me and to this project. Dr. Gille, I am so thankful to you for opening my eyes, ears and mind and making this work a far better product than I ever envisaged. Dr. Inda, thank you for energizing this work and shape my fieldwork lessons into a story that others were willing to listen. To Drs. Schwandt, Denzin, Miller, Greene, Bourgois, Haight and Cole- your classes re-ordered my world, your contribution to this dissertation remains invaluable.

I would like to acknowledge the entire staff, especially the project site workers of Sahai and Ashray, who made it a joy to go in for fieldwork each day. Their contribution to those at the margins is unparalleled and their commitment to the cause of health humbled me. Thank you for letting me seeing your truth. I would also like to thank all of the policy workers, health professionals, civic society leaders and government officials, who participated and enriched this project. A special thanks to Neville, Luke, Francis, Dean, Mike, Neville, Kunal and Meera- your support and guidance both and on and off the field was critical to the success of this work. I cannot thank you enough and hopefully can tell all your stories with the same sense of commitment as all of you show in your work.

A special thanks to the School of Social Work, Dean Korr, the faculty, the administrative and support staff for helping me along these past eight years. My rich experiences, both as a scholar and a teacher at the School have been integral and invaluable to my education.
My courage and conviction all belonged to my parents, who have been my pillar of strength and support throughout these years. I could not have imagined this for me and I know they did, even before I knew I could. Their generous hearts, bold spirits, energy, humility and unending curiosity have made me a better human being. I cannot thank them enough for allowing me the time and space to be me; taught me how to engage with both happiness and sadness and most of all keep going.

To Vikram, this journey would not have been possible without you. You challenged, nurtured and ultimately helped me become more than I could have been. Your patience over these years as I have struggled, triumphed and remained unsure has helped keep my sanity. But most of all, your spirit and kindness can be seen in each page of this dissertation. Thank you for being in my life.

To Situ, as you begin your own PH.D. journey, you are at the cusp of discovery and adventure. Your brightness looms large and fieldwork would not have been half as fun or half as trying without you. As I learnt about my participants, I got to know you once again – as a young adult and for that I will always be grateful. Your passion, idealism, sense of ‘can do’ and humor makes me proud.

To my extended brood- cousins (Chitra, I made it!!), aunts and uncles who have always given me their best. To my in-laws, and my “new” family thank you for welcoming the perpetual PH.D. student into your life. I will always remember your support and kindness as I navigated scholarship and marriage. To all my grandparents- we continue to walk on the bridges you built.

To my friends this is your work as much as it is mine. All of this was worth it because you cheered me on from the side and kept the belief that I would come through. Pinky you made me a better scholar, writer, thinker and friend, thank you. I began this journey with you and
could not have asked for a better travelling partner- cannot wait to see you on the other side of our projects. Thank you for reading each line of this dissertation with your excellent eye and leading me through. Aditi and Arpita- there is a special place for friends like you, I will always be grateful for your presence in my life. Sowbhagya, your support has been a lifeline in many ways and your insights in terms of both public health and life have helped this project and me immensely.

For the Champaign troop- Urmi, Rufina, Paola, Ga-young and Sonali- you kept my spirits up and never let me waver, I cannot imagine this work without all of you! Devika, Sahiba, Priyanka, Nitin and the rest of the Bombay gang, a big thank you for being the most amazing friends one could ask for. Priyanka, your great networking abilities helped me access some of those impenetrable walls of policy and for that I shall always be thankful. Your frank insight into the world of development was both illuminating and fascinating, and your support over these years was incredible, thank you!

A special note of thanks to all my Professors and teachers who have gave me direction and supported me through these years - Anita Ghai, Ameeta Parsuraman, Parthasarthy Mondal, Surinder Jaswal, Rajshree Mahtani and Chitra Srinivasan (your words will always remain with me; thank you for being one of the most incredible history teachers!).

This project was supported by the Daniel Sanders International Research Fellowship, University of Illinois Dissertation Travel Fellowship and University of Illinois Dissertation Completion Fellowship. These generous grants helped me to develop my thesis and I am deeply indebted for their support.
This project began in India, with the stories of my participants; my comrades; my partners. It would have remained without a soul, if not for the love and belief of my friends and family. I wrote this with all of you in my heart.
# TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION .........................................................................................1

CHAPTER 2: METHODOLOGY .......................................................................................52

CHAPTER 3: CRACKED WIDE OPEN ..........................................................................82

CHAPTER 4: REVOLVING DOORS .............................................................................113

CHAPTER 5: A NEW KIND OF SURVIVAL- LAYING RISK BARE ..............................159

CHAPTER 6: PHARMACEUTICALIZATION OF HEALTH .............................................213

CHAPTER 7: MODELS, MUTANTS AND EXPERTS ....................................................248

CHAPTER 8: CONCLUSION .........................................................................................272

REFERENCES .............................................................................................................285
CHAPTER 1: INTRODUCTION

THIS IS A WHIMPER.
It is not a loud shout, or a shrieking wail
But something less...perhaps something else
I am trying to build a response to what I saw during those days
Not wanting to overwhelm you
But just a little tremble for those who walked those streets
I am registering their presence
I am protesting
THIS IS A PROTEST.
I am not walking with a flag or singing songs of injustice
It is through the pen I can share
What I saw cannot be forgotten
Forgetting is risky.
In forgetting we lose our history and the future all at once.
I am remembering
THIS IS A MEMORY.
Their, mine and ours- all intertwined,
A bit shaky and never complete
I am whimpering, protesting and remembering.
(Moorthi, 2009, 2010)

New Responses: Epidemics and Lives

A quiet yet dramatic shift is underway in India today. Over the last few years the country has fundamentally begun to evolve its approach, response and treatment of millions of drug users and HIV positive citizens. Broadly subsumed under the rubric of the globally accepted model of harm reduction, this new program aims to provide injecting drug users with services such as needle syringe exchange, peer education, volunteer counseling and testing, outreach, condom promotion and pharmaceutical substitution. The programs and the overarching policy framework in India were spearheaded by a number of public, private and transnational actors. Harm reduction, it appeared, was altering the approach towards not only health but also polity within the country.
My research began in 2008 just as the harm reduction paradigm was given a national face and a “governmental” voice. I tracked the way this public health program began to develop roots and shape the lives of drug users. At the policy level the harm reduction paradigm first emerged outside the purview of the state. The Indian state, until this point, had only supported the abstinence-based model of drug treatment. Harm reduction thus grew through an international network of funding, coupled with the expertise and infrastructure of international development actors as well as the cultural knowledge and local resources of grassroots NGOs.

The positive results of harm reduction initiatives undertaken by non-state stakeholders and the pressure from community members forced the largely reluctant state to participate in the harm reduction paradigm. It then became clear that questions of drug treatment policy and practice were no longer the sole domain of the state but instead were situated in the negotiated territories of multiple stakeholders. My effort in this dissertation is to detail the chaotic, ever shifting and tenuous nature of relationships between these stakeholders; these relationships are inextricably linked to both global policies/demands and local realities/needs. I show how in these transitory conditions the state re-invents itself at each point, as do the other actors-evolving their positions and roles. My research shows that within such a policy context health and recovery are far from stable or bounded notions but instead get made and remade.

At the practice level, this paradigm brings the recovering drug user into central focus. The drug user under the abstinence-based paradigm was not only seen as a diseased non-agent but also as a 'non-citizen', one who did not participate in state activities or received much benefits from the state. But these new harm reduction rhetoric and interventions highlight the drug user’s active participation in the management of his/her own recovery. The drug user is encouraged to use safely to not only protect himself/herself but also the community and the
state; the focus is on the management of drug users’ behaviors and harnessing their potential (O’Malley, 1999; Pratt 1999; Rose and Novas, 2005).

I show how this brand of drug treatment in India while brought attention to the issue of drug use also rendered it visible primarily through the frame of HIV risk. Harm reduction was also unfolding against the backdrop of increased pharmaceuticalization (health understood less as prevention/care more as access to medicine) and communitarization (health as a community owned and implemented, reducing state responsibility) of public health. Further, the provision of these specialized services within the larger context of urban poverty, structural deprivation and social stigma forced both institutions and people to continually reconfigure harm, recovery and health in India.

My specific objectives for this research are twofold a) to understand how harm reduction policies and practices are shaped by the state, NGOs and international organizations; and b) to understand how harm reduction is impacting the daily lives of recovering drug users. I used ethnographic methods to ground these larger policies in the experiences, rationalities and life courses of recovering drug users, who were at the very center of these social transformations. During the course of this chapter, I will first provide the rationale for conducting the study in India and discuss the analytical framework of this research. Next, I will detail the key concepts around addiction and harm reduction as well as lay out the theoretical arguments of my research. In the final section of this chapter I will provide a summary of the chapters of this dissertation.

**Estimating the “Problematic”**

During the 1990s Asian countries began to witness the HIV epidemic, much after the rest of the world. Even though the proportions of the AIDS epidemic are not as frightening as Sub-Saharan Africa, it is clear that in terms of sheer numbers the Asian epidemic is staggering (Joint
United Nations Program on HIV/AIDS, (UNAIDS) 2010). In Asia approximately 4.9 million people were living with HIV in 2009. India has the highest HIV population in Asia. More than 60% of the continent’s infected population, estimated to range between 1.7 million and 3.1 million, reside in the country today (UNAIDS, 2009; NACO, 2010). India ranks third in HIV populations behind South Africa and Nigeria in the globe (NACO, UNAIDS & WHO 2010). Approximately 75 million people in India are abusing substances (including alcohol), and of this 186,000 inject drugs in India (NACO, 2010). Current estimates show that nationally over 9% of IDU’s are HIV positive and in some regions 68% of IDU’s (northeast India) are infected with the virus (NACO, 2010). These estimates are even more shocking when compared to the less than 1% HIV prevalence rates among the adult population in the country (NACO, 2010).

In June 2007 the national government of India revised the estimates of the infected HIV population in the country. They reduced the number of the HIV positive population from approximately 5 million to approximately 2.5 million people (World Bank, 2011). While launching the third phase of the National AIDS Control Program (NACP), Dr Anbumani Ramadoss, Union Minister for Health and Family Welfare claimed:

Revision of estimates based on more data and improved methodology marks a significant Improvement in systems and capabilities to monitor the spread of HIV, a sign of the progress we have made in understanding the epidemic better. This is welcome progress. Unfortunately, the new figures still point towards a serious epidemic with potential to expand if the prevention efforts identified in the NACP III are not scaled up rapidly and implemented in the desired manner. We must remember that India has nearly 30 lakh people living with HIV. These are people facing stigma, discrimination and irrational
prejudice everyday of their lives and need all our support and understanding (World Health Organization (WHO), 2007).

The international community and NGO sector were shocked by this drop in estimates and were worried about the efficacy of these new methods of data collection. More significantly, there was widespread fear that funding pools would dry up as donors would seek to move to higher HIV prevalence regions across the world. These fears seemed justified, if not slightly ironic, given that most funders had entered India on the assumption that there was a high HIV population concentration within the country. Surprisingly despite the reduction in estimates both the government and the international community remained invested in HIV and by extension in harm reduction. Dr Denis Broun, UNAIDS Country Coordinator voiced his support and commitment to the HIV program in India by saying:

The trends evident from the latest estimates validate India’s national AIDS strategy.
Taking encouragement from the new lower estimates, the national authorities should increase the strength of their HIV programs. We must scale up efforts to reach universal access to HIV prevention, care and treatment. Though the proportion of people living with HIV is lower than previously estimated, India’s epidemic continues to be substantial in numbers. Despite the lower prevalence estimate, the cost of prevention efforts required to control the epidemic remains the same (WHO, 2007).

The National AIDS Control Organization (NACO) in fact reported an increase in funds despite the change in estimates of HIV prevalence. The National AIDS Control Policy phase II (1999-2007) received close to 415 million dollars in bi-lateral and international support for its programs (National AIDS Control Organization (NACO), 2007). By the time phase III (2007-2012) of the policy began, this international support grew close to 927 million dollars (NACO,
Harm reduction programs in particular also witnessed a steady growth since 2007 with investments in several new states. The number of programs is growing each year with better services for drug users across the country (NACO, 2010). Indian public health also saw resurgence during this period with the launch of the National Rural Health Mission in 2005. This policy focuses on strengthening health infrastructure and raise public spending on health from .9% of the GDP to 2-3% by 2012 (Ministry of Health and Family Welfare, 2005).

The incident of the revision of estimates brought home one clear point- India was marked as an HIV hotspot and it was here to stay. India’s unique status in the global development/health sector and its powerful symbolic significance in the fight against HIV has remained intact and continued to evolve.

**Locating Harm Reduction in New Delhi, India**

India, in many ways is the poster child of the developing nations in Asia. After economic liberalization in the early 1990s followed by the structural adjustment plan (SAP) to revitalize the economy, the country has become an emerging economic giant. Despite recent downturns it continues to boast a steady growth rate, attract large economic investments and has a burgeoning middle class. Some experts claim that India will grow faster than any other large economy in the next 25 years (Economist, 2010). It is also one of the largest democracies in the world with over one billion people. India’s potentiality, one could argue is crucially dependent on maintaining its status as an educated, aware and safe country. HIV/AIDS, the first major epidemic of the globalized era threatens not only India’s economic growth but most importantly can cause deep fracture in the gains in public health.

My project thus arrived at a crucial juncture in India’s history of public health and economic future. I located my project in New Delhi for a number of reasons. Latest NACO
estimates show that Delhi has a growing injecting drug using population with high rates of HIV prevalence (NACO, 2010). The capital is also the fastest growing city in the country, with a population of close to 16 million (Government of India, 2011). While the city has seen significant infrastructural growth with a burgeoning commercial and business community, a significant portion of this population remain left out from these developments, these include the city’s migrant, homeless and the urban poor. These extreme demographics are easy to see in the landscape - large slums rest side by side to ostentatious malls and shopping arcades as well as grand multi-storied multinational offices. Health disparities are especially marked and despite its exceptional status as the capital, each day millions are left without the most basic services to sustain life.

In response to these issues a vibrant non-governmental sector and a committed civic society has emerged within the capital. With the large presence of international offices and bilateral organizations New Delhi, has become the seat of both harm reduction policy and intervention. In many ways New Delhi is representative of the harm reduction environment of the country and influences policies and interventions at a national scale. It remains a city very much in transition and an exciting hub for health policy and change. New Delhi is thus an ideal ground to study the emergence, politics and affects of this new model of intervention.

India’s experience is especially important to document, as other South Asian countries are keen to adopt and learn from the Indian model. Further, this project is one of the first in depth, qualitative investigations of India’s harm reduction paradigm (policies, practices or underlying values) and its programs related to drug treatment. Most harm reduction research in India continues to be HIV focused and is either quantitative or epidemiological in nature. This research will be one of the first studying this new paradigm of drug treatment and recovery.
Thesis Analytics and Approach

My ethnography will describe and analyze the conflicts and tensions surrounding harm reduction policies and programs in India. This task is especially challenging since the harm reduction paradigm impacts a wide range of actors and sectors both directly and indirectly. Within social work most research that study policy or interventions remain focused on impacts or processes without necessarily locating the concern in the larger socio-political, economic and cultural landscape that shape them. Moreover, there aren’t many studies that examine the way policies filter down and shape the daily practices of people and in turn how daily life processes and actions make their way into altering policies.

Also, quite commonly, studies tend to view policies or treatment paradigms as a black box- static or insular. Researchers are less likely to talk about how social problems were conceived by the state, what were the logics and implications of such conceptions and the issues surrounding the building of national programs or the dynamics between the stakeholders. The focus is usually located within a single site and aimed at evaluating outcomes rather than providing us with a grounded picture of the processes that were involved.

As a researcher, I was keen to address these issues outlined above and approach the harm reduction treatment paradigm as a set of dynamic meaning making practices of real people. By both talking to and observing policy makers, public health experts, donors, activists, NGO officials and recovering drug users, this research attempts to demystify how treatment paradigms come into existence, travel, flow adapt and influence social worlds. I show in my work, that the policy arena, an ever evolving and often a contested space, shapes the everyday lives of clients, at the same time clients’ activities, behaviors and adaptations co-construct and re-shape these
very health policies. Simultaneously, I engaged with the underlying processes of governance, the politics of health and the dynamics of human survival under harm reduction.

My project also led me across multiple sites. I followed harm reduction in hospitals, NGOs, donor agencies, government offices, communities and international development offices. I saw how the paradigm was adopted and transformed in these settings and delineate these ‘affects’ in my work. I also engaged with both the historical and the current socio-political-economic and cultural contexts to understand the changes and transitions. This attention to temporality allowed me to raise several questions. How were these stakeholders aligning themselves in a way that was different from the past? What were the unique implications of harm reduction on health as compared to previous periods? How were drug users being viewed differently under these new conditions? What were the limitations and possibilities of such a frame of reference for the future?

I viewed harm reduction as a “problem space” (Ong & Collier, 2005) to examine broader questions of health and governance. Foucault’s notion of problematization was especially important in developing such an analytic. “Problematization is the ensemble of discursive and non-discursive practices that make something enter into the play of true and false and constitute it as an object of thought” (Foucault (1984) as cited in Castel, 1994). Instead of trying to examine a condition and prepare a solution, it becomes important to reveal what makes these responses at all possible (Rabinow, 2007). It views a social policy or even a treatment intervention not as a given but actually one that is shaped by a variety of historical conditions, social environments and power relations; it is dynamic and constantly evolving and it is constituted by those seeking to address the problem itself. In adopting such a perspective social research asks-why is something considered a problem, what forces have come into play into “it”
being considered a problem and how is the solution developed in view of the problem. For instance, I posed questions such as- what led to a risk focused construction of drug use? What roles do developmental politics, growth in scientific knowledge about pharmaceuticals, emergence of evidence-based practice and human rights have to play in the development of harm reduction?

Given the rich interdisciplinary roots of social work I was keen to examine the limits and possibilities of such an analytic within social work. Problematization brings forth issues of power, knowledge, expertise and transformation. While there is an inherent danger of reducing ‘problematization’ to critical thinking and reflexivity, there are several benefits of such an approach. It can help social workers develop a more holistic perspective and instead of seeing issues in a static manner by using a single valence, problematization allows for multiple conceptualizations. There is critique that such an analytic position can actually stifle social action. I argue, however, that it can function as precipitator of innovative ideas and new methods of thinking, both on and, off the field.

Adopting the ‘problematization’ perspective allowed me to view harm reduction as a phenomenon that was constantly evolving and somewhat unfinished; I attempted to understand the rationalities and logics that surrounded the evolution of harm reduction given the broader health context. Such an analytic position was admittedly difficult to execute, both in research and writing as it can often lead to circular arguments or vague truisms. Overall however, such an approach aided to the richness of my thesis helping me think in new ways about old problems.

A final note concerns my multi-disciplinary approach towards harm reduction. Drug use has traditionally been field that has drawn a variety of points of view and my work drew deliberately and judiciously from public health, medical anthropology, sociology, development
studies and community health. While each of these disciplines informed my work, I continued to be guided by social work’s own emphasis on macro-micro practice, ethics, politics, advocacy, activism and social policy.

**Addiction and Abstinence-based Treatment**

Narcotics represent in their essence, a desire for more than just the bare necessities of life. The term narcotics, is closely associated with the Greek root *pharmakon*, which refers to both remedy and poison (Alexander & Roberts, 2003). The ability of drugs, one hand, to alleviate pain, excite, provide pleasure and generate creativity while on the other, cause destruction and annihilation is both alluring and challenging. Historically, most cultures and communities have some recorded history of drugs and though not always socially acceptable, drug use was never deemed a problem that required intervention. Scholars argue that it was only during ‘modernity’, loaded with its ethical values on productivity and rationality, that for the first time in its history, drugs became constructed as a problem. Also, as narcotics became widely available in the consumer phase of international capitalism, their impacts were more devastating and destabilizing than ever before. Lovell (2006), claims “What distinguishes a good substance from a bad one is not inherent to the substance itself, it depends on the effect sought, the quantity taken, the means of administration, the frequency of the practice, the context, individual vulnerability – all of which are highly symbolized”.

Today discussion about drug use not only draws upon much older debates about responsibility, free will, determinism, agency and power but also rests upon newer debates surrounding neurotransmitters, biology, physiology, and brain chemistry (O’ Malley & Valverde, 2004; Valverde, 1999; Bourgois, 2000, 2003; Weinberg, 2002). The National Institute of Drug
Abuse (NIDA)\(^1\) (2011), calls drug addiction “a complex but treatable brain disease”. Social theorists point towards addiction’s more cultural dimensions calling addiction a disease of conduct, one that is emotional, interactional, temporal and relational (Denzin, 1993). Addiction, most experts believe includes both psychological and physical dependency (NIDA, 2011)\(^2\).

Treatments for addiction and substance abuse have been historically driven by an abstinence-focus i.e. stopping the consumption of substances is necessary for treatment to begin. Despite the inherent contradictions of such a stance, one that expects drug users to quit drugs before they can be ‘treated’ for addiction, the abstinence model continues to reign in mainstream treatment literature and practice. The treatment options within this abstinence model are varied and include- detoxification, cognitive therapy, behavioral therapy, psychotherapy and long-term psychosocial rehabilitation. In such an abstinence model, drug use is considered problematic both for the individual and the community; drug users are viewed as deviating from societal (and moral) norms; they are considered non-productive and irresponsible members of society. Drug users, despite completing treatment, are usually still considered “in recovery”; in some senses they can never be fully cured or trusted to remain sober.

I would also argue that the symbolic power of addiction is so sweeping that we now have a “culture of addictions”; people thus can be food addicts, gambling addicts, sex addicts and even relationship addicts. Further, the mandates of the abstinence paradigm are so universally accepted that they are now readily translated to these different arenas. Addicts, it is assumed, are easily tempted, difficult to control and always at risk of returning to their vices.

---

\(^1\) The National Institute on Drug Abuse (NIDA) is part of the National Institutes of Health (NIH), a component of the U.S. Department of Health and Human Services. They are the central agencies that address substance abuse concerns within the U.S.

\(^2\) This means an addict has lost control over the usage of the substance, and will continue to use until intoxicated / ‘high’/ is under the influence of the substance. Once he/she starts using the substance, they cannot stop and will crave for it if it is not consumed. The person will develop a tolerance towards the substance and may need more and more to achieve the same kind of feeling.
The response to this addicted culture has been quick and far-reaching. A slew of life coaches, therapists, counselors and doctors have developed an entire industry of support, treatment and recovery around the tenets of abstinence, removal of desire and self-control. But the results of such interventions are not as clear or as convincing as one would hope.

Abstinence-based drug dependence treatment strategies are often under resourced, ill equipped to match the changing landscape of drug use and require drug users to spend a substantial amount of time away from their families and communities (WHO, 2005). Moreover, the prohibitive costs and problems in accessibility, keep those who need treatment away (WHO, 2005). Jared Richards, a harm reduction expert, shared with me that in his view the abstinence-based model was the fall out of the 1930s 1940s ‘westernized Christian values’. He points out:

They set up Oxford groups and then the Alcoholics Anonymous (AA) groups and tended to increase this (focus on) abstinence, to the extent of socially stigmatizing those who could not stay away from alcohol. The advent of 12 steps and Narcotics Anonymous pushed that onto the drug user. So we (India) had groups forming rehabilitation (centers), boot camp type rehabilitation (programs), which would treat people like they were less than humans- they were criminals, which under the law of course they are… Jared claims that these abstinence programs are especially hard on those people belonging to the low socio-economic strata. He argues:

To ask somebody to take six months of their lives to go into rehabilitation, which means stop your work for six months, leave your family for six months, which is not very possible, either for him or for his family. There have been a lot of times when we have put people into (rehabilitation centers) and their families come up and say why have you
done this, you have cut off our whole family income- that guy is fine, he is eating three meals a day but we have no source of income now, who looks after us?

Those who enter treatment are often at a high risk of relapse; statistics vary between 50-90% (WHO, 2005; NIDA & National Institute of Health, 2009). Then why invest in treatment at all? Negative health and social impacts of non-treatment in addition to the high economic costs of addiction far outweigh the costs of treatment. There is also a large industry of workers, as discussed earlier, in a variety of institutions such as prisons, hospitals, schools, community clinics and development agencies, invested in the business of treatment and recovery. Millions of dollars are spent each year globally, on demand as well as supply reduction.

Theoretically, drawing from Foucault’s argument on biopower, it could be argued that the problematic of addiction is given a new form through the very solutions sought to address it. Addiction to drugs represents one element of human urge that now needs to be governed and shaped and has given rise to an entire enterprise of health and recovery, which in turn sustains the problematic.

**Harm Reduction**

The genesis of harm reduction in the 1960s-70s in Western Europe was in response to the deteriorating conditions of drug users. Families, communities and societies ravaged by drugs struggled with the failures of abstinence-based treatment models and sought a different approach. Adopting a pragmatic rights oriented standpoint harm reduction adopted a middle path. It focused on reducing potential harm caused by drug use, rather than on eliminating the actual behavior of drug use itself (Erickson, Riley, Cheung and O’ Hare, 1997). It gained popularity in many nations in the West, including countries like Canada and Australia.
Despite this, there was, and continues to be healthy skepticism about harm reduction’s viability for a large developing nation like India. Early on small harm reduction programs, sustained by independent funding grants, were the only options available for drug users in the country. The advent of HIV fundamentally changed the environment of treatment and intervention in India. The government could no longer ignore the potential risks of such an epidemic and thus from a peripheral, local and small movement harm reduction grew into a national public health program to treat the problem of addiction. More significantly, harm reduction has been able to transform drug use from a criminal and a medical problem into a public health concern.

The Indian model of harm reduction has drawn many elements from its global parent model. However, given the complicated nature of the policy-practice environment and the large number of stakeholders present in India, there are many inherent contradictions and differences. I will now discuss some of these differences and complexities to provide a more nuanced picture of the Indian model of harm reduction.

First, one of the key features that separates harm reduction from other models of treatment is harm reduction’s acceptance of drug use. Harm reduction attaches no moral, legal or medical-reductionist strings to drug use (UNODC and Lawyer’s Collective, 2007). Since drug use is seen as “normal”, the drug user is also seen as normal rather than a morally, criminally or medically deviant person. It promotes itself as apolitical, value neutral and humanistic approach, parallel to the current new public health or healthy cities movement (Keane, 2003; Erickson et. al., 1997).

There are no clear legal provisions to decriminalize drug use in India and “normalize” such behavior. Under the Narcotic Drugs and Psychotropic Substances Act (1985) drug users
can be arrested and prosecuted for possession and or consumption of small quantities of drugs. In fact, provision of sterile injecting equipment for drug users may also amount to aiding and abetting of unlawful drug use and can lead to prosecution. The National Aids Control Organization (NACO) under the Ministry of Health, which is responsible for HIV/AIDS prevention and treatment, endorses harm reduction and views it as the best way to address the drug-HIV pandemic (National AIDS Control Organization, 2006). Despite their position on harm reduction, NACO has not addressed the issue of criminalization of drug use; NACO functions in a quasi-legal environment, one that continues to view drug users as deviant. The National Institute of Social Defense (NISD)\(^3\), under the Ministry of Social Justice and Empowerment in-charge of drug abuse treatment and prevention within the country, continues to support the abstinence-based path and opposes harm reduction. It views drug use as a criminal activity as well as a medical problem. The state does not have one clear position regarding drug use or drug users, but instead conducts its harm reduction activities within such an undefined space.

NGOs like Sahai and Ashray have adopted harm reduction’s mandate more readily. They were clear in their acceptance of drug use as a part of normal life and viewed drug users, not as deviants, rather as human beings who needed their support. International organizations like the UNODC and UNAIDS as well as donors like Bill and Melinda Gates Foundation also occupied the proverbial middle ground. They were willing to support interventions and even harm reduction policies, but were less clear about how to address issues of deviancy or long-term systemic changes that were needed to alter the drug users’ position in society. Sahiba Kaur, a harm reduction expert of UNODC, discussed this issue:

\(^3\) NISD funds over 300 drug treatment programs countrywide.
I mean within this whole harm reduction there is this whole debate on should we legalize and should we not. I think our position is clear we are not for legalization but I think on the other hand we also understand addiction that you can’t expect that because I have sent you to treatment center that you would be free of drugs for the rest of your lives and also HIV has also compounded the issue, because you need to immediately at least save the person from HIV…but our position is I think clear that there is a drug user, he or she deserves access to treatment and deserves an enabling environment where he can access the treatment.

She highlighted that it was important to create supportive policies to aid treatment but not necessarily legalize drugs. Despite a universal acceptance of harm reduction it became fairly obvious that there exist significant challenges in accepting the ‘normativity’ of drug use in the Indian context.

Second, within the global paradigm of harm reduction the drug user/client is seen as an active entity capable of making choices and participating in his/her own prevention, treatment and recovery (O’Hare, Newcombe, Mathews, Buning and Drucker, 1992). Harm reducing behaviors are seen as the pragmatic choices that drug users/clients will make if there are enough incentives for recovery, easy availability of services, adequate knowledge about drug use and HIV. This facet of harm reduction was in some senses, less problematic and more acceptable to stakeholders in India. During our discussions many of them spoke about the individual’s right to ‘choose’ treatment and their responsibility as institutions to support drug users health. The Indian harm reduction paradigm seemed to be clearly advocating for the drug using individual’s ability to make choices and participate in society, despite the uncertain legal position accorded to them. This created a complicated political context for drug users in India.
Third, closely linked to this notion of individual choice is the focus on human rights. Harm reduction is founded on the principle of equity and justice—drug users must be given respect and dignity irrespective of their choice to use or not. The Indian state promises equality and protection of life without discrimination as outlined in Article 14 and Article 21 of the Indian Constitution. The Directive Principles of State Policy (guidelines to the government) provide similar provisions to protect the health of its citizens. NACO also claims, “There can be no valid or effective response to HIV/AIDS without respect for the human rights, fundamental freedom and the dignity of human beings” (NACO, 2010). Further, the “Right to Confidentiality, Right against Discrimination and Right to Consent” are other protections assured to the citizen by the state.

International organizations like the UN agencies promoted these ideas as a core principle of their work with drug users. Sahiba Kaur shared her views about this issue:

I think currently the U.N. position is very clear—its a rights based approach, the rights the drug user has to access treatment and to save his/her life and we are looking at providing these services immediately on a war footing really, so we need to quickly get the policies changed and we need to drastically pump in money for IDU programs …essentially the drug user must have access to harm reduction as well as treatment’. Both human rights and individual choice for health were thus integral to how the Indian harm reduction paradigm was thought about and promoted.

Fourth, this focus on individual rights has led some critics of harm reduction (globally) to propose that harm reduction works mainly at the level of the individual especially those considered at high risk, rather communities as a whole. Upon further investigation it became clear that a similar claim could be made about the Indian harm reduction paradigm as well. Dr.
Alkesh Kumar from NACO and Rajat Dhingra a UNODC drug expert were quick to clarify that such a focus on specific target groups was a proven strategy in other countries. Individual changes were basically seen as proxy for community change and larger issues of poverty, employment and paucity of resources could not become the mandate of the harm reduction/HIV program. Dr. Alpana Deshpande, a public health specialist from WHO highlighted that:

The basic problem is that no one has defined harm reduction, people have listed what the components ...this is what you need to do in terms of harm reduction so some people who come from a community setting tend to define is very broadly. They want to address HCV, TB, marginalization, homelessness and mental illness but there is no resourcing for that because the government is not going to put any money in it and the HIV program is not going to put any money in it because at the end of the day that’s not their problem. Jared Richards, the head of research at Ashray (NGO) in contrast to these stakeholders argued for a more expansive perspective. He claimed:

Harm reduction is basically the reduction and prevention of HIV and HIV transmission. That would be the classical- but you can expand it to cover physical harm, social harm economic harm. So we are looking at reducing all those sorts of harm. It is (usually) individual focused at the micro level but at the macro level there is also the concept of community harm with that to reduce criminalization- not only individual it is also community.

Other NGO leaders also were in agreement with Jared’s viewpoint but saw the pitfalls of spreading themselves too wide in terms of their mandate, especially when they worked in communities that faced multiple challenges. Funding demands, high targets and programmatic concerns further placed limitations on the nature of harm reduction work these organizations
could carry forward whether at the individual or the community level. Farah Dastoor clarified some of these ideas:

Well in terms of its interventions and what these specific activities are targeted at, yes of course they are targeted at the individual – they are of course encouraging them use clean needles, come into clinics to receive their substitution medication. But, I wouldn’t say the harm reduction is completely divorced from the larger structures especially if they…because it pushes people to think beyond the pre dominant paradigm and main stream thinking of drugs itself is bad… There is another layer to everything and the fact that it recognizes that giving up drugs is not easy and is also not desirable for a lot people even though larger society may think drug free is good, but its not practical its not real and for a lot of drug users its not something they wanted to do or they want to do at the pace that society wants or expects them to do …So I think that sort of thinking or that level of reality check and more pragmatic ways of addressing the issue of drug use has come because of harm reduction.

The fifth and the final element of the harm reduction paradigm in India is the focus on HIV. Harm reduction as I suggested before, gained its momentum in India mainly as a strategy to reduce AIDS. UNODC documents clearly present harm reduction as a “hierarchy of achievable goals”, where they accord highest priority from the most “pressing but preventable health hazards such as HIV/AIDS” to reducing drug use itself (UNODC, 2007). However, all stakeholders agreed, that in the last few years, HIV prevention has superseded all other goals of harm reduction in India. Farah Dastoor supports this and said:

The problem lies again is that harm reduction tends to take a very narrow AIDS control approach, which I am afraid it has taken in India. India boasts of now all services- like
substitution, needle exchange, antiretroviral or counseling condoms etc., but has that really changed the state of affairs for drug users… that thinking has not really percolated down or has transmitted down to the classical drug sector- be it drug dependant, demand reduction sector or the punitive sector which is your jails, your courts, police…

Rajat Dhingra from UNODC places this HIV exceptionalism in perspective, “I can tell you we have an understanding with UNAIDS that two out of three, of every dollar that we receive, is meant for HIV prevention in the context of drug use”. Clearly the government’s harm reduction activities are also under NACO and this has only furthered harm reduction’s status as solely an HIV prevention strategy. NGOs like Ashray and Sahai though balance other foci such as drug reduction, overdose prevention and rehabilitation but their funding mandates are rooted in HIV reduction. Despite strong lobbying by stakeholders, with the government, to broaden the mandate of harm reduction and include more services for drug users, the current focus remains squarely on HIV.

Overall, the Indian harm reduction model while may not have a clear political/legal stance towards drug users it supports their choice to seek treatment as well as upholds their rights and freedoms. It focuses on largely individual level HIV prevention strategies, which exists in a highly fractured socio-political environment.

By this discussion I hope to have shown that the definitions and boundaries of harm reduction are not very clear or stable. Dr. Sanjiv Murthy, a veteran public health expert suggests that this confusion of stances and positions is not as much of a problem. Dr. Murthy claims that Indian harm reductionists are:
Not really tied down or bound to any one particular ideology, if it works then we do it.

There is no one who is wedded to one particular philosophy, unlike the west where there are those who believe in harm reduction and there are those who believe in abstinence.

He also claims that the difference is very much artificial and the two philosophies are interconnected. Abstinence is the ultimate goal, but it seemed no one is in a hurry to get there yet. In fact instead of recovery, it is a continuum of care model that best represents harm reduction’s goals. Jared Richards from Ashray echoes these ideas of continuum of care:

See everybody’s concept of recovery in terms of drug using is this linear concept- from drug use to detoxification, to rehabilitation, to after care, to abstinence- that doesn’t work. What we need to have is some kind circular mechanism where drug user can join in at any point and leave at any point so if we have a continuum of care which have components of – outreach, drop in center, the general health component, (care for) TB, HIV testing, ART component, the after care- the rehabilitation, residential care component. (Drug users) have a choice to join in any point of time, and leave at any point in time, which they do anyway. So that basically gives them the best chance of survival, because, the ultimate goal of harm reduction is the prolongation of life.

Theoretical Frameworks

Drug studies and HIV literature.

Majority of social work research constructs substance use as either a criminal problem or a medical disease (Sussman and Unger 2004) and is largely quantitative in nature. However, more recently interdisciplinary social science research has shown the influence of cultural norms, values, popular perception, economic disparities, substance availability, geographical positioning of communities, health resource disparities and the influence of social policy on drug use
patterns and behavior (Singer, 1995; Singer and Baer, 1995). These scholarly works have greatly contributed my own framing of addiction within the Indian context.

Ethnographic studies such as those conducted by Kane (1981), Taylor (1993), Bourgois (1998) and Stead, MacAskill, MacKintosh, Reece and Eadie (2001) vividly describe the lives and stories of drug users and the dynamics and interactions that shape drug use within impoverished communities. These studies focus not only on subjectivities, identities, motivations and trajectories of drug users; but also on the structural inequities such as poorer facilities and services, substandard housing, poor planning and underinvestment; increased stressors from crime, violence and incivilities; and the negative social and psychological climate within these contexts. By locating personal narratives drug use and addiction within the larger narratives of socio-cultural decay and distress these researchers were able link the micro behavior with the macro concerns. This work is thus an important foundation for my own research that intends to re-contextualize drug use and recovery within macro concerns. Further, I will forefront the stories, lives and experiences of recovering drug users placing the notion of subjectivity at the center of my work.

The harm reduction literature in particular has been central to my work. In the past few years’ questions about the efficacy/ functioning of various harm reduction measures and the underlying philosophy has generated much debate and critique (DesJarlais, 1995; Fischer, Turnbull, Poland and Haydon, 2004; Moore, 2004). A large number of studies both within social work and other related disciplines have examined harm reduction interventions such as needle syringe exchange programs (NEP), pharmaceutical substitution programs and outreach efforts. Overall these studies have found that harm reduction strategies promote health seeking behaviors, reduced the likelihood of HIV infections or other blood borne viruses, increased
exposure to primary care and different treatment regimes and reduced injecting behavior (Wodak & Cooney, 2005; Ksobeich, 2003; Bourgois, 2000; Friedman and Alicea, 2001; Gibson et. al., 2008). In reviewing the literature were several aspects of harm reduction interventions studies that I used to understand my own experiences in the field.

Drawing from the work of Holt (2007), Gomart (2004, 2002), Koester, Anderson, Hoffer (1999), Ning (2005) and Pound et al., (2005) I looked at how harm reduction interventions were re-configuring drug user subjectivities. These researchers’ investigated ideas of will, agency, resistance and coercion in the drug treatment context. In the study conducted by Gomart (2002, 2004) of a French methadone clinic, she details how the staff placed ‘generous constraints’ on the clients. These rules, regulations and practices were not meant to create a ‘passive, dependent or immobile’ client, instead, it is through substitution that the drug user can learn to connect, form relationships and participate in society. In her work she argues, freedom from addiction is thus not an absolute kind of freedom but one that emerges through, in some senses by courting dependence in a controlled fashion.

Ning (2005) also addressed such issues in her work in a methadone clinic in Canada. She pointed out that drug users are often categorized as liars and unreliable but instead her work showed that this problematic behavior could be better understood as ‘complicity to achieve their own objective’. Unlike Bourgois (2000) whose work proposed that methadone clinics could be viewed as oppressive and strict sites of social control, Ning instead suggests that clients found ways within these regimens to serve their own needs. Holt (2007) developing this line of research challenges any clear binary between agency and dependency. In his work, clients struggled to see methadone as a treatment as it required dependence on medication. He further suggests, given the larger (neoliberal) emphasis on becoming a rational and risk-averse subjects,
clients’ anxiety about dependence often increased, when entering substitution programs. Building on their commentaries, I challenged the dichotomous stances that view drug users either as dependent, passive and governed by discipline or as rebellious and non-conforming. I draw on this literature to present a more nuanced view of drug users participation and resistance to the harm reduction paradigm.

Research by Sharma et al., (2003), Bastos & Strathdee (2006), Rhodes et al., (2007), Fraser (2004) and Panda & Sharma (2006) on needle syringe exchange programs was critical in shaping my arguments around the usefulness of such interventions in reducing drug use, their effectiveness in the Indian context and the treatment issues that emerge in such conditions. Harm reduction programs that have used the needle syringe exchange and outreach have found benefits, especially for the hard to reach street users (Des Jarlais & Semaan, 2005; Gibson, Flynn & Perales, 2001). Studies show that drug users understood the risk of HIV/AIDS and tried to reduce risks by exchanging used needles for sterile ones (Rhodes, et. al., 2003; Ksobeich, 2003). Despite the positive indicators supporting needle syringe programs, there are many legal, structural and geographical barriers for drug users. For instance, though disposable needles are available at pharmacy stores, IDU’s may avoid these stores both out fear of arrest, stigma or poverty (Cooper, Moore, Gruskin and Krieger, 2005). Other factors that act as barriers include the unavailability of needles in drug injection sites (for instance when the NEP is closed, and there is craving) and if the drug user is desperate to use drugs he/she may not bother with a clean needle⁴; fearful of being caught or arrested at the exchange site; drug users are also often afraid that carrying injecting equipment would place them at legal risk and they would rather share

—

⁴ There was a strong craving and drug withdrawal will overcome any risk perception of the drug and how it will be considered as a threat to the individual.
needles at the public injection site (Rhodes et. al., 2003; Small, 2007; Cooper, Moore, Gruskin & Kreiger, 2005).

Research found that drug users often had misinformation about the status of asymptomatic HIV infected people, inadequate knowledge as to how to cleanse needles effectively and lack of awareness of one’s own HIV seropositivity (Bryant & Treloar, 2006; Perngmark, Vanichseni & Celentano, 2008; Golub et al., 2007). The fear of being known as HIV positive was another barrier against safe injecting practices (Golub et al., 2007). Research has found that those drug users who are unable to inject themselves and 'hangers on' who 'contribute nothing to the acquisition of the drugs, are often the last to use the needle and at the highest risk (Gossop et al., 1997).

Sub cultural rules and norms about use also played a role in shaping safe or unsafe injecting behavior. For instance a person with the greatest resources (largest amount of pooled money, or provided the injecting equipment), regardless of HIV status, had the right to inject first (Unger et al., 2006; Crisp, Barber & Gilbertson, 1998; Kozal et al., 2005). The gender and sexuality of those present may at times be more important in deciding who is allowed to inject first (Latkin, 2007; Degenhardt, 2005; Crofts & Hay, 1991; Marsh & Loxley, 1991). Those who supply their home as a venue for injecting or those denied first use on a previous occasion as well as individuals who inject others were likely to be rewarded with first use (Johnson & Williams, 1993; Crisp, Barber & Gilbertson, 1997). Assertive individuals were more likely to secure the first use of a needle and syringe, as may those persons who need to overcome withdrawal symptoms or claim to have veins, which require a very sharp needle (Crisp, Barber & Gilbertson, 1998).
At the interpersonal level sharing needles with friends or partners was often seen as a sign of trust and intimacy and this may have prevented drug users from using sterilized injecting equipment. Loxley and Ovenden (1995) found that sharing usually took place with a close friend or lover. Respondents felt that sharing with friends was safe, as long as they knew the friend for a long time, or he/she came from the same social circle as the respondent. However, a closer examination of what 'knowing' meant indicated, that it was seldom related to an in-depth knowledge of the individual's sexual and drug using history, and only occasionally associated with HIV testing. Other practices such as the mixing of drugs in one syringe and measuring out a portion of the solution into other syringes (known as frontloading and backloading), also places IDUs at high risk (Page & Jose, 1999; Crisp, Barber & Gilbertson, 1997).

Research conducted on opioid substitution therapy provided key insights about the main concerns surrounding such interventions. Methadone is the most commonly prescribed synthetic opiate in drug maintenance programs and has been in use since the 1950s and 1960s. However, more recently Buprenorphine is being used for substitution, especially in many Asian countries including India\(^5\). Opioid substitution therapy is one of the most evaluated strategies of harm reduction, especially methadone substitution (Pauline & Kreek, 2004; Marsch, et al., 2005; Kinlock, Gordon, Schwartz & O’ Grady, 2008). Several studies have also evaluated Buprenorphine maintenance therapy and found that it was strongly associated with a drop in criminal behavior, better health outcomes and improvement in social conditions (Gibson et al., 2008; Johan, Syanborg, Dybrandt, Kreek, Markus 2003; Gowing et al., 2006; Wood, Kerr & Montaner, 2007). The efficacy of pharmaceutical substitution improves if it is in conjunction with psychological interventions, counseling and behavior therapies (Bruno, Gregory, Patrizia, 2007; Greenberg, Hall and Sorenson, 2007; Grubber, Delucchi, Kielstein and Batki, 2008).

\(^5\) Naltrexone and Levo alpha acetyl methadol (LAAM) are some other pharmacological agents.
The studies conducted by Bourgois (1995, 1998, 2000, 2003, 2009) were especially important in helping me shape my discussion around embedded contexts of drug use, the nature of harm reduction interventions and the bio-politics of pharmaceutical substitution therapy in particular. His provocative work highlights the daily struggles of drug users on the street and within clinical settings. He challenges traditional notions of risk and outlines the ways in which drug users are written out of public policy and provided isolated services that do not reflect the complexities of their needs. For Bourgois “social suffering” and “everyday violence” create conditions where drug users face institutionalized apathy and brutality. His work documents the ways in which the daily suffering generates what he calls “destructive subjectivities” of the “righteous dopefiend” which permeates all spheres of social and institutional life. Building on these similar ideas, I drew from Paul Farmer’s seminal work (2005), which exposed the way power inequities generate structural violence in different global locations. The problems of economic survival compounded with disease create conditions where people are faced with acute challenges. His work details how the connection between structure and agency often are difficult to establish, but through an investigation of circulating power networks, he shows how these become linked as old inequities lead to new conditions of social injustice. I used his conception of structural violence to detail the context of deprivation surrounding drug users in India.

Joao Biehl’s (2007) work in Brazil and Diddier Fassin’s (2007) work in South Africa, was especially important in understanding the interplay of a ‘new state-society’ partnership where patients are encouraged to participate in their recovery. Biehl’s work highlights how the state only responds specifically to these group needs, leaving out broader ‘life sustaining assistance’ for the entire population. Biehl’s work grounds the struggle of the Brazilian state and its people amidst the international developmental and pharmaceutical politics, showing why
certain people benefit, while the marginal are left behind. Fassin’s AIDS ravaged South Africa is the site where previous inequalities of the apartheid era are re-arranged in this world of disease, testing, pharmaceuticals, human rights and private experience. In his book Fassin lays out the diverse ways in which citizenship and health come into question as the struggle for resources continues. For both Biehl and Fassin the human diseased experience becomes the landscape to show how states continue to engage in politics of exclusion while at the same time embracing this new culture of social justice, equity and pharmaceutical rights.

Risk literature.

The harm reduction paradigm in India has ushered in the discourse of risk in both policies and interventions. The discussion of risk today has become the dominant mode of thinking about not merely drug use and HIV but public health in general (Petersen & Bunton, 1997). I draw from a rich theoretical body of work that examines the dimensions of risk and its relevance to our discussion on harm reduction.

Scholars argue, that this shift towards a ‘risk focused’ response is more than strategy of efficient containment of large public health epidemics. In fact, it reflects the new nature of governance and approach to management of populations within states (Foucault, 2003; Rose, 1996; Bunton, 2001). These scholars postulate that states are extending the neoliberal approach (are equated with a free market- maximized competition and free trade achieved through economic de-regulation, elimination of tariffs, and a range of monetary and social policies favorable to business and indifferent toward social, environmental and welfare needs⁶) from

---

⁶ Neo-liberalism refers to the reduced influence of the Keynesian welfare state economics and the ascendance of the Chicago School of political economy -- von Hayek, Friedman, et al. Neo-liberalism is most often invoked in relation to the Third World, referring either to NAFTA-like schemes that increase the vulnerability of poor nations to globalization or to International Monetary Fund and World Bank policies which, through financing packages attached to "restructuring" requirements, often adversely impact the political institutions and social formations of these nations (Brown, 2003).
polity and economy to social actors, institutions and policies. Classical liberalism, with a welfare rationale, emphasized the responsibility of the State for the care of its citizens. But under neo-liberalism a new thinking has evolved where there is an increased focus on costs and benefits, even social interventions are looked via the lens of profitability and competition. Moreover, these principles are filtered down to individuals/clients participating in these social programs (Brown, 2003).

To understand how broader practices of governance and power come to bear upon individual selves I draw on Foucault’s theory of power. Instead of viewing political power as something that tries to dominate, subjugate and deny individuals, Foucault highlights how power can be more usefully understood in its ability to shape and create human beings as particular kinds of subjects (Rabinow, 1984). It is not to say that the political system denies any ‘real freedom’ of the individual to act. Instead Foucault’s work draws attention to how political actions, technologies and strategies are devised in a way to promote individual and entrepreneurial actions in every sphere of life (Rose, 1993).

Individuals, for Foucault are both the subjects and objects of power; “individuals are always in the position of simultaneously undergoing and exercising power. They are not only its inert or consenting targets; they are always also the elements of its articulation” (Rabinow, 1984). This relationship between human subjects and political power is clearly one that requires empirical investigation. However, it most powerfully provides us tools to rethink about policy logics and its impact on citizens.

Citizens, these scholars argue, are now responsible for the “care of the self” (Rose, 1999, 2001; Gordon, 1991; Rose and Miller, 1992). With increased involvement of private enterprise

---

7 The logics of such rationality are not always easily visible or as fully bound; these leakages in thinking can inform our thinking about power.
in the business of social services, lowering of investments by governments in welfare and increased activism among patients and affected groups, this move toward “individualization of care” is quite evident. Rose (1998) discusses:

The guidance of selves is no longer dependent on the authority of religion or traditional morality, it has been allocated to ‘experts of subjectivity’; who transfigure existential questions about the purpose of life and the meaning of suffering into technical questions of the most effective ways of managing and malfunction and improving ‘quality of life’. These new practices of thinking, judging and acting are not simply private matters. They are linked to the ways in which persons figure in the political vocabulary of advanced liberal democracies- no longer as subjects with duties and obligations but as individuals with rights and freedoms.

Rose most effectively draws Foucault’s thinking in helping us to understand how the human being is re-configured as ‘homo –economicus’, which means that all aspects of human life and institutional action are based on such a calculus of utility, benefit, supply or demand (Brown, 2003). Individuals are given the freedom to make rational and responsible choices (Dean, 1999). It is this same ‘economic rationality’ that has popularized risk as a crucial component of health interventions. Risk is considered a reliable and calculable measure that is thus viewed as a more ‘sound’ way to make investments in the social sector. By reducing the qualitative element in these calculations, these risk models claim to be more effective as they reduce behaviors, affect and actions to variables and categories (O’Malley, 1999).

Within public health there has been a marked increase in preventive medicine and promotion of a healthy lifestyle as well as fields like epidemiology and statistics have grown in prominence and played an important part in evolving categories of at –risk subjects, surveillance
of populations and disease profiles (Miller, 2001; Petersen & Lupton, 1996). Also the growth of patients’ rights and the consumer movement have created greater awareness and impacted how health is perceived (Rose, 2005). Knowledge about risk is essential to make proper healthy choices for the modern citizen and thus has become an important in the fight for better services and treatment.

Overall, I have argued that the emergence of risk in health can be traced to three main developments. First the shift from a welfare focus to a neoliberal form of governance led to an increased emphasis on economic driven thinking. This approach paved the way for risk to emerge as a mechanism of social control and intervention, as it was believed to be more ‘economical’ in terms of investing financially in those key areas that are proven ‘scientifically/statistically’ (Gordon, 1991). The state is keen to invest in those areas that were going to provide the maximum return. Second, the growth of preventive medicine, which promotes healthy behavior for the present based on future calculations as well as the growth of disciplines such as epidemiology and statistics have reinforced the primacy of numbers and calculations over other forms of knowledge. Third, social movements and rights based struggles have evolved into consumer centric logics where the choice to be healthy is given freely. There is debate about how these three elements are interlinked and the primacy of one factor over the other. However, for the purposes of our discussion it is vital to recognize all three elements as crucial in the evolution of risk. Beyond these reasons, risk has also gained ground because development in research, which established the link between problematic behaviors and illness/disease.

I have also argued that this risk based approached has had profound implications on how marginalized groups like drug users are viewed. Some scholars argue that risk-bearing subjects
are quite often considered in isolation i.e. both in terms of the conception of the problem and in terms of its inevitable solution (Bourgois, 2009; Moore, 2004). Lovell (2002) and Burris et al., al. (2004) highlight that risk as a concept tends to largely focus on individual behaviors without necessarily examining larger issues of poverty, stigma, discrimination, legal barriers and lack of supportive health infrastructure. In fact risk, these researchers’ argue, is quite often abstractly connected to specific populations without necessarily examining the peculiar contexts that create risk in the first place (Moore and Fraser, 2006; Duff, 2003). Notions of risk and vulnerability (Rhodes, Singer, Bourgois, Friedman & Strathdee, 2005; Ezard, 2001) reinforce individualism, moving the burden away from the state or social environments (O’Malley, 1999; Pratt 1999).

These scholars propose that drug users are reconfigured into risk subjects they are obliged to adopt a ‘calculative and prudent personal relationship to risk and danger’ (Petersen & Bunton 1997). They also highlight that drug users must not only care for themselves but are given the freedom to choose health. Without acknowledging the constraints or limitations that impact their lives, public health, social work, medicine and law then question stigmatized groups like injecting drug users about their ‘irrational choices’ (Moore, 2004). Risk then presents a unique conundrum. While on one hand its usefulness as a concept in identifying groups most vulnerable, highlighting healthy options and promoting a preventive stance is undeniable. On the other hand, as I have argued before its application within the field generates grave concerns especially for the struggle of better resources, equitable treatment and just laws.

Some efforts have been underway to shift this view of this overly calculative and context free vision of risk that masks inequalities related to gender, ethnicity, race or poverty (Bourgois, 2009; Rhodes, 2002; Bourgois, Lettiere & Quesada, 1997; Friedman, Jose &

---

8 These ‘risk models’ no longer focus on the concrete subject of intervention instead on the aggregate. The individual is considered only in terms of the relationship with broader risk bearing categories; focused on the patterns of understanding the characteristics of aggregates and distributions (Pratt, 1999).
Stepherson, 1998). One of the most prominent approaches in this direction is one of ‘risk environment’ proposed by Rhodes (2002). “A risk environment approach seeks to understand the environmental determinants of harm as a means to creating ‘enabling environments’ for harm reduction” (Rhodes). This ecological approach aligns well with the approach of social work and its person-in–environment paradigm as well. These studies in risk have important implications in my investigation of risk reducing interventions such as needle syringe exchange, condom promotion and outreach. Studies by Rhodes (2002), Moore and Fraser (2006), Lovell (2002) and Moore (2004) were especially useful in evaluating the way risk discourse shaped harm reduction interventions in the field and ultimately framed drug users responses.

**Studies on biological citizenship.**

Beyond the risk-focused interventions harm reduction in India has brought in pharmaceutical interventions like Opioid substitution therapy (OST). Pharmaceuticals have increasingly come to dominate medical responses to epidemics across the globe and as researchers’ have noted, changed the way they engage with the state. To better understand these relationships I draw on an emerging body of literature on biological citizenship.

Citizenship has evolved with transformations in society and polity. Throughout the 18th and 19th century, the notion of citizenship was largely civic and political (rule of law, voting, administrative boundaries etc.) and linked to the nation-state (Rose, 1993). The citizens were duly contracted to the state through myriad laws, rules and regulations that provided legitimacy to their existence. However, it was during the 20th century the notion of rights expanded to include social rights (health, education, employment, housing, equal opportunities etc.) giving primacy to human dignity, life and liberty  (Rose and Novas, 2005). Modern citizenship is egalitarian in nature, a reciprocal relationship between rights and duties that requires a
framework (like courts, hospitals, parliaments etc.) for recognition and mechanisms through which they can be fulfilled (Faulks, 2000). With the expansion of social rights in the political sphere, the right to access to health care and medicine became critical for citizenship.

Further, the growth of pharmaceutical and biotech companies, expanding HMOs, privatization of medical care and rising costs as well as inadequate health insurance safety net have all brought health into central focus in current debates (Petryna, Lakoff & Kleinman, 2006; Rose, 2007). The growth in global mobility has heightened concerns regarding the spread of disease and epidemics as are seen in cases of the Avian flu, AIDS/HIV, SARS etc. has also forced states to participate more fully in the health of citizens.

However health is not an absolute/determinant concept. It is essentially an indeterminate, relative or elastic concept that is seen largely as the absence of problems. This indeterminacy about health especially becomes significant in discourses about citizenship. Health thus cannot become a direct aspect of citizenship i.e. government can provide conditions to support it but not really guarantee it (Osborne, 1997). Further health has no absolute boundaries and these flexible lines make it more ambiguous to demand as right or duty. We see that many states are pulling out of older curative models of nationalized health initiatives and moving towards a different model of public health. The old system primarily focused on establishing hygiene and reducing disease/illness (Ashton & Seymour1988). Some scholars argue that the nature of this new public health is reflective of ‘neo- liberalism or advanced liberalism (Gordon, 1991; Rose and Miller, 1992; Rose, 1993). In this neo-liberal environment, these researchers highlight that the individual is expected make ‘healthy choices’ after evaluating the risks and take the responsibility for shaping their own biological lives⁹. The healthy body is now an important

---

⁹ There is greater focus on the duties of the citizen and their social obligations. But these discourses are not restricted either to national boundaries or a single generation (Turner, 1990).
signifier of moral worth - where the individual can express self-control, self-discipline, self-denial, and will power (Crawford, 1994).\(^{10}\)

Foucault’s work based on investigations of the penal system and other social institutions such as the clinic, attempted to provide insight into how the modern state in the century engaged with its citizens. In doing so, Foucault theorized the way power moves from the abstract realms of state politics into the everyday life of its citizens - shaping them from the inside out. Foucault argued that modern states were no longer interested in as much to take life or repress it instead they were keen to foster life\(^{11}\). It is this notion of power that he termed biopower. Foucault defines biopower as “what brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of transformation of human life” (Foucault, 1976). Biopower was unlike sovereign power (the earlier form of state power). The aim of biopower was no longer to end life, but to move through it and shape it completely (Foucault, 2003).\(^{12}\) It is through biopower that Foucault draws the link between the state and the individual, with such an understanding of power he proposes that citizens are harnessed to participate in the state processes.

---

\(^{10}\) The consumer body has become a key marker of identity- as subjects constructs themselves in conformity with social norms and as separate and distinctive from other selves (Falk, 1994). This attention to the body is not only to ward off disease but also aesthetic. A body industry has emerged (gyms, fashion magazines, medical establishment, pharmaceutical industry) extolling the healthy, risk averting body (Koval, 1986). Along with this has developed an increasingly sophisticated array of experts of both mind and body (plastic surgeons, psychologists etc.).

\(^{11}\) In Foucault’s early work such as Madness and Civilization (1965) and later books The Birth of the Clinic (1989) such as Discipline and Punish (1978), he lays down his early thesis on subject formation. These books were based on detailed historical study of institutions (such as prisons, clinics, hospitals) and disciplines (such as criminology, psychiatry and medicine) in Europe from early 18th century to modern times. They trace the diverse ways through which individuals were drawn from populations (such as diseased, the insane and the deviant) identified, classified and isolated for apparently humane reasons. These practices of power and knowledge objectified specific groups of individuals. These modes of division can be jointly called ‘dividing practices’ (Rabinow, 1984). Foucault traces the interconnections of these dividing practices with the growth of scientific disciplines that provided rationales and techniques to categorize and contain populations ( spatially and socially).

\(^{12}\) The administration of bodies and the calculated management of life carefully supplanted the old power of death that symbolized sovereign power. Bio power was an important part of the development of capitalism – the controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of population to support the development of economic processes (Rose, 2007).
From the 17th century this power over life evolved in two basic forms (these were not antithetical), they constituted two poles of development linked together by a whole intermediary cluster of relations. One of these poles was centered on the body as a machine, its disciplining, the optimization of its capabilities, extortion of its forces, the parallel increase of its usefulness and its docility, its integration into the systems of efficient and economic controls; all this was ensured through procedures of power- an anatomo-politics of the human body (partly drawn out in his later texts of governmentality). The second pole formed somewhat later, focused on the species body- the body imbued with the mechanics of life and serving the basis of the biological processes; propagation, births, and mortality, the level of health, life expectancy and longevity can cause these to vary. Their supervision is effected through an entire series of interventions and regulatory control- a biopolitics of the population (Rose, 2007). The disciplines of the body and the regulations of the population constituted the two poles around which the organization of power over life was deployed.

Today there is indeed a proliferation of knowledge, institutions, laws and services that have focused on the human body as a site of transformation. The term biological citizenship is used to encompass all those citizenship projects that have linked the conceptions of citizens to beliefs about the biological existence of human beings, as individuals, families, lineages, communities, populations, societies and species (Rose and Novas, 2005). Rose and Novas argue unlike the age of eugenics there are different ideas about the role of biology with respect to the state. The biological responsibilities of the citizen are transforming, propelled by new technologies that are able to investigate, predict and go beneath the surface- thus the body in its
very material sense of genes, molecules, tissues, organs and muscle becomes evaluated and useful/useless (Rose and Novas, 2005; Sunder Rajan, 2006).  

The shaping of biological citizen involves more than just the state. It now involves public bodies, private corporations, health providers, insurers and individuals themselves. This means reshaping of the way in which persons are understood by authorities – political authorities, medical, legal personnel, penal professionals, potential employers, insurance companies- in terms of categories such as the chronically sick, disabled, blind, the deaf etc.. Biological citizenship can be individualizing to the extent that individuals begin now to use the biomedical knowledge to understand their own selves, which can affect self- perception and self-beliefs (Rose and Novas, 2005). In fact, this biological knowledge intersects with the regime of the prudent and enterprising individual that is actively shaping his/her life through acts of choice.

Now responsibility for the self includes both the corporeal and genetic/ molecular. These citizens are encouraged to find new ways / techniques of managing their everyday life, in relation expert knowledge. In fact carrying the similar prudence to their daily life activities and fitting seamlessly with the larger goals of the risk-averse society. These citizens must inform themselves about current illness, susceptibilities and predisposition, take appropriate steps, conduct life responsibly in relation to others, the enactment of such responsible behavior become routine and expected (Dumit, 2006; Ong & Collier, 2005).

Biological citizenship can also be a collectivizing conception, in that it links citizens through a number of different ways. Rabinow (1999) proposes the notion of ‘biosociality’ to reflect these new biosocial groupings. There is a proliferation of patient groups/ those afflicted

---

13 Certain vital developments have already become routine in medical care such as genetic testing, amencenotrisis, ultra sound etc.. These have brought forth a new perspective in viewing the human body and machinations.

14 He argues that while older forms of classification of bio-identity such as race, gender, class continue to exist, they are now being refined, re-constituted and changed under this new knowledge.
by similar somatic concerns. They are refusing the mere status of patients and forming ‘bio-
social’ groups/ collectivities (some communities are linked electronically). These biosocial
groupings around a specific health concern have a long medical history. But unlike before when
such collectivities were at odds with the medical establishment, these new groups are more
involved with the medical establishment, know greater amount of specific medical knowledge-
‘informational bio-citizenship’ and knowledge/expertise about one’s own problems (Rabinow &
Rose, 2006). They are making demands of the state to get better treatment, ending stigma,
gaining access to services, and exerting their rights bio-citizens. According to these researchers’
activism and responsibility are a part of the obligation of the active biological citizen – one who
must live through acts of calculation and choice (Petryna, Lakoff & Kleinman, 2006). These
activities and responses of the biological citizen recast the notion of citizenship, from a top down
notion (state bestowing rights) to a bottom up concept.

Now our discussion turns to one particular manifestation of these new health ties between
state and citizens (biological citizenship) that is mediated via pharmaceuticals. The emergence
of pharmaceuticals within health care has in a short while radically altered the response and
approach to disease. In the case of addiction the change towards using pharmaceuticals for
treatment has been rather slow and mired in controversy. Based on our previous discussion, the
availability/ non -availability of large-scale pharmaceuticals to marginalized drug using
populations can be viewed as one such ‘citizenship’ project. It is I argue, similar to Biehl (2007)
and Ecks (2005) conception of a type of engagement with not only the state but with other civic
institutions that make pharmaceutical care available and possible. Pharmaceutical citizenship,
thus ‘redefines belonging, exclusion, duties and rights' (Ecks). In some ways such a form of
citizenship relates to people’s access to these pharmaceuticals (who is left out), implications of
taking pharmaceuticals on their other rights as citizens (can they fully participate in civic life) and the ability of citizens to shape their survival through pharmaceuticals (what kind of life is grantee through these pharmaceuticals). Ecks based on Dipesh Chakrabarty’s (2000) argues that there is a friction between citizens who are patients and entitled to medication because he/she is fully a citizen and those who can only realize their potential as a citizen through the practice of medicine taking.

In extending this argument to the case of harm reduction in India, one can clearly see that it is this kind of tension that underlies the dynamic among those promoting and taking OST medication. This literature was extremely useful in analyzing and interpreting the broader political and social implications of the OST program in India. Drug users were now being re-cast into pill popping medicated citizens, who, my project argues evolving a new relationship with the state mediated by the medication. Governance had moved away from more punitive structures and drew on a more fundamental element of life to ‘govern’. My work draws from this body of biological citizenship literature to discuss and critique these ideas. 

**New modalities of governance and expertise.**

Harm reduction much like HIV has impacted multiple levels of polity. Previous national epidemics usually resulted in vertical health programs controlled by government bodies. But these newer epidemics not only cross traditional geographic boundaries in their impact but involve an entirely new set of partnerships between government, non-government, quasi-government, bi-lateral and transnational bodies. There are a variety of researchers’ who have attempted to study the impact and relationships of such stakeholders and how they have come together to study both disease and health.
I have drawn from the theoretical work on governmentality literature that renders drug policy and practices ‘thinkable in new ways’ (O’Malley, 1999). Drug researchers argue that the present drug policy and practices reflect the changes from such a classical liberalism model to a model of neoliberal governmentality (O’Malley; Valverde, 1999). The classical liberalism model, with a focus on welfare and the promotion of healthy lifestyle (Lupton, 1995), saw drug consumption as problematic, addictive and dangerous. The drug addict itself was seen as a deviant, whose ‘desiring subject and body’ needed to be ‘disciplined’ (Bunton, 2001). The neoliberal or advanced liberal strategy adopts a more inclusionary approach instead (Bunton). By this we mean that today neoliberal governance relegates the responsibility of health and well being to the individual. There is a redrawing of the social and health policies by promoting enterprise and self-reliance. Social work and physician based care is giving way to self help and help lines and clients are taking on the status of being a ‘consumer’ (Rose, 1996).

Previously, social problems were addressed through central planning and the state took part in providing majority of the services. Under this new system the competitive private sector meets ‘consumer demands’ and there is a ‘pluralization of intervention technologies’ or therapeutic options available for the person to use (Rose, 1996, 2007). From welfare for those individuals in need, it is broadly shifting to a system of monitoring the health of the population and identifying abstract factors that are deemed liable to produce risk in general (Armstrong, 1997). Populations are being increasingly managed on the basis of their risk profiles such as age, social class, occupation, gender, locality and consumption (Bunton, 2001). The state must

---

15 It would be important to examine how these new conceptions of self-reliance differ or support older ideas of self-change and responsibility that exist in the much older Alcoholics Anonymous philosophy.

16 This kind of thinking developed first in the private sector – practices of insurance companies, private security firms and commercial enterprises, concerned to reduce the costs of crime that fall on them (Garland, 2001). Commercial and insurance based thinking about crime control focuses upon reducing or displacing the costs of crime, prevention, rather than punishment and upon minimizing risk rather than ensuring justice. Only in the late 1980s did it begin to influence state agencies and practices.
now function by such rationalities (in many cases to the detriment of itself and its population as
seen in the case of the Third World); calculation of cost and benefit becomes central to all state
practices. Now social policy must ‘meet profitability tests, incite and unblock competition, and
produce rational subjects, it expands the entrepreneurial principle within the social sphere- thus
linking the neo-liberal governmentalization of the state with the development of a neo-liberal
social sphere and neo-liberal subjects (Brown, 2003).

While the state itself is not the center of my study – its emergence and transformation are
key to my understanding of the formulation of health-harm reduction policy. Mitchell (2006)
writes that the state ‘is an object of analysis that appears to exist simultaneously as a material
force and as an ideological construct’. While Marxist functionalist perspective saw the state as
the instrument of the capitalist class interests there were others who saw the state as bounded
institution, distinct from society regulating populations within the territory (Sharma and Gupta,
2006). More recently theorists have adopted a more critical stance and interrogated that the state
in fact can be seen in relation to or as a result of the relationships between different social
institutions such as the family, civil society what form the state takes, the everyday practices that
constitute the state (Abrams, 2006), especially arguing that the boundary separating civil society
and the state is an effect of power relations (Rose, 1996).

As serious questions are raised about the state’s cohesive, unitary, autonomous and
authoritative status in citizens’ lives, Mitchell (2006) lays out that this reification of the state is
itself something that is constituted through certain practices and discourses17. By such a turn in
the analytic, the state is deconstructed into processes, techniques, roles and institutions and the
emphasis shifts towards the way it governs, appears, enacts and transforms social bodies. In

17 Rose (1996) and Abrams (2006) argue that disciplines like political science and other social sciences have helped
to shape this view of the state’s own specific role and its relationship with those it governs.
moving away from an assumption that the state is at center of social institutions, and instead by investigating how the state comes to assume such a position as the co-coordinator of governance of social and individual conduct, “it forces us to reconsider the ‘mechanics of rules and workings of power through such apparently mundane state activities such as collection of taxes, distribution of food to the poor or the issuance of passports” (Sharma and Gupta, 2006). Power is dispersed and emerges in these roles and processes of non-state institutions, communities, and individuals (Foucault, 1991; Rose, 1996).

Ferguson & Gupta (2002) highlights that it is more important to study the mechanisms by which the ‘state’ comes into being as the “supreme” authority, one that manages all other institutional forms and social relations. By drawing from such an anthropological view of the state, which shows its multi-layered, multi-centered and dynamic nature it attempts to at the same time lay out how the state can yet appear coherent and unified. For Ferguson and Gupta the state can be excavated through the study of non-state institutions such as the family, community and economy, and these sites can in-turn be better understood through lens of governance and state rule that shape the everyday (Sassen, 1995; Ong, 1999).

I also draw from literature that examines the role of NGO’s and other private or transnational organizations in the sphere of public policy and practice. Social theorists propose, that the emergence of NGOs can be specifically linked to neoliberal approach to governance and the ‘roll back’ from traditional welfare/development tasks; government is thus encouraging private / quasi private players like NGOs to adopt these roles (Kamat, 2002; Escobar, 1995). This move is often times couched in terminology of empowerment, self–governance and personal responsibility for welfare and development (Sharma, 2008). However, these notions are usually defined in ways, which not only ignore local realities but also often replace old
hierarchies with new ones, now based on “expert” construction of knowledge and practices. I especially discuss these ideas in my work while describing the new roles peer workers occupy in the harm reduction paradigm.

The state itself, by “privatizing” these functions, is able to govern and manage without fully taking on the responsibility of welfare for its citizens- thus functioning more profitably; the NGOs, quite often remain within the framework of the state’s functioning and almost become a disjointed arm of the state. However ethnographic accounts have shown us that the theoretical tool kit of governmentality does not completely account for the often messy and complex relationships between the state and NGOs, especially in the context of the growing influence of international actors. The clients and NGO workers often behave contrary to mandates and further challenge any neat categorizations. But overall this theoretical frame of governmentality allows us as researchers to problematize state and non-state institutions and critically examine their identity in terms of practices, processes and actions instead of assuming them abstract wholes.

Non-profits in particular, have grown tremendously in the last few years, especially in countries like India. They have become a major provider of services for the state- as we see in the case of HIV. Research by Salamon (2002) shows that these organizations occupy a variety of roles besides service provision, they are involved in advocacy, representing the needs of communities, community building and even creating value. Salamon’s research highlights that this new wave of non-profits have adopted the enterprise culture- they are now competing, marketing, viewing their clients as products, segmenting their markets and differentiating themselves from others. They have also begun to build their own infrastructure and taken on a business like approach to their work. These changes as I have highlighted before reflect the
neoliberalization tendencies of the social sector in general and also reveal the way in which development, health and other social issues have now be rendered readable in new ways.

Kamat (2002) and Escobar (1995) show that these changes in the non-profit sector have increasingly also started to find new political links with organizations globally and thus in some ways bypassed the national governments. The state’s roles have evolved into the administrative, knowledge management and decision-making arenas and the non-profit and global organizations have stepped in to take over the daily tasks of intervention. Research specifically focusing on the contracting system and the welfare state also has important implications for my work. Over time as social services have become increasingly burdensome, expensive and unwieldy states have begun to contract with the private and non-profit sector to provide these services. Research shows that this balance between the public and private sector is changing as the private sector is now more and more dependent on the government to sustain it and the government is redefining its own relationship with the citizen in such cases (Smith and Lipsky, 1993). While contracting can appear to be a good mixture of government and non-government several issues of social justice, equity, geographic differences (non-governmental organizations are reluctant to work in certain regions) and division of resources become problematic.

HIV related research has particularly shown that these policy shifts have new implications for the global-local policy space. Swindler (2007) argues that with many different actors are engaging in new partnerships that cannot be easily classified. Aradhana Sharma (2008) who also draws from theories of neoliberal governmentality to talk about the growing prominence of the transnational discourse of empowerment and the role of NGOs/quasi-civic bodies. Especially in the context of India, foreign funding has helped to support the growth of
the non-state actors. Sharma highlights how increasing NGO presence points towards growing privatization of government tasks/roles. But, she argues that the Indian state cannot completely relinquish these tasks, especially as the post colonial state gains its legitimacy through these tasks. Sharma’s ethnography of a government supported NGO, shows however that the distinctions between the state and the non-state are not as clear as activities, funding and political agendas criss-cross to create a complex bricolage of power, agency and roles.

Kavita Misra’s work (2006) on the rise of the non-governmental sector, in providing HIV/AIDS related services in India, is another critical contribution in this direction. Misra uses Foucault’s theories on governmentality to show how the “modern” Indian state gains legitimacy in some ways by both ‘constructing’ the crisis of HIV/AIDS and then attempting to manage it by using discourses of expertise on health and risk. This expert discourse is also used by NGOs and ties these local actors/institutions with global institutions to change the way the AIDS (and a variety of related issues) is addressed in the Indian context. NGOs and the state work in an uneasy relationship and embedded within their struggle for health are deeper battles regarding the body, sexuality, cultural politics and individual freedom. Thus, NGOs working on HIV/AIDS emerge as critical socio-political actors often undertaking fluid and multiple roles and troubling neat categories of governance, rights and health.

Tanya Murray Li (2006) examines how notions of development are constructed and operationalized by the government, especially as failures are shaped as successes and populations struggle to assert/demand rights from the state. Li’s work highlights the goings-on within contemporary states, where hegemony and domination are “terrains of struggle”. Citizens and often even government officials compromise and negotiate with the state as it continues to both fail and hold promise for them. While my own work does not directly address the imagery
of the state, it does attempt to understand how the state is participating in addressing a public health concern. I seek to draw from Li’s work, as I attempt to understand how the citizens and non-state actors learn to negotiate and re-imagine the state in their interactions.

Ferguson and Gupta’s (2002) key ethnographic study of a maternal health project in India and shifts in the social sector within African nations has also influenced my understanding of these transactions between state, non-state/transnational actors and citizens. Their study questions any pre-conceived spatial or hegemonic mappings of state or non-state institutions. It instead forces us to reconsider how one must study these entities as they interact, combine forces, challenge and reconstruct social policy and practice.

Overall these studies provide an important theoretical foundation for my to understand the new ways in which governance and expertise is understood and analyzed within current contexts.

**Organization and Chapter Summary**

The dissertation includes a total of six chapters. This includes the Introduction, Methodology, as well as five findings chapters titled- Cracked Wide Open, Revolving Doors, A New Kind of Survival-Laying Risk Bare, Pharmaceuticalization of Health and Models, Mutants and Experts. The last two chapters of the dissertation are the Conclusion and References.

In the Introduction chapter, I discuss the key issues surrounding my research, the analytics and the research literature. The Methodology chapter details the actual process of conducting the research, the research design and the data analysis. The third chapter, Cracked Wide Open explores the historical conditions that shaped the emergence of harm reduction. I intend to both highlight the emergence of a new modality of drug treatment as well as the construction of injecting drug users as a high-risk group. This chapter will delineate the
historical involvement of key stakeholders such as the government, NGOs and show how harm reduction emerged as the solution for rising rates of HIV.

The fourth chapter, Revolving Doors, continues to examine the role of the stakeholders and their dynamic relationships. The lines dividing ‘state’ and ‘non-state’ activities are increasingly becoming hazy, also with a health -welfare and a rights-based focus the state role is not shrinking as many neoliberal theorists suggest but shifting in diverse ways. The neoliberal state is continually evolving its role as manager and knowledge producer at the same time as it forefronts its position as health/welfare provider. Confronting the tenuous links that separate the global from the local this part examines how the global agendas, funding flows and expertise travel to and within the harm reduction networks. Extensive research, developing of local disease networks of affected people, technical training, crafting new risk groups and professionalizing the practice of health are only some of the widespread ‘impacts’ of the global development agenda on the daily politics of harm reduction in India. I show how the Indian drug treatment sector participates and resists these processes of both knowledge production and management –discussing the implications of such collaborations and divergences for drug treatment in India.

The fifth chapter called A New Kind of Survival- Laying Risk Bare, discusses the needle-syringe exchange programs. These are critical sites where drug users are first inducted into this risk-focused health practices. However without adequate resources NGO’s often are forced to ration out limited supplies of clean injecting equipment. I discuss the notion of ‘embedded (within the context of use) risk’ instead of harm reduction’s notion of behavioral risk- proposing that the latter abstracts the conditions under which risk is created and sustained.
Engaging with the moral economies (Bourgois, 2009) that shape both drug use and street life I show how daily exchanges of risk are integral to both survival and health.

The sixth chapter titled Pharmaceuticalization of Health describes the rituals surrounding Buprenorphine substitution therapy specifically invoking the image of the kneeling open mouth drug user- ready to receive the dosage of Buprenorphine from the NGO worker. I discuss this ‘voluntary’ nature of this submission and its inherent problematic assumptions of the deviant, untrustworthy and risky drug user. As recovery gets reduced to largely medication and dosages, healthy life becomes inseparable or dependant on a pharmaceutical life. I argue that this limits possibilities of health rather than expands it (as the model claims) leaving those unwilling or ineligible outside the purview of recovery. This section also highlights the programmatic issues that surround pharmaceutical substitution within the country locating it within debates of drug treatment in social work.

As public institutions fail to provide even the basic services and stigmatize drug users, these patient-citizens are increasingly turning to NGO’s/civic organizations to make demands, seek services and organize themselves. NGO’s are conduits through which drug users become ‘visible’ to the state and become relevant within the national discourse. I argue that harm reduction services have helped to create political categories that drug users are able to attach themselves to, expand their reach and even bring non-injectors and their families into these ‘circuits of care’. It is through the generation of formal and informal networks that these citizens are able to chart out new ways of living within the neoliberal state. Using examples of the NGO ID card, the HIV status/CD4 count or hospital records I discuss how old strategies of survival are weaved within this new network of disease and health to survive.
The seventh chapter is called *Models, mutants and experts*, which discusses the experiences of the peer workers. The ‘peer workers’ are not only the frontline providers of harm reduction services but also the walking symbols of the ‘success’ of the program itself. Thus, on one hand, these peer workers must become and often are perceived to be the harbingers of a controlled, if not drug free, lifestyle. While, on the other hand, the peer workers constant return to drug use or failure to reduce harm in their lives reveals not only the dangers of drug use itself, more significantly, the fragility of this ‘bio-regime’ as a whole. These ‘not good enough peer subject’s’ are then, at once harm reduction’s ideal front and its most vulnerable or destabilizing link. This tension between the progressive and the risky peer worker represents harm reduction’s own strains within the Indian context. This section draws out how the drugs-AIDS industry is in fact creating a creamy layer of experts that link themselves to local contexts without necessarily contributing to grassroots activism or sharing resources with the larger affected populations. I argue that the development sector politics, limited resources, shifting global agendas and fragility of their positions all contribute to the constitution of this particular type of insular local expert.

The Conclusion chapter traces the knowledge, practices, policies and services that constitute drug use under harm reduction as a public concern. Drug users in effect represent one of the most marginalized categories. Their lives have little political and social significance in most spheres- rendered important only through their potential to spread disease and harm. My effort is not only to raise their voices but also listen to our own as we rationalize life and living, hope and survival. I conclude my linking how private concerns are constituted into a national drug crisis and get reformulated through policies, daily practices and private responses. Agency and structures collide in ethnographic intersections that seek to enrich social work discussions on
emergent diseases, health system responses, state participation and community involvement. The final chapter is titled References and includes all the citations.
CHAPTER 2: METHODOLOGY

My ethnographic research aims to understand the health policy context of the harm reduction paradigm and examine its impacts on drug users in the city of New Delhi. I began this project with the intention to examine the way the city’s dispossessed, addicted and disempowered were securing their health using the harm reduction network of programs and interventions. However, during my preliminary fieldwork I quickly realized that this story would be incomplete without investigating the broader role of NGOs, government, civic society and bilateral organizations.

Guided by my research questions, I went to New Delhi in August 2008 to conduct fieldwork for eight months until April 2009. The design of this project involved multiple methods- participant-observation in both intervention and policy settings, semi-structured and life history interviews with 75 stakeholders as well as analysis of reports, policies and programmatic and other textual material. Each of these methods of data collection occurred simultaneously and informed each other. Most sites were pre-planned but others were included as they emerged to be critical during my ethnographic inquiry. By immersing myself in the daily lives of drug users, policy stakeholders and peer workers I was able to go beyond viewing harm reduction as a uni-dimensional program.

My interest in this research topic began during my years as an undergraduate student in New Delhi, when I began working at Sahai (NGO) for a research project. Drug use issues became a core component of my work in the ensuing years as I expanded my knowledge about the local cultures of drug addiction and treatment in different parts of India. I returned to New Delhi once again in 2005 to volunteer as a research assistant for Sahai and then a few years later in 2007 to collect preliminary data for my doctoral dissertation. During this second visit I
became more deeply acquainted with Ashray another NGO, which focused on drug treatment. It was during this last visit that I also began to notice the shift in priority from abstinence treatment to harm reduction. Harm reduction had suddenly gained ground and become the new ‘it’ phenomenon; harm reduction programs were getting the bulk of attention and funds while the abstinence-oriented programs were barely pulling through. Lawmakers, activists, NGO workers and public health specialists all spoke about harm reduction as if it were a ‘magic bullet’ and were excited about the prospects it held for reversing the HIV epidemic in India. My visits to specific projects of these NGO’s only strengthened these observations. Armed with new funding to initiate these programs and I noticed that multiple non-state actors were now involved in the construction of this treatment paradigm. Harm reduction had given rise to a number of compelling concerns around health, social justice, treatment access, development, pharmaceuticals, state participation and citizenship, that ultimately became the key concerns of my dissertation. This became the turning point for my dissertation project and helped to shape my final ideas, research questions and approach.

In this chapter I will detail the research questions that guided my study, the ethnographic approach, the research design, site description, data collection and analysis procedures as well as the ethical concerns that arose during the course of my study.

**Research Questions**

During the course of my research I was guided by two main research questions.

1) How do the state, NGOs and international organizations interact, negotiate and shape 'the harm reduction paradigm'? I specifically examined:

- How is harm reduction conceptualized and promoted in the policies and programs of the Government of India?
• What are the ways in which international agencies shape and influence these harm reduction policies and intervention programs?

• What are the diverse ways in which NGO’s make harm reduction operational in their programs and interventions?

2) How is harm reduction impacting the everyday lives of drug users in recovery? I specifically looked at:

• What are the ways in which these people incorporate harm reduction into their everyday life and what meanings do they give these practices?

• How does harm reduction shape the subjectivities of drug users?

• What are (if any) the differences in the experiences of recovering drug users with diverse programs of harm reduction?

• How is the relationship between the drug users and the state /NGOs changing under harm reduction regime?

An Ethnographic Approach

My research adopted a multi-site ethnographic design. My motivation to adopt this design was primarily driven by my interest to examine the policies and programs of harm reduction through multiple lens- socio-cultural, political-economic and historical. As I discussed before, most studies within social work, view the actual construction of treatment paradigms as a black box. My work approaches the harm reduction treatment paradigm as a set of dynamic meaning making practices of real people, one that changes across contexts. To best understand these processes and the complex inter-linkages between policy, interventions and social lives I chose the ethnographic design.
The ethnographic framework has other key features that made it appropriate for the type of study I wanted to undertake. By looking at particular social phenomenon both within the current context and over time, ethnography allows the researcher to study the phenomenon in different time frames. I was keen to view historical events as elements of my analysis and not merely the backdrop to my study. An ethnographic approach allowed me to understand the logics, power dynamics and rationalities of the events in the past and the way they continue to shape the future of this treatment paradigm. Instead of a snap shot of program/policy I was able to see the way harm reduction shifted, evolved and developed over time.

Ethnography also adopts multiple epistemological positions- on one hand it understands phenomenon as constructed and subjective, while on the other it also views phenomenon as objective and real. To me, as a researcher, this inter-subjective stance i.e. real events and objects exist in the world but the frames of understanding that we apply to view them can lead to different implications and affects within our lives, was crucial in the way I approached social realities of my field site. I did not to engage in false reductionism or claim that all reality is but a perspective. Instead, I argue it is important to remain both ‘experience near’ (Geertz, 1973) while recognizing my own role as an ethnographer that is putting together this ‘social world’. Hammersley (2002) provides a pragmatic approach towards balancing these dichotomous positions and refers to it as subtle realism. He argues that research investigates independent and knowable phenomenon but all knowledge is based on human construction. For instance, harm reduction includes ‘real’ treatments such needle syringe and pharmaceutical substitution, which have visible and measurable impacts on reducing unhealthy behaviors. However this reduction in risky behaviors can also be perceived by some stakeholders, as a way to control or shape unruly populations and promote neo-liberal conceptions of personhood. I
was especially interested in adopting such an inter-subjective or subtle realist stance in order to examine these diverse perspectives of risk reduction and the varied implications it held for my participants.

Ethnography rests on the tension of ambiguity between the known and unknown i.e. it allows for the researcher to travel and change lines of inquiry as the phenomenon itself transformed. Even though I had conducted preliminary inquiries and had clear research questions, I had to remain flexible enough to move, challenge and shift my focus as the project evolved. At times I had to redraw or review the boundaries within which the exploration was to occur. I had originally, for example, intended to interview only the officials working exclusively on harm reduction but soon realized that issues of drug use and harm reduction came under the purview of HIV/AIDS specialists. This meant, I needed to extend my reach and examine harm reduction within the broader context of HIV. I also had to move across a variety of settings from hospitals, training centers, research institutes, drug recovery clinics, bi-lateral organizations and global funding agencies following the trail of harm reduction activities, interventions and programs. While some of these sites were pre-determined others became significant during the course of my inquiry. An ethnographic approach allowed for this dynamic movement even within a well-defined research space.

As a final note, most qualitative research, and ethnographic accounts in particular, are often de-valued as they are seen as invalid or too local to have any usefulness outside the specific setting of the study. I will now discuss these issues of validity, reliability and generalizability.

Guba and Lincoln, (1982) argue that the validity of research knowledge must not be based on the fact that “we were there and the participants know”, instead researchers must remain vigilant about the assumptions and inferences are made, the data that constitutes evidence
and the rationality behind an argument. In my study I undertook many steps to assure the validity and reliability of the data collected. In doing so, I do not revert to post-positivist explanations of neutrality, confirmability and credibility. Instead, the validity and reliability of my findings rest on prolonged engagement with concern and my participants, persistent observation over time and across contexts; and using different methods such as observation, interviews and textual data. I also used member checks i.e. going back to some of the stakeholders to confirm my findings and interpretations. I have painstakingly tried to assure the reliability of the accounts by triangulation of data from multiple sources, including multi-vocal narratives, and generating accounts that are authentic to my experience within the field (Lincoln and Guba, 1985; Mishler, 2000).

Another critical issue related to ethnographic work is the concern of generalizability i.e. the way can one particular example, case study, population or context be used to explain the phenomenon overall. Quantitative studies instead use logics of sampling and statistical theory to mitigate concerns of generalizability and claim qualitative lacks the ability to do so because of the specific nature of its study and small sample size. My research is based in New Delhi and focused on the dynamics of harm reduction within this context. At the same time, I view it as a site to observe the interaction of diverse stakeholders, ideas and processes as they unfold and understand their implication for broader issues of treatment, public health and governance that can be applied globally. The danger here is to then assume all specific examples are but illustrations of larger, complex and more abstract concerns. To avoid such a misstep, I advocate instead a dialogue between the micro and macro.

In describing the extended case method Michael Burawoy (1991) highlights the manner in which the researcher can examine "the macro world through the way the latter shapes and in
turn is shaped and conditioned by the micro world, the everyday word of face to face interaction’. Burawoy argues that the goal of good social scientific research is to not only to learn about a situation but also from that situation- to make claims that will have validity beyond the current context. By connecting specific processes, events and observations to other examples in different contexts by using theoretical frames, the specific can become generalizable. But it is not always theory confirmation that assures generalizability some times though there are departures from theory similar results, descriptions of issues and contexts of phenomenon can be also generalizable. My work hopes to both contribute to theory and the silences/gaps in the theory, as well as recoup marginalized voices of addicts who are often written out of ‘scientific’ renditions of addiction.

**Research Design**

I am including a table to show the various elements of the ethnographic research design.

<table>
<thead>
<tr>
<th>Research Question 1</th>
<th>Sites</th>
<th>Sampling</th>
<th>Inquiry details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. How does the State, International Organizations and NGOs shape harm reduction?</strong></td>
<td><strong>Participant Observation</strong>&lt;br&gt;1. Policy/Advocacy Meetings&lt;br&gt;2. Trainings for peer workers&lt;br&gt;3. NGO forums&lt;br&gt;4. NGO projects of Ashray and Sahai</td>
<td>These sites were chosen based on their relevance to the research concerns</td>
<td>1. Policy/Advocacy Meetings-3&lt;br&gt;2. Trainings for peer workers-2&lt;br&gt;3. NGO forums-3&lt;br&gt;4. Ashray and Sahai project sites in Nadi Nagar and Kharagpur-3 Months at each site &amp; approximately 10 hours each week.</td>
</tr>
<tr>
<td><strong>Interviews</strong>&lt;br&gt;1. Government Officials</td>
<td>Snowball and purposive sampling</td>
<td></td>
<td>1. Government Officials-3&lt;br&gt;2. NGO workers-34</td>
</tr>
<tr>
<td>Research Question 2</td>
<td>Site</td>
<td>Sampling</td>
<td>Inquiry details</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>--------------------------</td>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>How is harm reduction shaping the lives of recovering drug users</strong></td>
<td><strong>Participant Observation</strong></td>
<td>Snowball and purposive sampling</td>
<td>All clients who accessed the harm reduction treatment programs. 3 Months at each site &amp; approximately 10 hours each week.</td>
</tr>
<tr>
<td></td>
<td>Ashray and Sahai projects at Nadi Nagar and Kharagpur (NGO’s, New Delhi)</td>
<td>Snowball sampling</td>
<td>17 clients were interviewed. All were male except 1 female.</td>
</tr>
<tr>
<td><strong>Life History Interviews</strong></td>
<td>Snowball sampling</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ashray and Sahai projects at Nadi Nagar and Kharagpur (NGO’s, New Delhi)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Textual Analysis</strong></td>
<td>Relevant documents were identified by the researcher and key stakeholders</td>
<td>Over 50 documents, materials and reports were included in the analysis</td>
<td></td>
</tr>
<tr>
<td><strong>Review of policy documents, research related specifically to harm reduction, annual reports, program documents and bilateral/international agencies documents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. NGO workers
3. Bi-lateral Funders/International development organizations
4. Public health consultants
5. Civic society leaders

3. Bi-lateral Funders/International development organizations - 6
4. Public health consultants - 9
5. Civic society leaders - 8
Site Selection

Unlike most traditional ethnographies however, my research was embedded in multiple sites that were chosen based on the dynamic nature of harm reduction and evolved organically during the course of the study. In this section I discuss the different sites and their contexts.

As I discussed in the previous chapter I had chosen New Delhi as my site to investigate this new model of public health. The city has a high drug-using population and some of the longest running harm reduction programs in the country. Its importance as a site is enhanced by the presence of major international organizations and government offices, making it a critical center for harm reduction policy and intervention. I will now describe the main settings within New Delhi.

Policy meetings. In order to understand how various policy stakeholders interact and how harm reduction policies and programs are formulated I chose certain policy settings to conduct my research. Since harm reduction policy is largely subsumed under the HIV rubric I attended a number of events/celebrations, policy meetings, advocacy sessions and trainings that were related to both HIV and drug use. The advocacy meetings were usually hosted by the civil service organizations and NGOs usually in collaboration with the UN agencies. Trainings for peer workers were conducted by NGO workers but supported by the government. Strategy and policy focused meetings were a collaborative joint effort by a number of different agencies and often included the government as well.

I was usually invited to these meetings either by the NGO workers or by one of the civil society agencies. The meetings were held in public halls, conference centers and a few times within the offices of the stakeholders. I chose these events based on the importance and
relevance to the key focus of the research. The policy meetings and those focused on advocacy provided insight into inter and intra stakeholder dynamics. It helped to shed insight into the way the stakeholders’ talk about and frame harm reduction; they also were useful forums to see how each stakeholder interpreted issues of health and treatment. NGO forums and training sessions were equally useful in providing information about activism, issues of knowledge transfer, problems in training workers on harm reduction and diversity in perspectives about harm reduction. I was unable to attend any donor meetings or high-level policy negotiations due to the confidentiality concerns.

These are the following organizations whose officials I interviewed during the course of my study

1. Government
   • National AIDS Control Organization (NACO)
   • Ministry of Social Justice and Empowerment (MSJE)
   • National Institute of Social Defense (NISD)

2. International Organizations
   • United Nations Office of Drug Control (UNODC)
   • United Nations Joint Program on HIV/AIDS
   • World Health Organization (WHO)
   • World Bank

3. Bi-lateral Organizations
   • DFID (British Development Organization/PMO)
   • GTZ (German Development Organization)

4. Civic Society/NGO/Public Health Consultants
• Lawyers Collective (civic society)
• SPYM (NGO, Delhi)
• All India Institute of Medical Sciences (hospital)
• HIV/AIDS Alliance (Research/Consulting)
• Futures Group (Health Consultants)
• Bill and Melinda Gates Foundation (Donors/implementing organization)
• Clinton Foundation (Donors/implementing organization)
• Population Council (Research/Consulting)
• Family Health International (Research/Consulting)
• India Network of Positive People (civic society)
• Delhi Network of Positive People (civic society)
• Indian Harm Reduction Network (civic society)
• SASSO (NGO, Manipur)
• Emmanuel Hospital Trust/ORCHID (Hospital/Non-profit North-east)
• HIV/AIDS CARE (health organization)

**NGO settings.** To understand the way harm reduction programs were being implemented on the ground and to learn about the life experiences of drug users and peer workers I chose to situate my study in two NGO settings.

Sahai and Ashray\(^\text{18}\) are two of the most prominent harm reduction NGO's of the country and they served as the primary sites for my fieldwork. I focused on the pharmaceutical substitution and needle exchange programs in the communities of Kharagpur and Nadi Nagar. These programs were run by these NGOs, in conjunction with the Government and international

\(^{18}\) Name changed
agencies. These programs are in the highest drug-using sites of the city and were considered successful models by these NGOs. Both of these organizations were also chosen because of their involvement in a wide range of activities beyond providing harm reduction services. These include policy formulation, participation in national and international alliances, conferences or coalitions, partnering with foreign universities and transnational organizations to conduct research/interventions and supporting both state and non-state actors in the country.

Over nine years ago I first came into contact with Sahai (in Hindi means support) during the course of my undergraduate research thesis. Through the research process, I began to learn about the organization and its crucial role in pioneering drug recovery in India for over twenty years. Sahai was clearly a leader in the field, with vast experience and multiple projects within Delhi. Sahai is a therapeutic community that was started in early 1980s by Regis Monterio and his wife. Sahai’s most famous legacy is its 70-bed drug rehabilitation center, in the heart of the city. They also run a hospice care for HIV positive drug users, a women’s treatment center and many community projects across Delhi and few other states in India.

Over the course of the next few years I also came into contact with Ashray (meaning shelter in Hindi) a sister NGO of Sahai. Established in the 1980s by Owen D’ Souza a recovering drug user, Ashray began as small peer led organization that worked on issues of urban poverty and drug use. Over the next twenty years it grew into a large NGO with projects all across the city of New Delhi and India. Owen shared, “Ashray started off as an agency not involved in drug use we simply were looking at issues related to health, related to justice, related to a national context of poverty…our roots were Christian since we emerged from a Christian rehabilitation center”. It was hybrid organization of professionals and “affected” individuals, in the early 1990s their focus shifted more specifically to drug use issues and later HIV. Ashray
has played a critical role in bringing harm reduction discourse into the mainstream drug
treatment paradigm. It undertakes direct intervention work funded both by international donors
and the national government.

Both Ashray and Sahai began their journeys together. Their leaders are closely related
to each other, thus over the years the organizations have collaborated and exchanged knowledge,
projects and even staff. However, their divergent histories are reflected in their practices of harm
reduction services as well. Ashray’s mandate is to address drug use within the context of urban
poverty and harm reduction programs were seen as pragmatic and necessary response to
community needs. Most of Ashray’s staff is currently on the harm reduction program and clearly
identifies itself as a “harm-focused” organization. Sahai on the other hand has essentially always
first seen itself as an institutionalized drug abuse treatment program. Harm reduction services
have been added to Sahai’s repertoire much later, in response to changing needs of clients and
knowledge about drug treatment services. In fact, most of Sahai’s staff at its projects followed
an abstinence model of recovery. The balance between these two elements remained an essential
source of tension and strain within the program.

I will now provide a brief description of the actual field sites of the projects in Nadi
Nagar and Kharagpur to detail context of my research.

Ashray, Nadi Nagar, New Delhi. “People either come here dead or come here to die”, was
how Muquim a street drug user described his community of Nadi Nagar\(^\text{19}\) (community by the
river, in Hindi) during my very first visit to my field site in 2008. I had only traveled about two
hours from one end of the bustling and modern New Delhi to the other end of the city. Moving
from a car, to a train (metro) and then finally to a rickshaw, I finally reached the community
located in the heart of “Purani Dilli” (old city in Hindi). The journey itself was not extraordinary

\(^{19}\) Name changed
in fact I knew many who made this journey every day for work, business or to see family. But I also knew as a native that this was a different world- a chasm so wide that the two hours felt more like traveling back two decades.

The walled city\textsuperscript{20}, with its labyrinth of small lanes and crumbling old forts, which nestle small industries and shops, is bursting at it seams. Nadi Nagar, a Muslim dominated community most known for housing Delhi’s busiest crematoriums\textsuperscript{21} is also the site of Ashray’s\textsuperscript{22} (meaning shelter in Hindi) oldest projects and one of the country’s first harm reduction interventions. The road leading to Ashray’s project is lined with chai (tea) stalls, dhabas (street restaurants) serving eggs, rice and dal (lentil), barber shops as well as street vendors selling brightly colored marigold, jasmine and rose garlands, wood, woven mats and other materials needed for the last rites. As evening falls, the vendors and businesses are replaced by hundreds of Delhi’s homeless, who sleep on the pavement protected by the tall white and dilapidated walls of the ‘ghats’ (Hindi term for an area built on the river bank with a series of steps leading to the river, often used for ceremonial rituals and bathing) of the river Yamuna.

At every 20 feet of the road a set of broken cement stairs lead you up from the main road and then down to a narrow alley. The alley way is lined with brick homes, small temples, open public toilets and abandoned buildings. As I walked along through the alley, between the rubble and mayhem I caught sight of the river, sparkling brightly in the morning light. But this is an illusion of course, because much like the rest of this Dilli (Hindi term for Delhi) the river Yamuna too is dying. Clogged with industrial toxic waste, city sewage and filth from domestic

\textsuperscript{20} Old Delhi has remained the capital from the Mughal period, once the seat of power and culture. It has many old forts, palaces and buildings. The old city is enclosed by an old fort wall enclosing 1500 acres with many gates. While the physical walls have been broken down or demolished over the years, the area remains cut-off from larger currents of development within the city.

\textsuperscript{21} The reference to death is recurrent and both directly in reference to the city’s dead who come here to be burnt as well as the large number of homeless and poor migrants who seem to flock here as if only awaiting death.

\textsuperscript{22} Name changed
pollution- the Yamuna was probably the community’s biggest symbol of decay. I wondered, and not for the last time during my fieldwork, how Ashray’s workers kept hope alive in such desperate surroundings.

Ashray has two separate sites in Nadi Nagar, one that provides OST (opioid substitution therapy), abscess management and Needle Syringe Exchange Programs, funded by the central government’s National AIDS Control Organization (NACO). The second site barely a mile away, funded by the Delhi State Aids Control society (state government) provides only OST and abscess management services. Each project site had 2-3 small rooms and a large courtyard where the activities were carried out.

My days at Ashray would usually begin around 10 am watching as workers cleaned and set up, in preparation for the clients. I roughly spent equal time at both the sites of Ashray. The Nadi Nagar projects are Ashray’s flagship sites and thus became a natural choice for me to study and observe. Ashray’s Nadi Nagar project started almost 10 years back and over the course of these years it has been funded a variety of international and national institutions. According to many of the clients the range of services (from nutrition, shelter, job placement or even water for bathing and grooming, clothes, and education) are shrinking ever since the government has taken over funding.

*Sahai, Kharagpur, New Delhi.* Sahai’s 23 (in Hindi means support) Drop-in center (DIC), was located a few kilometers away, in the Muslim dominated community of Khargpur 24-northeast part of Delhi. Largely composed of evicted groups from other regions of the city (during the 1980s urban renewal programs), it includes a fair mix of low and middle-income homes- the community is considered still “in transition”. I had taken the sleek and shiny new metro

---

23 Name changed
24 Name changed
(subway) to reach Kharagpur\textsuperscript{25} on one of my first trips to the field site. However, once outside the train station, I was barely able to pay any attention to the vista of the community that stretch\textsuperscript{ed} before me. I was busy navigating the crowded Kharagpur roads. Careening buses, overflowing community taxis and speeding rickshaws have literally made this main road a death trap\textsuperscript{26}. A large and equally busy over bridge adds to the chaos of this intersection. Under the bridge is a dangerous, dusty, noisy, narrow dirt patch, which happens to be home to a large number of street drug users and their families. As I was crossing the road I noticed them, they went along their daily chores ignoring the cacophony around them, later I would get to know some of these families through outreach with Sahai staff.

Once on the other side, I made my way from the crowded road and into a small lane lined with homes and shops that were tall enough to block the sunlight. After walking a few dingy blocks, I noticed a small board that signaled the entry to Sahai’s offices. The DIC would usually open by 9 am each morning. The staff would begin their day by cleaning the rooms, sterilizing medical equipment and setting up their workstations. The center had four rooms, all stacked up one behind the other. The front room was for dispensing medicine and abscess management. The largest room was right behind it, this is where the clients would stay all day, usually watching T.V., chatting, sleeping and eating. The room next to it was used for counseling and staff meetings. The last room included a small kitchenette and a computer for administrative work. Funded by a private agency Sahai had greater flexibility in terms of its role, but because of the limited time for which funding was available Sahai’s work was always restricted.

\textsuperscript{25} Even though Kharagpur is an old community it is not adequately connected to the main city- the introduction of the metro seemed like the biggest development the area had seen in a long time.  
\textsuperscript{26} This road junction was in the top two roads of Delhi in terms of accidents.
I had first met Regis during my undergraduate research project and while physically he hasn’t changed much— the cockscREW curls, the lean frame with his famous footballer legs and bright eyes, it is clear running this NGO has taken its toll. The current economic climate has meant that many of Sahai’s oldest projects including its famous rehabilitation center have had to downsize or completely shut their doors. A large number of his old staff have either relapsed, died due to overdose/ HIV, or have moved to other organizations. During my fieldwork the NGO was not only undergoing its toughest financial crisis in years but also facing a crisis in its staff.

Sahai and Ashray have evolved into their present roles as harm reduction NGO’s through different routes – while Ashray has grown organically, Sahai has been a late entrant. However on the ground both these NGO’s negotiate similar community conditions, structural barriers and stakeholder dynamics. As I moved and worked between these two NGOs, I was able to meet hundreds of clients (a term that was commonly used to refer to drug users by the NGOs) who came everyday to both Ashray and Sahai’s centers in Nadi Nagar and Kharagpur. It was through these relationships, interactions and stories that I began to see how “gestalts of recovery” and “environments of care” were created differently by each of these NGOs.

Data Collection

The first month of my fieldwork was spent in renewing old contacts, developing schedules with the NGO’s and making linkages with a variety civic society institutions, international organizations and activist groups. While my previous relationships at both Sahai and Ashray were very helpful in gaining a foot hold in the NGO sites they were also surprisingly useful in opening doors in the policy arena. The leaders of both Ashray and Sahai are well respected in the field and it was their goodwill that helped facilitate meetings with both
government and bi-lateral agencies. Most policy officials and experts were extremely busy and found it challenging to give me enough time to discuss issues in detail, thus often leading to multiple meetings and many informal conversations. After an initial set of interviews it was through a snowball and purposive sampling method that other specialists were identified.

Within the NGO context, the staff at both Ashray and Sahai were especially helpful in facilitating the initial interactions with the clients, guiding me through the community and keeping me safe. While I realized that this may prevent clients from directly approaching me, it was the only way to negotiate these contexts. Clients at Ashray were used to researchers and opened up to me almost immediately talking about their addiction, critiquing Ashray and discussing their concerns. The organization had a much larger space and open lay out that offered more opportunities to interact with clients informally. At Sahai, clients were not really sure about my role and more slow to open up. The daily routines and the physical lay out (especially the cramped space) allowed for little individual interaction with clients – without the presence of NGO workers. A watershed moment was the time when the organization had to shift their premises a number of times. These transitions provided a greater opportunity for interaction and helped me establish a relationship with many clients.

I had originally planned to spend six months with both NGOs, dividing my time in a week. However upon reaching the field, I realized it would be more productive to spend three months in each site exclusively and gain a deeper understanding of the dynamics of each NGO. I would usually spend time until mid afternoon at the NGO site, by which time bulk of the client related work would be completed. Both NGOs would shut down by 4pm, workers would spend an hour after that for paperwork. During the afternoons I would set up appointments to conduct interviews with other stakeholders i.e. government officials, public health experts, lawmakers,
funders, bilateral agency experts etc. On days when there were conferences, workshops or policy meetings I would prioritize those over visiting the NGOs. Over the course of week I would spend approximately fifteen to twenty hours at the NGO sites. The rest of the time was spent conducting interviews with stakeholders, attending conferences, workshops or meetings and collecting textual material.

**Methodology and Sampling**

In this section I will provide details about the methods used and sampling procedures to collect data.

**Research question 1.** How does the State, International Organizations and NGOs shape harm reduction? To answer the first research question I employed several methods:

- **Participant observation in policy settings.** Participant observation in policy settings was necessary to understand the actual processes, activities, negotiations and conflicts that gave form to the harm reduction policies. As outlined before I conducted participant observation in a variety of policy settings and focused my primary attention on a few key players.

  The stakeholders that I observed most closely included- the government bodies of National AIDS Control Organization as well as Ministry of Social Justice and Empowerment and their bureaucrats, the NGO’s Sahai and Ashray and their workers, as well as international organizations and donors, such as the United Nations Office of Drug Control (UNODC), The Joint United Nations Programs on HIV/AIDS (UNODC), and the Bill and Melinda Gates Foundation (BMGF). I also paid attention to the participation and roles of civic society groups like People Living with HIV (PLHIV), Indian Harm Reduction Network and Lawyers Collective. All of these stakeholders were chosen due to their prominent role in harm reduction policy and
programming as well as their dominant presence within the New Delhi HIV-drug use sector. These stakeholders represented a diverse set of perspectives and points of view.

Within the policy context, I conducted participant observation where key stakeholders (NGOs, bilateral organization, civic society and government) converged to discuss harm reduction policy and interventions. I attended NGO led and government sponsored training workshops for outreach workers, national conferences for injecting drug use, HIV and Hepatitis, where both government, bilateral organizations and civic society were represented, workshops conducted by technical experts, national coalitions of people affected by drug use and HIV as well as public health campaigns and advocacy group meetings.

Each of these settings provided unique opportunities to understand stakeholders’ views as well as actions with regard to shaping harm reduction policy, developing risk focused health strategies, new ways of thinking about addiction or recovery and adapting human rights to the discourse of harm reduction. It was also useful to understand their relationship with other stakeholders.

In each context that I observed I took special care to inform the facilitator about my role and permission to be present. In some cases when this was not possible I informed the stakeholders I was observing, about my goals prior to the meeting. Over time, most stakeholders had either met me or heard of my work and I no longer needed to explain my special presence at these settings. Despite the large group of stakeholders involved, the key representatives who participated in these meetings remained relatively small and limited. This made my task easier, as I was able to easily identify and track these stakeholders across a variety of contexts.

My role as a participant observer in these contexts was challenging. I would take copious notes about their interactions, affect, speech and body language. Even though I was
focused on these key stakeholders I would also make notes about other groups present at these meetings. I paid attention to formal rhetoric and public discussions as well as informal conversations. Throughout this process there were times when I could not take notes, but would do so after I returned home. As I became more familiar with the stakeholders I began to notice patterns of interactions, specific agendas, cliques or alliances, specific stances, ways of communicating, power balances and hierarchies; special events, arguments, and negotiations were key areas of interest to me as a researcher, since it helped to especially highlight the stakeholders’ viewpoints.

I also slowly began to participate more actively at some of these meetings, trainings and workshops, by actually engaging in discussions or group activities. While I had developed individual relationships with each stakeholder, in these forums I had to appear neutral and not aligned to any one group. This was not only a delicate balance of diplomacy and engagement but sometimes stressful due to the underlying tensions that existed between the stakeholders.

**Participant observation in NGO settings.** A crucial element of the participant observation was to understand the specific role of the NGOs. I conducted extended participant observation at both Sahai and Ashray. I was primarily working at the community project sites but also spent time observing the NGO workers when they attended policy meetings.

In order to fully understand the role of the NGO I roughly followed two groups of peer workers/NGO staff. The first group of about four workers from both Sahai and Ashray were involved at the administrative, research and policy level work. I would shadow them as went to policy meetings, conducted trainings, attended workshops and managed the harm reduction programs on the ground. This group was educated, English speaking and belonged to the middle
or upper middle class socio economic group. All these workers were men and were aged between 30-60 years.

The second group that I observed included eight key workers from both the NGO’s, who were involved in direct intervention on the ground. I would observe this group of staff as they conducted their interventions (needle syringe exchange, counseling and outreach). This group was largely composed of Hindi-speaking, semi-literate and belonged to the lower economic class. This skewed sample represented the composition of the group. My sample group included one female but the rest were male, their age range was 20-50 years.

I chose members of each group of peer workers based on their willingness to participate as well as their role and position within the NGO. The pace and routine of both these groups of peer varied and I had to constantly adjust depending on their schedules. For the first group of workers there were no set routines and I was often asked to join them on a moment’s notice to attend a meeting or training. The second group of workers had a much more clear set routine of certain activities within a day and I would follow them as they went about their activities.

All clients and staff knew my role as a researcher, though some did not completely understand its purpose. I would usually take field notes during the time I observed and they even dubbed me as the ‘lady with the notebook’. I took note of their manner of service delivery, interaction with clients and other stakeholders, involvement with the community, how they translated abstract concepts of harm reduction into practice and their stances within different policy contexts. Whenever possible I would help in administrative tasks like taking down names and ages during outreach, compiling data for their annual report, help file paperwork, develop presentations and conduct a SWOT analysis.
Semi-structured interviews with stakeholders. The semi-structured interviews were conducted with key members of each of the aforementioned stakeholder groups and other important stakeholders. These members were chosen through snowball sampling. The NGO heads provided a list of names and contacts of key people involved in harm reduction work within the capital. I would usually contact them and set up an initial meeting to meet them and share about my work. Following this meeting we would set up a mutually convenient time for a second meeting and interview. I found that over the course of two meetings there was better rapport building and time to engage in a more detailed discussion of the issues at hand. It also helped to clarify previously discussed concerns and validate previous comments. In some cases where the participants were too busy to meet twice again I would have a formal interview and often follow up with an informal telephone call. I would also talk with these stakeholders during the course of participant observation at various policy settings.

The interviews itself were usually conducted in the offices of the stakeholders or in a private space. The questions included the context of harm reduction policy, its history in India, the rationale behind these new interventions, the perceptions and concerns about harm reduction, the relationships with other stakeholders, the perceived benefits and problems with harm reduction. The interview protocols are attached in the appendix. Even though the questions were pre-formulated, I would usually include few follow-up probes based on the answers. I also made certain adjustments in the questions depending on the person I was interviewing and based on their expertise/role. As I went along the interview process I began to frame questions more effectively based on my previous experience. The interviews lasted approximately for an hour to an hour and a half and were conducted in English and Hindi. All the interviews were recorded and transcribed.
At the end of each interview I would ask the participant to refer me to other stakeholders within the field. I continued this process of sampling until I had reached data saturation i.e. the interviews were revealing no more new information. I tried to meet with at least two members from each organization who worked at different levels within the organization. Since harm reduction is fairly new and an emerging field the number of people working on this issue specifically are limited. I was able to access most key national and regional leaders in the field through this process.

**Semi-structured interviews with NGO workers.** Similar to the interviews with the stakeholders, I conducted semi-structured interviews with NGO heads, project co-coordinators, outreach workers and counselors. These interviews were aimed to shed light on the role of the NGO in promoting harm reduction both within the grounded contexts of practice and the policy contexts.

These members were chosen through both snowball and purposeful sampling. I first asked the NGO heads to provide me names of key people within the organization that I could interview. At the conclusion of those interviews, I asked for referrals to others within the NGOs. I also interviewed those peer workers with whom I conducted participant observation (both groups of peer workers) as well other key workers within the NGO. Sample size was determined by the data collected i.e. once I reached data saturation I stopped conducting more interviews.

Since most of these workers were also ‘in recovery’ my questions explored not only their professional roles and views about harm reduction (especially issues around service provision, client relationships, funding concerns, community issues) but also their personal experiences. These interviews were particularly helpful in clarifying my observations and understanding their actions. By triangulating the data in this manner, I was able to gain a better
sense of their perceptions, rationalities, pressures and negotiations around what they called ‘harm reduction’. Similar strategies were used around questions, probes, confidentiality concerns and question formulation, as discussed in the previous section.

**Textual Data.** I reviewed textual material -policy, legal and administrative documents related to harm reduction, newspaper articles, reports and policy briefs and NGO literature, to supplement my primary data and historically contextualize the research. I collected this literature from the stakeholders’ offices and public libraries. My sampling of this material was driven by questions generated in the observation and interview data and the research questions. Since there is very little scholarly work on drug related issues, the main data source is the in-house research and reports of development agencies and NGOs. I collected all key materials dating as far back as the early 1990s when the HIV epidemic first began.

**Research question 2.** How is harm reduction shaping the lives of recovering drug users?

The methods employed to answer this question included:

**Participant observation in NGO settings.** Within the intervention context, I conducted participant observation with recovering drug users or the ‘clients’ of Ashray and Sahai. I wanted to gain insight into the actual daily life struggles of clients and go beyond their words.

Observation data is also a powerful way to both validate narrative data but also raise concerns that would have been otherwise ignored. I observed the clients of the two projects of Ashray and Sahai as they accessed harm reduction services. I focused on how they accessed the two main services - Opioid Substitution Therapy and Needle syringe exchange programs. I paid attention to their actions, comportment, affect, talk, interactions with NGO workers and other clients.

I would take detailed notes to keep track of these interactions and though I could not take notes during outreach I made a record of the events upon reaching home. I noticed both
short term and long-term changes—especially noting how those who participated in the programs enacted their recovery. The process of participant observation was both tedious and enlightening. While it was not always easy to keep track of the events in the NGO, considering the large number of people who came and complex number of activities that occurred almost simultaneously it also became an incredible source of information. I was able to crosscheck assumption, challenge my own ideas and reveal discrepancies in the people’s thoughts and actions.

The regular clients of these two programs were all male with only one female client. The only time I saw other female clients was during outreach in the red-light areas of the city. However, since these women never came to the NGO for other services I did not include them in my study. The clients ranged in age from 18-65 and belonged mainly to the lower middle class. Most of the clients possessed very little education and were without any formal form of employment. Many had a criminal background (besides their use of drugs) and a large number were HIV positive.

*Life history interviews with drug user clients.* In order to gain a deeper understanding of the lives of these clients, their trajectories of drug use, their current struggles with recovery, street survival and harm reduction I conducted life history interviews with clients of the two harm reduction projects. The sampling procedure was both purposive and snowball sampling. Project heads first provided me a list of clients who they identified as ‘stable’ (can provide consent and understand the implications of their participation) and willing to participate in an interview. These clients had spent a minimum of two months in the program and a maximum of about two years. Since many clients were continuing to use drugs and had other mental health concerns the NGO heads were mainly responsible for recruiting. After each interview I asked the client to
provide a referral to other clients. After seeking the required clearance from the NGO head I would approach the new client asking them if they would like to participate in the study.

I would choose a secluded place to conduct the interview and would often sit with the client for more one single session. These interviews would last for about one to two hours and were recorded and later transcribed. These interviews began with a small set of probes the questions were driven by the narrative of the client. The questions were focused on their experiences as a drug user, treatment issues, acceptance and understanding of harm reduction, problems with the NGO, community/family concerns and outlook for the future. I also asked about their specific impressions of the services such as needle syringe exchange, outreach and OST. I have attached an example of the protocol in the appendix. After the interview I would continue interacting informally with the participants and keep hearing updates about their lives. These recorded interviews were later transcribed verbatim.

**Data Analysis**

One of the crucial challenges in analyzing ethnographic data is to manage the vast quantity of data collected as well as evaluating, interpreting and theorizing. During the first stage of this process I transcribed each interview verbatim. This was a long process that continued over a few months and extended for about five hundred hours. Since some of the interviews were in Hindi, I transcribed them in Hindi and later translated them for the purposes of this dissertation. Transcribing and translation are often seen as the first step in the data analysis process. This is because both of these procedures require a first level of transformation of data from oral to verbal. During this process I was careful to make notes about the emotions, context of the interview and body language that provided the framework for this talk.
Next, I analyzed these transcripts using strategies of both content and narrative analysis. After multiple readings of each transcript I highlighted critical themes/concepts, using an emergent coding scheme (Denzin and Lincoln, 1994). This process involved a close reading of the interviews, selecting key quotes that reflect important ideas related to our research question. I paid attention to both overt and latent content i.e. focusing on participants’ talk and their intentionality. I also made note about the overall patterns, ideas and focus of these narratives as a whole. Since there were a large number of themes, they were further divided into specific domains.

During the second stage of analysis, I organized my field notes of observations. These notes were collected over eight months in a variety of different contexts. I began by first identifying key events, special occasions and important transitions that were critical to my research questions. Next, I highlighted the processes, long-term shifts and overall patterns that I had observed during my time in India. I followed this by identifying key concepts that emerged and began to make connections to broader contextual factors as well as historical changes. Finally I made a matrix of key concepts, and ideas based on these observations to help me shape my theoretical arguments.

During the third stage of this process I reviewed the textual data to help fill in the gaps, provide a context and inform my ‘field knowledge’. After completing all these steps of data organizing and analysis the next and final stage was focused on interpretation and theory building. I identified key events, conversations, ‘thick’ descriptions (Geertz, 1979) and ‘analytic insights’ from field notes, identified and compared them with the specific thematic domains -to look for patterns, explanations and differences (between speech and activities). These were then
interpreted and examined through specific theoretical frameworks such as drug studies, biocitizenship and the heath-development framework.

**The Drama of Ethnography**

Ethnographic research is both challenging and conflicting; extended periods of engagement with communities can create multiple ethical and research dilemmas. As a social worker, intervening and ‘improving’ social practices and behaviors define one’s role. However, as an ethnographer it was important observe and balance one’s participation without always actively intervening. This was especially challenging when I witnessed questionable social work practices and clients’ rights being violated. Clients would also often directly seek me out to voice their issues with the NGO and its staff. I couldn’t necessarily step in on all occasions and struggled on the appropriate course of action many times. On certain occasions I spoke with Muquim (project head, Ashray) and Brian (project co-coordinator, Sahai) without blaming or naming the staff members, instead framing it as a concern of managing staff burnout, maintaining client adherence and rights of both parties.

At other times even though I clearly saw clients stash away their medication, I took the decision to neither stop them nor alert the staff (for whom this was a major concern). This was a difficult stance because I knew that they were injecting these substances that were likely to block their veins and cause severe abscesses. However, I recognized that these practices were long standing and most likely would continue if they were forcefully stopped. I did engage with clients on many occasions to discuss reasons around dosage, illicit use and safer practices.

The only times I intervened actively in cases was when clients would directly ask me for help regarding abscesses, wounds or injuries that were either being ignored or given less priority by the NGO. Often the over worked NGO staff would overlook clients’ health issues. My
intervention would help redirect attention and address these concerns in a timely fashion. This balance between staff and clients is delicate and it was important for me as a researcher to maintain good relations with both groups without compromising on values of either good research or basic humanity.

Ethnographic fieldwork involves both a deep commitment to the concern and rich engagement with the community that does not end once the data collection finishes. I continued to think about and communicate with some of my participants even after I left India. The incompleteness of such a format of research opens up many possibilities for learning, revising and creating for the future.
CHAPTER 3: CRACKED WIDE OPEN

Re-imagining, re-imaging, re-casting and re-cycling
Repeat, Repeat, Repeat, Repeat
Returning, refurbishing, refining and re-collecting
Repeat, Repeat, Repeat, Repeat

There was never a problem of Nasha (drugs)
Only these people.
There was never a problem of Nasha (desire)
Only these people.
There was never a problem of Nasha (addiction)
Only these people.
There was never a problem of Nasha (loss of consciousness)
Only we people.

We can only be free until we return to where we became entangled.
(Moorthi, 2010)

The advent of global diseases, advancements in pharmaceutical technology, growth of bio-medical knowledge and shifts towards diseased focused activism has fundamentally altered how states across the world respond and adapt in matters of health. With increasing number of stakeholders participating in the actual policy making, programming and delivery of health it has become important, now more than ever before, to examine and understand these relationships between states (governments), NGOs (non-governmental organizations), civic institutions, bi-lateral agencies, international development organizations and diseased communities. In this chapter I chart out the historical conditions, social environment, political milieu and cultural processes through which harm reduction interventions have come to exist in India.

Once considered to be a peripheral response towards drug abuse, harm reduction has recently gained immense popularity and more formally been inducted into the national government’s strategy against HIV. In many senses, harm reduction does not exist as an isolated paradigm of drug treatment in India. It is subsumed under the behemoth political, social and economic structures and institutions created to fight HIV/AIDS in the country. Hence to
excavate its presence and detail its actual impact on the people was quite difficult. Yet, it is important to study harm reduction’s peculiar form in the Indian drug treatment context, due to the long term and far reaching consequences on health and polity.

The harm reduction model in India is unlike any other the state has seen. It functions as a shadow policy and health model that remains quasi-accepted and fluid. Its emergence is the result of unique networks and collaborations of a globalized health sector that has grown despite contrary repressive policies governing addiction. Unlike other national health interventions, harm reduction’s status highlights the liminal spaces where governance is negotiated and translated into programs for marginalized groups. I inquire into the way the substance abuse problematic shaped. What forces led to its construction and in what fashion was there a response generated?

Over the course of this chapter I discuss the emergence of the paradigm of harm reduction. Unlike other health programs in India harm reduction did not emerge from a top down approach. In fact, I argue, harm reduction grew through the complex arrangements and networks between grassroots organizations and international organizations. Later even though the government adopted this model, it remained in the shadow of the HIV policy struggling between competing philosophies and conflicting political stances. Despite these contradictions and dynamics harm reduction has not only recast drug use as a national issue but also evolved a new approach to drug treatment and expanded its reach to multiple sectors and regions. In this chapter I trace the historical conditions of drug use and HIV as well as the contemporary discourses of public health to make an argument about how harm reduction came to exist and what it reveals about governance and policy within modern nation states.
Encountering the national drug problem.

As I began my work in the field, one of my first tasks was to map the scope of drug abuse in India. I quickly realized that this task was not simple, in fact numbers were deeply political and the contemporary drug narratives inherently contradictory. In fact, whenever I spoke about my research to family, friends and colleagues in India, they expressed surprise asking- Do we even have a drug problem in the country? While the occasional rave party, escapades of a famous film star or drug addicted teens catches the media’s attention, the national imagery of drug use continues to be largely in the context of crime- peddling, smuggling and narco-terrorism; drug users are usually labeled as male, poor and migrant (Datta, 2010). In the national imagery, drug use was considered to be an issue of the northeastern states of India. Then why was I, a researcher in the U.S., even bothering to study this peripheral concern?

India has a long and complicated relationship with drugs. Mythology, culture and customs richly document its heady presence in the psyche, affect, narratives and life ways of Indian communities. But the more lasting and perhaps murkier narrative, as one of India’s most recognizable illicit exports, clearly overshadows any cultural references. Today drugs can be easily procured in any narrow lanes of India’s crowded cities and small towns. Every evening a car entered the parking lot of my upper middle class neighborhood in Delhi. The three youth occupants spent a few hours using drugs and then sleeping, while its affects wore off- a scenario that was unthinkable a few years back. These youths I learnt later, procure drugs from the neighboring slum areas, which was an emerging hotbed for all kinds of narcotics. No longer are drugs bounded in poor and marginal spaces, they are quickly bleeding out into all spheres of
social life of the urban landscape in India. The increased availability of drugs both licit and illicit then makes drug use a uniquely hidden issue, one that is very much in plain sight.

Historically, opium and cannabis were used in many parts of India. They were both culturally accepted and socially ritualized. Their availability was especially aided by the fact that geographically, India lies between the highest opium producing regions of the world, the Golden triangle (Laos, Myanmar, Cambodia, Thailand) and the Golden Crescent (Iran, Afghanistan and Pakistan) (UNODC, 2005). India is also one of the world’s largest producers of licit opium, a large portion of which is diverted to the illicit drug markets of cities like Delhi and Mumbai (Machado, 1994). Opium was generally consumed unrefined within the Golden triangle till the 1940s (heroin was unavailable). Opium was exported to the laboratories of Bangkok, Hong Kong or Marseilles to be processed into heroin (McCoy, 1972). However over the last few decades, the transforming geo-politics of the region forced heroin refinement laboratories to move closer to the opium fields\textsuperscript{27}. The Burmese military cracked down on dissident ethnic groups involved in heroin production and alternative routes to the lucrative western markets arose.

These new overland routes from Myanmar to Yunnan Province of China and then onto Hong Kong crossed into the northeastern states of India (particularly the north-eastern states of the country. Assam, Meghalaya, Sikkim, Tripura, Arunachal Pradesh, Manipur, Mizoram and Nagaland\textsuperscript{28}), bringing drugs to the country’s doorstep (McCoy, 1991). India also became a major port for drug trade to the west after the revolution in Iran. Other factors like improved laboratory techniques in previously “cultivating only nation” and the availability of cheap

\textsuperscript{27} Since Heroin takes up less volume and is easier to hide than opium and this transition decreased the costs and chances of detection.

\textsuperscript{28} The last four states share a common international border with Myanmar, the world’s second largest illicit opium producing country.
production chemicals aided the introduction of abundant and cheap heroin into south Asia, especially in India (McCoy, 1991).

Not only did drugs flow easily through these international borders, the injecting drug using epidemic also become widespread by the 1980s (UNODC & Ministry of Social Justice and Empowerment, 2006). National apathy towards this region, added to a lack of information about drugs and disease further compounded the issue. Brown sugar, a cheap derivative of Heroin, cost about Rs. 30 per gram (around $ 2 dollar), it soon replaced opium and cannabis as the drug of choice (West, 1992; Dorabjee and Samson, 1998). Most users ‘chased’ or inhaled heroin, injecting drug use was not common during these early years, since the purity of the drug was high. In Delhi, hospital data indicates a 60% increase in the demand for drug treatment during 1980 and 1984, which is attributed to increased availability of heroin due to this transit traffic (Dorabjee and Samson, 1998). The emergence of brown sugar in the market led to an increase in its addiction among the low-income group across the country (Jiloha and Sain, 1992).

However the major change in drug use pattern occurred when India enforced the Narcotic Drugs and Psychotropic Substances Act (NDPS) in 1985, based on the Single Convention of 1961 (U.N.). Countries such as the U.S. via the U.N. forced (with the threat of withdrawing aid) many developing nations to change their national strategy in keeping with ‘international conventions’ (Dorabjee and Samson, 2000). Until the early 1980s opium was available to registered users from Government of India authorized shops (Dorabjee and Samson 2000). But under the new restrictive law there were severe sanctions placed on both using and cultivating illicit opium. The U.S. global ‘War ON Drugs’ had found a new frontier.

---

29 It was not until 1989 that as a part of a national study an assessment of drug abuse, drug users and drug prevention centers was carried out in Dimapur (Nagaland), Imphal (Manipur), Guwahati (Assam) and Shillong (Meghalaya).
30 India is a signatory to three UN Conventions- Convention on Narcotic Drugs, 1961; Convention on Psychotropic Substances, 1971; Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.
The NDPS Act shaped a criminal regime, punishing all aspect of drug use—“with extraordinary powers of enforcement, diluted rules of evidence, included presumption of culpability and reversed the burden of proof” (Tandon, 2008). This Act was modified in 2001 to include provisions like different legal sentencing for possession versus consumption and options for treatment instead of jail – more humane sentencing for dependent drug users. Section 71 of the Act however also empowered the government to establish drug rehabilitation centers for those who needed medical attention. Other provisions included: The Government may, in its discretion, establish as many centers as it thinks fit for identification, treatment, education, after-care, rehabilitation, social reintegration of addicts and for supply, subject to such conditions and in such manner as may be prescribed, by the concerned Government of any narcotic drugs and psychotropic substances to the addicts registered with the Government and to others where such supply is a medical necessity.

The Government was clearly working with a punitive or medicalized perspective towards drug use, in-line with global practices and knowledge. Jared Richards (research head of NGO Ashray) discussed some of the implications of criminalization with me:

When the NDPS act was first enforced the user if he got caught with any amount of drugs, (he) would immediately pay for it 10 years- non-bailable offence, now its okay- if its a smaller amount he is sent for treatment or lesser sentence- one of the points we had to argue for that was putting the guy into prisons doesn’t really help because your cost for

31 Raju v. State of Kerala AIR 1999 SC 2139 where appellant was sentenced to 10 yrs & Rs.1 lakh fine for possession of 100 mg heroin worth Rs. 25. Absence of withdrawal seen as evidence that accused not drug dependent. Supreme Court held such small quantity could not have been meant for sale.

32 However these ‘lighter punishments’ have not necessarily decreased police brutality and violations against drug users or clarified who and when immunity is provided to drug users. Moreover, the treatment options provided as an alternative to jail term are restricted to traditional abstinence treatment centers and do not include harm reduction interventions.
prison is much higher than our cost for keeping him in the DIC (Drop-in center)- the legal proceedings cost a hell of a lot, number four your not helping him in the prison- your looking at a closed environment lot of people, TB is rampant, Hepatitis B, is rampant- we are not helping anybody (from a public health perspective as well)…

Efforts to curb the heroin supplies through the NDPS resulted in “heroin droughts”, leading to a sharp hike in the street price and lower quality of brown sugar (Dorabjee and Samson 1998). Drug users found a more cost effective way of getting the same ‘high’ shifting towards injecting drug use. Mixing of injecting drug users (IDU) with non-injecting users further popularized injecting drug practices among peers (Manning, 2001). Anecdotally drug experts also cite another reason for the transition towards injecting drug use. Faced with agonizing withdrawals, many heroin dependent users sought medical assistance. This assistance included the administration of the injectable form of Buprenorphine (BP), a pharmaceutical substitute for heroin (Kumar 1997; Panda and Chatterjee 1997; Dorabjee and Samson 1998).

Drug users realized the benefits of this new drug and by the late 1980s and early 1990s injectable BP gained popularity, becoming a huge epidemic in the big cities (Nizamie & Sharma, 1990; Biswas, 1994; Dorabjee 1994; Panda and Chatterjee 1997). The Government attempted to monitor and control abuse of BP by removing the tablet form from the markets, making it available only in select rehabilitation centers / hospitals. However, the injectable form of the drug continues to be available in pharmacies and the pills are easily procured in the black markets. By 1992 injecting drug use had spread and established itself all across the nation (Sarkar et al., 1991; Kumar and Daniels, 1994; INCB 1996; Bhardwaj, 1995).

33 There were many reasons why drug users preferred this BP to heroin. It took care of their withdrawal from heroin; this legal drug was easily available in pharmacies; it was also one-fourth the cost of heroin; clinically it was much safer- unadulterated, manufactured with strict quality control and had little potential for an overdose.
After the 1980s drug use emerged as a significant trend across many states in India even though alcohol still is the most widely abused substance. The injecting epidemic in particular saw a sharp rise in the early 1990s coinciding with the spread of the terrifying HIV epidemic. The most recent estimates of drug use are based on the National Survey conducted by United Nations Office on Drugs and Crime (UNODC) and Ministry of Social Justice and Empowerment in 2001-2002 (UNODC & Ministry of Social Justice and Empowerment, 2004). The National Survey estimates 73.5 million persons are dependent on substance in India alone, of which 62.4 addicted to alcohol, 8.75 million are cannabis users, 2.04 millions are opiate users and .29 million are addicted to sedative hypnotics. The survey also indicated that other drugs such as Sedatives/Hypnotics, volatile substances, Hallucinogens, Stimulants and pharmaceutical preparations were also abused. While the proportion of drug users is still very small compared to the general population of over one billion, most experts believe that these numbers underestimate the exact extent of the problem. As the sample size was small (40,697 males only), the estimates can at best be taken as a broad approximation of the total numbers.

For more current data I had to rely on rapid assessments (small surveys with limited samples) conducted in different regions with drug using populations. Rapid assessments in Punjab and Haryana reveal rising rates of drug use in these states (UNODC, 2009). A rapid situation assessment (RSA) was also carried out in 2005-06 in India by UNODC in drug treatment sites across the nation. 5800 drug users participated in this survey (93% males and 7% females). It was found that 80% used alcohol, 76% used cannabis, 76% used injectable Buprenorphine and 76% used heroin by injection. 70% were smoking heroin and 64% used

---

34 This National survey took the combined inputs of the National Household survey on drug and alcohol abuse (conducted in 2001), the drug abuse monitoring system (DAMS), rapid situation assessments and thematic studies together to provide these estimates.
propoxyphene, 78% of this sample switched from non-injecting to injecting use, with 51% reporting sharing behavior (UNODC, 2007).

Current research suggests that extensive use of heroin and pharmaceutical drugs is on the rise in major cities including my field site of New Delhi (UNODC, 2007; Datta, 2010). Approximately 14% of injecting drug users in Delhi is HIV positive, an extremely high statistic compared to less than 1% adult prevalence rate (NACO, 2010). Most drug users are male, belonging to the lower socio-economic strata and a large proportion are homeless (UNODC, 2005). Drug use in India continues to be a male phenomenon, a rapid assessment survey carried out in 2001-02 showed that an average of 7.9% of women used drugs and about 7.5% women were using in Delhi (2.8% were injecting drug users). Majority of drug users are illiterate, a 21% literacy rate overall but Delhi and few other metropolitan cities (including north east states) have a higher literacy rate of about 44% (MSJE & UNODC, 2004). Poverty, lack of employment and homelessness are the main concerns for most drug users across the nation (UNODC, 2005). In the north-east states, though (unlike the rest of the country) most drug users are home based, their struggles are around issues of employment and resources (UNODC & MSJE, 2006).

When I concluded my fieldwork in Delhi in April 2009 there were no updated estimates of drug use and treatment, the situation has not changed even until I submitted this dissertation, in late 2010. Overall there are two key factors one must consider in examining this issue of numbers and the problematic of drug use. First, is the lack of accurate and reliable estimates for the issue of drug use within India. There are large gaps in our knowledge about the exact nature of how many people are using, what and how do they use, demographics and life circumstances impacting their use. This has partly to do with the nature of the concern – drug users tend to remain at the margins of society, often difficult to access. Most data about drug users is
collected through treatment and detoxification centers. This skewed sample is then used to extrapolate for trends in the larger population, creating a margin for error and problematic assumptions. Often times NGOs and international organizations carry out small surveys and independent mapping exercises. Usually, these are restricted to the heavy drug using regions and urban centers like Delhi, Mumbai and Kolkatta. These small studies help to provide a quick and textured picture of emerging drug use issues across the country, though again must be viewed with caution. Also a large part of the data collected within the country is linked to the United Nations drug database. In fact, it was challenging to find detailed national level data about drugs and drug use independent of the UN system. Despite the deficiencies this data was quoted widely, referenced and used by all agencies to support claims of the emergent injecting drug epidemic.

Second, some public health experts claim that this paucity of accurate estimations reflects, a much broader issue, the way drug use is perceived both by law-makers and the society at large. For the longest time, drug use was treated as somewhat the stepchild in the social sector- experts believed that substance abuse was not a national problem of importance. The statistics while shockingly large in absolute numbers are still proportionately impacting a much smaller population and in a country of whose development agenda is firmly dominated by poverty, unemployment, education and basic nutrition, drug use seems almost a luxury concern, one that could easily wait its turn.

Today, though awareness around drug use has certainly improved, as I suggested at the start of this section, the public perception of drug use is still vague and there is a tendency to undermine the issue. The notion that drug use is in fact a national problem, that is both directly

---

35 There are many smaller studies that report drug use prevalence and incidence but none of these comprehensively can provide a national picture. Most of this UN data is however collected with the help of Government of India (various ministries) and local NGOs.
and indirectly impacting a large number of people in social, psychological and economic terms is still not widely acknowledged. Drug use has only recently and perhaps a little reluctantly been acknowledged as a national problem. Its ascent in the funding and development agenda can be almost solely attributed to the associated risk of HIV.

**An epidemic on the rise, the early responses.**

Manipur state AIDS Control Society has accorded the title of Brand Ambassador of HIV/AIDS to Mr. Khundrakpam Pradipkumar, recently crowned Mr. Manipur (60 kg wt), who has been living with HIV for over a decade now. His mission as an Ambassador is to take a leading role in spreading HIV/AIDS messages to people, particularly the PLHAs to motivate them to ‘live and achieve’ even with HIV in them.

Pradipkumar’s journey from a CD4 count as low as 16 in February 2000 to being crowned the best body builder of the state in his category in 2007 is indeed a message to the thousands of PLHAs in the state that ‘being HIV positive is not the end of the world’.

Besides his courage and endeavor, Pradipkumar’s success is attributed to the invention of Ante-retroviral Therapy (ART), which he has been receiving since 2000. His CD4 count by July-August 2007 reached 367. He is a member of the MNP+ (Manipur Network of Positive People), an enrolled client at ART centre and an inspiration among the fellow HIV positives of the state (Manipur State Aids Control Society website, Retrieved 2009).

A brand ambassador for a deadly disease – seems at once appalling, empowering, and novel. Later, the profile very briefly mentions that Pradipkumar had been an injecting drug user. He had started using drugs at the age of 13. A large part of his youth he had spent injecting heroin (no. 4), taking tranquilizers, cough syrups and popping pills. Before HIV, it would be
unthinkable for an injecting drug user to be featured as an ambassador on a government website. It is a testament of HIV’s powerful ability as a disease, to shift entire narratives of drug use-making the illegal and problematic drug history visible and permissible through a new prism. Drugs became all but a prologue to Pradeepkumar’s main heroic chapter as an AIDS mascot. It is this very kind of uneven association that that marks the broader history of drugs and HIV within the country.

Currently approximately 2.5 million people in India are living with HIV/AIDS (World Bank, 2010). Estimated adult prevalence in the country is .34% (males -.44%, females-.23%). 87% of HIV infections are still occurring through heterosexual routes of transmission while parent to child infections are about 5.4%, injecting drug use at 1.6% and men who have sex with men 1.5%. (NACO, 2010). India is experiencing ‘a heterogenic epidemic’ i.e. its patterns are diverse within a large nation like India36 (NACO). In six states Maharashtra, Tamil Nadu, Andhra Pradesh, Manipur and Nagaland the rates of HIV are four to five times higher than the rest of the country (NACO). Within some groups it is a ‘concentrated epidemic’ with a very high prevalence among injecting drug users IDU -9.2%, men who have sex with men (MSM)- 7.3% and female sex workers (FSW)- 5.4% (NACO). Other high-risk groups include transgender (TG) and bridge populations like migrants and truckers. Trends from global and national level agencies show that these groups contribute to 75% of infection in Asia (UNAIDS, 2008).

In 1986 India’s first case of HIV was diagnosed among sex workers in Chennai, Tamil Nadu (Simoes, 1987). By the end of 1987 of the 52,907 people tested 135 were found to be HIV positive and 14 had AIDS (Kakar & Kakar, 2001). The northeastern states of Manipur, Mizoram

36 Among IDUs, Maharashtra (24.4%), Manipur (17.9%), Tamil Nadu (16.8%), Punjab (13.8%), Delhi (10.1%), Chandigarh (8.6%), Kerala (7.9%), West Bengal (7.8%), Mizoram (7.5%) & Orissa (7.3%) have shown high prevalence of ≥5%. Trends among IDUs are on a decline in Manipur, Nagaland and Chennai while there is a clear rise in Meghalaya, Mizoram, West Bengal, Mumbai, Kerala and Delhi (NACO 2008).
and Nagaland\textsuperscript{37} were the worst affected in terms of the HIV epidemic (Panda, 2002). There was both genuine fear and lack of knowledge, both about the disease and the systems needed to manage it. Dr Ghosh (1986), a prominent public health specialist voiced some of these concerns at this time:

Unlike developed countries, India lacks the scientific laboratories, research facilities, equipment, and medical personnel to deal with an AIDS epidemic. In addition, factors such as cultural taboos against discussion of sexual practices, poor coordination between local health authorities and their communities, widespread poverty and malnutrition, and a lack of capacity to test and store blood would severely hinder the ability of the Government to control AIDS if the disease did become widespread (1986).

HIV/AIDS, it seemed would expose the many weaknesses of the Indian public health system—poor rural health, the failures of the blood bank system, poor monitoring of health programs, lack of focus on nutrition and general health, mismanagement of resources, difficulties in accessibility as well as prohibitive costs of health. Dr. R.V. Ramalingaswami, former director general of the Indian Council of Medical Research, in a Time magazine article in 1986, articulated the national sentiment at the cusp of this pandemic, “we in India have been shaken and face a moment of truth” (Pierce, Pratap & Vollers, 1986).

This account of the early phase of harm reduction would be incomplete without the story of Manipur and the northeast states of India; not only, were these states be considered the birthplace of harm reduction intervention in India, but Manipur was also the first state to include harm reduction in its state policy in 1996. The experiments in intervention, policy and interactions between stakeholders that occurred in these regions, became blueprints for the harm reduction model at the National level, much later. Due to fieldwork commitments in New Delhi

\textsuperscript{37} Manipur and Nagaland are high prevalent states in the country in terms of HIV.
I could not travel to the north-east and no clear document trail existed, it was through interviews with living activists and public health experts (many have succumbed to HIV and others have moved organizations, countries or professions) that I began to piece together this early history of harm reduction in the country. As with most histories it was ridden with conflicting information, conflation and gaps. And as with most memories ordinary people became heroes while others disappeared all together in the narratives. These are some of those histories.

The state of Manipur was one of the worst hit by the early wave of the epidemic, poor health infrastructure, high rates of drug use and the paucity of knowledge created a deadly recipe for a crisis. The first case was detected in 1989 and injecting drug users (IDU’s) were the first to be impacted. Injecting drug users are at a high risk for both being infected and passing HIV/AIDS because of frequently sharing of injecting equipment as well as engaging unsafe sexual practices in the broader context of poverty, stigma and marginalization (Golub, et al., 2007; Rhodes, Singer, Bourgois, Friedman & Strathdee, 2005). But it was a study published soon after that sent shock waves through the community and in the power corridors of the state. A group of drug users were tested for HIV without their consent, not only did more than half test positive, but also their names were published in the local newspapers.

Dr. Khom, who works with Emmanuel Hospital Association (EHA) a prominent HIV coalition, recounts these early days:

I was working the state government of Manipur public health officer in a district of Churachandpur district – when the epidemic started … since then Manipur was also identified as a potential hotspots or an or epicenter. The government of Manipur at that point of time set up a surveillance unit as a part of the public health group…in collaboration with ICMR (Indian Council of Medical Research) office in Calcutta…we
used to collect samples of injecting drug users and sex workers … few of the samples collected were positive that’s when all hell broke loose kind of thing there was a ‘tamasha’ (Hindi word meaning commotion) in the (legislative) assembly, they (demanded) the list of the names (of HIV positive patients).

More than half of all injecting drug users within the state had become positive in the year following the detection of the first case. The HIV prevalence rates in the state shot from 0-80% in a matter of few months (Prakesh, 1996; Sarkar, Chatterjee, McCoy, Abdul-Quander & Metsch, 1996).

Some of the earliest responses to the epidemic came from the grassroots. NGO’s like SASSO in Manipur, began to realize that alternatives to the abstinence-based approach were needed. Until now, the only treatment approaches for drug users included rehabilitation and detoxification services. Moreover, some of the abstinence- focused centers, particularly in the northeast, were notorious for using force and treating drug users in an inhumane fashion. They also had a high rate of relapse and required a long commitment from the both the drug user and their families. In order to understand the scope of the issue and community needs, the NGO’s and international organizations began to conduct mapping studies. Dr Khom shared:

When we did those studies that’s when we had a lot of interaction with the communities and again and again what we heard is that you know harm reduction… we need to be protected you know, (they were) very scared of getting (HIV) infection, I mean we need to be protected-what is that you can do for us and that’s when we said we are willing to do this (harm reduction), if this is something that is going to help…. sure we are willing to do it so without necessarily going to wait for a policy from the government…

38 Today the state has hardly .2% of the country’s population with almost 8% of HIV positive cases in the country (Manipur State Aids Control Society, Retrieved 2010).
These early efforts at harm reduction functioned in a quasi-legal space, in that, there were no laws or policies supporting these actions. Dr. Khom highlighted that some of these programs began by small independent NGO’s who were simply responding to the crisis they were witnessing on the ground. Farahana Dastor, a civil rights lawyer also noted that:

Harm reduction in India basically took roots within the community with say a handful of by a handful of organizations that were set up by drug users themselves and worked with drug users in slums. They were having just start up programs or just services without really thinking about its legality or how they are going to continue it or how they are going to sustain. They (did so) without much planning, piloting or scientific background, but nonetheless what was important was that it was rooted from the ground, it came from the bottom up rather than the other way around. And secondly, it was about courage about strong action, which people thought was needed and without really waiting for approvals from x,y, and z, realizing the urgency of the situation and getting things on the ground. But having said that it also affected the manner in which other formal agencies like the state or other institutions, which dealt with drug use and drug dependence took to, harm reduction – harm reduction was then quick to be dismissed as some thing on the side, not really a matter of larger public health concern.

Sakhin, head of SASSO (prominent NGO in the northeast) recalls, “We didn’t know what we were doing was harm reduction, but we were already doing these things”. He told me that before the epidemic most of their focus was on “getting clean, but the relapse rates were very high and there was fear (and shame) in going back to the center”. In fact, SASSO began with the “collective effort to stay clean (from drugs)”. Simultaneously, they believed it was important to “remove stigma and not just be considered as a useless person, who is not able to do anything,
instead focus on helping the community and the people who are there”. To emphasize this latter element, the SASSO members would clean roads, clear garbage, and participate in community activities. They also brought awareness to the plight of drug users through street plays and campaigns. Dr. Khom added that these peer outreach groups “would distribute (clean drug) paraphernalia, (conduct) bleach and teach programs, (provide) distilled water, spirit and things like that and interact with the drug users”.

Sakhin highlighted that “one of the biggest challenges we have is that we are living (north east) in the conflict zone where you know lots of insurgency groups are there and apart from that pressure groups is very strong out here”. Many of these groups would take violent action against people who were identified as drug users. For instance, they would cut off a drug user’s limbs or threaten their families. Drug users were thus underground, afraid to seek help, go into recovery or even accept clean injecting equipment. They were more likely to share equipment in the shooting galleries (drug using spots) and contract HIV or other blood borne diseases. Sakhin stated:

In the initial stage there were comments/ feedback from the community people, saying that you guys are encouraging the user community to use drugs...we had a series of meetings …only after that slowly people realized and began to accept both drug users and harm reduction.

Another key effort during this period included the establishment of one of India’s first needle syringe exchange programs in Manipur, in 1995. This collaborative effort was sustained by the research and financial support of Aus Aid, the technical expertise of the Macfarlane Burnet Center as well as the guidance of local public health experts. This led to the formation of
Shalom (Society for HIV/AIDS and Lifeline Operation in Manipur), which grew into the region’s most well respected drug-HIV organization.

Back in Delhi, Ashray had at the same time decided to experiment with small-scale needle syringe initiatives, in the drug-ridden parts of the city. The Bangladeshi illegal migrant population had brought with them the injecting epidemic and many drug users were dying because of untreated abscesses and HIV. Owen D’ Souza (Ashray head) also used his own funds to begin opioid substitution therapy using oral Buprenorphine. “At that time, no one wanted to fund us”, he told me with a smile. Today of course, in hindsight, he realizes the risks he took in launching the program without any visible support- financial, technical or administrative. Jared Richards the project head of Ashray also shares some of the experiences of these struggles:

It took a long time it took approximately 12-14 years of lobbying with the government on harm reduction. (But) we had to convince ourselves first, we didn’t come into the picture with the belief that it works. So in 1992 informally we started our own pilot with Buprenorphine (an Opioid substitute), then we expanded it into a full-fledged project in 1993. Our head we had this idea that there people on the street who don’t’ want to quit and we are not helping them by taking them out of the environment and putting them into rehabs which is what we were doing and he read about this drug called Buprenorphine and he said lets try it out and we did. We started very small the first pilot maybe had about 10 people on it and then when it worked- when we found that it was well accepted people liked Buprenorphine instead of going to their pusher for heroin, jobs were being stabilized and people just had a healthier lifestyle, then we extended it up.

“We became the translators of harm reduction to the drug using communities”, shares Owen. SIDA and local drug experts like Dr. Khom and Dr. Talukdar were instrumental in
shaping these programs. By the middle of the 1990s, the non-state harm reduction interventions finally began to garner the government’s attention. Dr. Khom recalls, “We published, so we got lots of publicity before we know it…. a lot of questions were (being) asked to the state government- what’s happening (about harm reduction). They (Manipur state government) had to say that it is a good practice (since it was more successful than any other intervention)”. He specifies that they kept calling it a “model intervention” or “pilot project”, since they were functioning outside the legal boundaries. It also kept their work from being slotted into any specific pre-existing scheme and program. They presented their work in a number of conferences across Asia and other countries became interested in these harm reduction efforts in India; this helped to generate both support and funding.

As Dr. Khom puts it, “It has been a long journey of harm reduction… of selling the idea of harm reduction”. The roles of NGO’s like Ashray and SASSO, international agencies like WHO, UNDCP as well as bilateral organizations like DFID, NORAD, Aus Aid (Australian Government’s International Development Agency) and SIDA (Swedish Government’s International Development), emerged significant in this early phase of harm reduction. These harm reduction efforts began on a small scale in the northeast and metropolitan cities of India and over time grew to other parts of the country. Overall this early phase of harm reduction is mainly marked by the collaborations of NGO’s, international organizations and bi-lateral agencies. Though NGO’s saw their own role as crucial one cannot discount the role played by these bi-lateral agencies. While NGO’s on the ground were engaging in harm reduction activities

---

39 Ashray during this period approached Oxfam, who already had programs in the north-east states and asked for their support in helping SASSO expand their programs of harm reduction. With Oxfam’s support and Ashray’s technical expertise, SASSO was able evolve its own program. They conducted a situation assessment followed by a sensitization and awareness program focused on harm reduction.

40 Since I was not able to gain the perspective of the officers from SIDA and Aus Aid (both agencies have since stopped their harm reduction programs) my understanding of these years was based solely on the views of the NGOs involved.
without necessarily labeling it so, the bi-lateral and international organizations were participating more purposefully drawing on the global harm reduction paradigm to shape these local efforts. These programs were able to do a couple of key things. First they were able to devise unique programs that suited local needs with incredible regional diversity. Also, their flexible funding structures and well-endowed funding pools allowed these agencies to develop well-designed and comprehensive programs. They were not driven by funders’ specifications rather grew from the ground up, remained dynamic and evolved as community needs changed. Second, the bilateral agencies had specific expertise in harm reduction and thus were able to draw in both technical and financial support for these projects from both within and outside the country. Harm reduction was well established in many western nations and these bilateral agencies were able to bring in those practices to bear upon the Indian context. The Indian NGOs were able to adjust and reformulate some of these strategies into their own harm reduction work creating a hybrid model. Third, these projects, though small, were not only able to demonstrate the viability (and issues) of harm reduction in India but also brought forth the nature and extent of drug use within the country. Even though HIV was became a central organizing feature for these services. Fourth and finally, they paved the way for introducing a greater participation of transnational organizations within the Indian health policy –practice context, which had the potential to transform the harm reduction space in India.

**Government responses- the evolution of the harm reduction paradigm.**

In 1986, shortly after the first case of HIV was detected, the government responded by constituting the National AIDS Committee (NACO, 2005). Established under the Ministry of Health and Family Affair the program’s principal activity was limited to monitoring HIV infection rates among risk populations in urban areas. The National AIDS Control Program I
was launched a few years later in 1992 and lasted until 1999\textsuperscript{41} (NACO, 2006). It was the first large-scale public health effort to prevent the spread of HIV. The main goal was to co-ordinate the national response towards HIV, raise awareness and improve surveillance (NACO, 2006). The National AIDS Control Organization (NACO), a semi-autonomous body was formed the same year to oversee this national effort. This effort was aimed at slowing the spread of HIV infection \textsuperscript{42} (NACO,1999). This plan established the administrative and technical basis for program management and also set up State AIDS Control (SACs) bodies in 25 states and 7 union territories (NACO, 2006). During this policy period public information campaigns were started to address stigmatized/taboo topics like sex, drugs and sexuality. The National Blood Transfusion policy was launched as well as the entire blood bank system was revamped, the sentinel\textsuperscript{43} survey was instituted to monitor prevalence (Kumar, 2008). STD clinics were set up and new drives to promote condoms were initiated as a part of this policy initiative (NACO, 2005).

Several international donors such as the UK Department for International Development (DFID), the Norwegian Agency for Development Cooperation (NORAD), USAID, the Ford Foundation, the International Development Association which is a wing of the World Bank, the United Nations Development Program (UNDP), and the United Nations Drug Control Program (UNDCP), agreed to support the NACP (Kumar, 2008). The final estimated cost of NACP-I was US$27.5 million from the government of India, $2.2 million from the WHO, and International Development Agency credit of $84.2 million (Kumar, 2008). The government, at this point, was

\textsuperscript{41} This first phase was extended to 1999 when it was realized in 1997 that barely half of earmarked funds had been utilised.

\textsuperscript{42} It focused on initiating a national commitment, increasing awareness and addressing blood safety. It achieved some of its objectives, notably increased awareness. Law banned professional blood donations.

\textsuperscript{43} These are described as “sentinel” because they are meant to indicate trends, not provide comprehensive information. Blood samples collected from the sentinel sites are tested for HIV to give a “snapshot” picture of HIV prevalence in those sites.
still trying to understand the disease and constitute an effective response. Harm reduction, was not even acknowledged by the government formally and neither was it fully understood.

Around 1994-95, the Government supported All India Institute of Medical Sciences (AIIMS) began its own efforts at harm reduction. AIIMS is India’s premier academic and teaching institution. Their drug treatment hospital is functional both as a clinical service department and academic institution. Funded by the Ministry of Health AIIMS, has played a critical role in shaping the national drug abuse control program. Using a medical model they were keen to apply harm reduction intervention for both alcohol and drug use. Their efforts were mainly focused at testing Buprenorphine maintenance and developing broad guidelines and a protocol for treatment. Dr. Chatterjee, the head of the drug treatment center at AIIMS, shared that during this period they tried to convince the government to expand Buprenorphine maintenance to heroin users. However, the government and the Narcotics Control Bureau (in-charge of trafficking and supply reduction) were squarely opposed to such a recommendation. AIIMS continued its efforts offering scientific evidence and participated actively in national meetings to share their perspective. Though they remained closely linked to the government’s efforts in shaping policy over the next decade, their impact was limited in the larger community context, especially in terms of activism and advocacy.

Until 1997, a strong denial persisted among decision makers of the existence of injecting drug use beyond the northeastern states in India, calling it negligible and insignificant (UNDCP& Government of India 1995). Despite a reported increase in drug injecting all across the country, as early as 1990 (Chowdhury and Chowdhary, 1990; Naik et al., 1991), there was little data available on the prevalence and incidence of HIV infection among injecting drug users (Sarkar, et al., 1993; Singh, Mattoo, Malhotra & Varma, 1992). In fact it was only as late as
1999, for the first time, the National AIDS Control Organization (NACO) Policy document included Mumbai, Calcutta, Chennai and Delhi as cities with substantially large numbers of injecting drug users that were deemed at risk of HIV infection (NACO, 1999). Drug use could no longer be dismissed and nor could the threat of HIV overlooked. NACO, begun the process of mapping, investigating and re-organizing the systems of public health, even though harm reduction specifically was not yet on the agenda. The country, it seemed was on the cusp of something new and radical.

The harm reduction model began evolving from a peripheral intervention into a national program in the next few years, fairly rapidly. NACP II followed the first policy period from 1999 until 2006. It undertook a more long term, behavior change centric approach to reduce the spread of HIV\(^4^4\) (NACO, 1999). NACP II had a larger scope of activities and also received far greater financial support of around 445 million dollars from groups like USAID, DFID, Aus Aid, CIDA, UNDP, Global Fund and the World Bank (Kumar, 2008). This type of support was virtually unheard of and drew the attention of the nation’s public health sector almost immediately.

Instead of a broad prevention strategy NACP II adopted a targeted intervention (TI) approach aimed at high-risk groups (HRG’s) (NACO, 2006). Globally this public health rationality was governed by the thinking that given the disproportionate HIV prevalence (as highlighted above) among these high-risk groups- female sex workers (FSW), men who have sex with men (MSM) and injecting drug users (IDU’s)\(^4^5\) (as well as bridge populations like migrants

---

\(^4^4\) Under this phase, India continued to expand the program at the state level. Greater involvement of NGOs and other sectors and line departments, such as education, transport, and police. Capacity and accountability at the state level continues to be a major issue and has required sustained support.

\(^4^5\) Those drug users who have injected in the last three months.
and truckers), it would make most sense to invest with these groups. By saturating these HRGs the spread of HIV could be stemmed and the general population would be spared.

NACP-II set up more than 1,000 TIs, mostly through non-governmental organizations, for the HRGs (NACO, 2006). The projects were meant to use peer educators to counsel, provide condoms through social marketing and give information to encourage a change in behavior. The country also was divided into high and moderate prevalence states, based on the high-risk populations as well as high and moderate vulnerable states based on the demographic characteristics of the population. While community level interventions like public health campaigns, STD clinics and improvement of the Blood bank system continued, TIs were to become the new modality of all HIV related care henceforth. Under this phase the government also began to expand the program at the state levels. Managerial, technical and financial systems were also set up to develop and implement focused strategies to reduce HIV prevalence among high-risk groups (NACO, 2006).

For drug users specifically, these changes in the national agenda were certainly encouraging. However, there were certain limitations in terms of the number of TI’s for drug users and the scope of services that were provided. For instance, the government was still reluctant to start providing Opioid Substitution Therapy (OST) at this time. Part of this reluctance was driven by the lack of expertise within the government and part were the legal barriers preventing the provision of Opioid to drug users. Prerna Kapoor who works for UNAIDS, details some of these issues:

At (those) NACO meetings they (were) saying that the HIV funds are not there to support the OST programs- the Ministry of Social Justice and Empowerment (MSJE) can do that, that’s not our forte and the MSJE said we will not support harm reduction- some amount
of ping pong and one didn’t know what was going on. Some amount of pressure from community groups and donors has played an important role and I think community groups were ready to take it on and there were donors who were ready to support it.

Even though small-scale projects by Ashray and other NGOs’ had shown the effectiveness of OST, it was not until the “five cities” project supported by DFID, that the central government really began to take notice. This DFID funded project started in 2005 and continued until 2007, funding was channeled through the Program Management Office (PMO) 46. Harm reduction projects from four networks reached out to more than 100,000 IDUs across India (DFID, 2007). NGOs carried out extensive advocacy work to influence an attitude change among various stakeholders. But most crucially OST was established in four urban and three rural sites across the northeast states of Manipur and Nagaland, and in eight further states and three union territories including Delhi (HLSP Institute, 2006). More than 4,500 IDUs benefited from OST and over two thirds successfully completed treatment or were in treatment at the end of the project.

I met Aakansha Jain, who was working with one of the projects in the northeast to understand more about this project. Aakansha recalls:

This was the largest OST program in India till date in Manipur and Nagaland, it started looking at 800 IDUs, it ended up being 1200 and it went to 1800 because it was flexible...the donor was flexible and we were managing’. At this point, the government of India had not yet adopted OST. They questioned OST both as an effective strategy and a viable intervention, both in terms of funding and expertise. It was only a 14-month project and we realized that there was physical change in people who went through OST 46 PMO developed a Challenge Fund to encourage community-based innovation and emphasized fostering links between civil society and government.
we were able to demonstrate and the states really became conscious of the effect – the positive impact of harm reduction.

Despite the encouraging results, after three years, DFID decided to withdraw its support for the OST program. Aakansha talked about some of the tensions and pressures of this transition period:

National AIDS Control Organization (NACO) also had to respond and again there was a lot of policy and advocacy activities and we started preparing papers saying so many people are on OST and we have to do something about and again we wrote to DFID saying you have to extend it you cannot just over night withdraw. Simultaneously we were also trying to find out what was the optimum period for OST.

Prerna Kapoor shared, “When DFID was phasing out of it, basically the government was left with a program, which they had to take forward, because we just don’t leave people who are on OST and that led to funding it (by the government)”.

Aakansha, who now works with HIV/AIDS Alliance, talks about the collaborations that ultimately helped to launch OST in India:

In that period different people contributed at different levels\(^47\). SPYM (a national NGO) contributed in a big way…they were linked very closely to the NGO’s working with the Ministry of Social Justice…they (NGO’s) were basically involved in demand reduction but extended to harm reduction and started also understanding about OST. They did a mapping and we realized that in India there is a lot of drug use, which was needed. Ashray (NGO), in the process of networking again started discussing with a lot of SACS (State AIDS Control Societies) (the usefulness of harm reduction). Manipur (and

\(^{47}\) In 2004 UNODC in collaboration with AIIMS had also begun a small pilot project in five centers and later expanded this to 15 centers across the country.
Nagaland) immediately showed an impact the other projects working in the area realized that ... I think two basic things happened one was the impact- it really brought the attention of NACO, because Manipur and Nagaland were the main challenge because progress of drug use and HIV...and then this (OST) was seen as a very workable solution, supplying needle syringe yes was important and we had to continue that and that was part of it, condoms was part of it (as well). There were smaller studies, which showed that if the person was on OST the adherence to ART (Anti-retroviral treatment) also improved and those things started getting documented and so it brought the attention of national organization.

Another key development during this stage was the entrance of the Bill and Melinda Gates Foundation (BMGF). Not only did the presence of BMGF dramatically increase the financial resources available for HIV but it also included a new format of functioning. I will describe their strategy in further detail in the next chapter. BMGF’s focus on high-risk states in many senses galvanized the government and public health sector in these areas. During this phase they conducted independent mapping exercises to understand the issues and began to identify areas to invest especially in terms of personnel, materials and resources. In addition, they also helped to set the People Living with HIV network, which has over time grown into the largest public disease network in the country.

In 2007 a government delegation supported by UNAIDS and UNODC went to China to see the OST program, to learn and gain a better understanding. This exposure, Rajat Dhingra a UNODC expert, claimed was crucial. NACO officials were able to see how another Asian country with many of these similar concerns could effectively manage and run such a program. This acted as a final precipitating factor in shifting the dynamics around OST and the adoption of
harm reduction. NACP III was launched in 2006 and will continue until 2012 (NACO, 2006). The financial support, amounting to about 842 million dollars, has come from organizations like the Global Fund, the Bill and Melinda Gates Foundation, USAID, DFID and the World Bank (Kumar, 2008). Overall, NACP III has been by far the most ambitious in its scope and implications for both HIV and harm reduction.

NACP III formally included “harm reduction strategy” in 2007 and initiated the opioid substitution therapy (OST) program for 40,000 injecting drug users across the nation (NACO, 2008). NACP III aimed to dramatically scale up targeted interventions, with an aim to halt and reverse the epidemic (NACO, 2006). “Government will encourage NGOs working in the drug de-addiction area to take up harm minimization programs as part of the HIV/AIDS control strategy in areas which have a large number of drug addicts” (NACO, 1999, paragraph 5.10). It included an integrated package of prevention, care and support and treatment with the aim of reducing incidence.

According to NACO most recent estimates there are 1531 Targeted interventions across the country (NACO, 2010). By developing guidelines and training modules for health care staff and services, this new policy aimed to improve the quality of medical care for AIDS. It planned to further decentralize its activities from the state to the district level and also involve various government departments and the private sector in its efforts. At the end of 2010, TI’s covered 1.7 million most at-risk people, (53% for FSW, 72% for IDU, and 82% for MSM) (NACO, 2010). The city of Delhi has about 68 TI’s one of the largest numbers in the country. These interventions were implemented by NGOs and community based organizations, which have

---

48 NACP III evolved through a year long preparatory process through consultations with communities, national experts, affected communities.
49 While majority of the OST programs are government funded there are some smaller projects that are directly funded by international development agencies.
become the backbone of this new program. Partners like BMGF, WHO, USAID, UNODC and UNAIDS are heavily involved in this program by providing technical management and financial expertise.

**In the shadow of HIV - building the harm reduction model in India.**

I have shown thus far that harm reduction policy and intervention did not evolve in a linear fashion but developed through a series of interactions, negotiations and collaborations. Through this process, of incremental changes, small research projects, advocacy and international support of grassroots interventions, harm reduction has become a major policy and practice initiative in India. Jared (project head of Ashray) over a cup of hot chai in his office summed up these changes:

The last year has seen great changes in the Indian state health – health policy- the Ministry of health has gone fully out to start up and scale up Buprenorphine, the whole Harm reduction concept has been shifted around, we are doing it the right way, we are following WHO guidelines, developed our own country’s protocols, we are starting with accreditation. Before the government started giving us cash we had to get funds from outside of India for Buprenorphine and before the laws were changed we had to find a loophole and the loophole we found was that we were doing long term detoxification. Long-term detoxification is still under what Buprenorphine is given on for the sake of the drug control. We had to change laws to allow them (IDUs) to come to the DIC (Drop-in center) without any harassment, we had to lobby for those laws, and we had to lobby for the NDPS act to be changed.

Harm reduction policy and interventions in India hold many lessons for us both as social scientists and social workers. Two decades ago it was virtually impossible to imagine that a
country like India would have evolved one of the most forward thinking drug and HIV policies in the world. Today, harm reduction as a paradigm has established itself changing the way in which Indian drug users can access and treat themselves.

In this chapter I have argued that this development of harm reduction as a quasi-legal policy has emerged despite governmental opposition and reluctance. The success can be attributed to the new partnerships between transnational players and local groups. However, as HIV itself became a large-scale issue, it recast drug use, especially injecting drug use as a national problem. Harm reduction, which thus began as a radical alternate to the government position was soon take over by the government. This government adoption of harm reduction is not complete, since certain Ministries continue to have reservations. But the government involvement has been able to extend the harm reduction program many areas and also brought about greater standardization, greater investment and overall increased attention about the issue.

From a social work policy perspective this chapter shed new light about the way health policies evolve and develop and the new roles states come to occupy during this process. Drug use, which was until very recently considered a dangerous affliction, through the framework of AIDS acquired a more legitimate position with regard to the state. The state by itself was pushed into participating in this program and reformulating its own perspective about drug use and treatment. NGOs and bilateral organization in a large part are responsible for transforming the terrain through community level initiatives, advocacy and lobbying. Unlike, other models of health where the citizen is seen as the end point of the intervention and policy, harm reduction placed the citizen and the disease at the center of all discussions. Also the interventions and policies directly fed into each other- as the policy evolved so did the interventions, which in turn shaped new policies. There were a large number of actors involved in drug treatment and they
were spread across many regions with a diverse set of interests; before harm reduction they existed in isolation. Harm reduction played a crucial role in bringing them together, address issues and create a new response - one could say it became an organizing field. This would not have been possible without the presence of harm reduction.

I called harm reduction a shadow policy, for it grew under the umbrella of HIV. It also was never really conceived fully or as comprehensively as it came to exist later. While in some ways it has greatly compromised the way harm reduction is perceived within the public health context, in other ways it has actually been a boon for the paradigm. HIV had the global development sector support- financial, technical and most crucially in terms of public voice. Without the momentum and strength of the HIV industry, harm reduction would have found it difficult to break ground.

In conclusion, I argue that harm reduction emerged as a unique solution under the Indian HIV problematic. While there were other ways in which drug treatment could have been addressed, harm reduction emerged as salient. The local advocacy, international pressure and successful demonstrations of its effectiveness all made harm reduction the ideal solution. Through this process stakeholders, communities and government got connected into networks of care and support. Stigmatized behaviors came out of the shadows and one could argue, this helped to propel changes, which grew far wider than the domain of health and polity. In the next chapter, I undertake a more critical discussion of the nature of these relationships.
CHAPTER 4: REVOLVING DOORS

*Here they come*
*Here they go*
*Problem seekers?*
*Maybe!*
*Problem solvers?*
*Perhaps...*

*But where do they go and what do they solve*

*Us...Them...where is the resistance*
*Should there be some?*
*We were separate us and them...*
*No, we became them and they us.*

*Undoing of health*
*Bringing new beats to old relationships*
*Life gets treated in new ways*
*People become clients*
*Addiction becomes risky*
*Politics becomes disease*
*Money becomes governance*
*Now, what are the beats?*

*Who are these new problem seekers and problem solvers...?*
*(Moorthi, 2011)*

The coming of HIV/AIDS in India was a litmus test for the country’s fledgling and overburdened health system. In the process of fighting the epidemic, the country began to chart out a radical alternative for drug treatment in the form of harm reduction. Both public and private stakeholders worked together to build the “the nuts and bolts of the program”; simultaneously they worked to garner public support for these interventions, formed and tweaked policies, conducted research, trained workers, evolved protocols and addressed the changing needs of the community. The terrain was uneven and harm reduction services seemed to have generated an entirely new set of struggles, hierarchies and tensions between the players. I call this the “politics of survival”.
These policy directives have evolved a program of treatment that draws from global best practices, universal ideals of human rights and new social technologies of risk and pharmaceuticalization. At the same time there is a growing community based, grassroots health movement that is drawing from ideals of broader health mandate that is grounded in political and social justice. Harm reduction programs and policies thus seem to reflect these dualities of global-local and public–private, an uneven terrain or perhaps hybrid amalgamation, where agendas are often temporary, perspectives easily replaceable and ideals fluctuating around the economies of survival. This chapter undertakes a critical investigation of this harm reduction environment to examine its ramifications for governance, health and citizenship.

At the intersections of the healthy welfare state.

HIV, both in its scope and impact, shook governments and health systems in a way that older responses and frameworks were rendered weak. India is traditionally considered a welfare state. But even before the advent of HIV, the country was struggling to redefine itself under the pressure of structural adjustment reform. Post HIV, the conditions changed radically; states had to reframe their own participation in health provision, with the advent of international organizations, NGOs, bi-lateral agencies. These changes were not solely seen in the public health arena, but could be seen in the larger development sector as well (Kamat, 2002; Misra, 2006). However, it was in the domain of public health and specifically HIV where the affects of such changes were particularly dramatic and worth further examination.

Health is considered a public good, one that will serve to benefit the entire community or country beyond the single person (Smith and MacKellar, 2007). However, most welfare states including India have found it difficult to ascertain the exact nature of their role or the level of involvement required to address the health needs of their citizens. Today, there are several
questions raised about whether health is best served by the public utility model or instead must involve private markets (Biehl, 2007). Even more fundamentally, the very definition of health has expanded over the last few decades. Research shows that not only is health connected to social, structural and environmental causes (Bourgois & Schonberg 2009; Farmer, 2003) but also that, health can be impacted by conditions that travel across political and geographical boundaries (Scheper-Hughes, 2005; Petryna, Lakoff & Kleinman, 2006). The rise in communicable diseases coupled with growth in medical technology, the pharmaceutical industry and health-focused activism have all sealed the future conception of health as an issue with a global reach (Epstein, 1996; Nguyen, 2005). Health thus continues to remain both indeterminate and nebulous at best, leaving scope for much debate and discussion about the state’s participation in providing appropriate services, structures and supporting conditions.

The welfare state, not only must make sense of these newer conceptions of health but also carve a niche for itself in the evolving health market place, which today includes many non-state stakeholders. More significantly, the position of the welfare state, in terms of a political and sovereign entity, has come under attack during the current period of neo-liberalization and globalization (Yeates, 2001). Financial, activist, medical, pharmaceutical and social networks surrounding public health issues now seem to inter-penetrate and shape what is occurring within the health sphere of each state (Biehl, 2007; Petryna, Andrew Lakoff, Arthur Kleinman, 2006).

Some theorists argue, that the state has always had certain constraints on its functions, for instance, in choosing different development strategies or deciding on resources allocation (Weiss, 1997, 2000; Deacon, 1999). But most agree that the last few decades have witnessed qualitative shifts in the way states participate in the new global economy (Brown, 2003). They also point out that the state is no longer the principal actor in social policy contexts, it has
become one of the many actors, which include transnational corporations, international bureaucracies, business and professional organizations and social or political movements (Freidman, 1999). Since states are no longer the sole authority or mediators, these scholars suggest that the state cannot be always seen as representative of the people’s will (Sassen, 1998). Sovereignty, according to Sassen (1996) is not the sole purview of the state. Thus, the crisis of the state is often also seen as a crisis of democratic institutions (Martin and Schumann, 1997).

The responses to these threats regarding the scope and function of the welfare state have been varied. Scholars like Ferguson (2006) argue that the state has not necessarily lost power or there is less regulation but in fact there are new configurations of state power that now deserve our attention. This growing body of literature that looks at the way the state continues to govern through and within non-state institutions- a type of “governmentalization” of power that shapes bodies and communities.

Ong (2008) in her work suggests that neoliberalism “can be conceptualized as a new relationship between government and knowledge through which governing activities are recast as nonpolitical and non-ideological problems that need technical solutions”. Her work significantly addresses how governments try to optimize their functions through the “technology of neoliberal governance”. She further argues that within postcolonial, authoritarian and post socialist societies neoliberalism is often introduced as “exception” i.e. “market-driven calculations” are used to manage populations and administration of special spaces. Such exceptions result in the creation of populations who are given either unique social protection or lose certain privileges; this create zones of exclusion and inclusion. This exception to the welfare mainstream can result in unequal distribution of rights, entitlements and even lead to new formations of citizenship; in fact, citizenship can get linked to new spaces thus, re-
articulating and re-defining its very essence. She provides the examples of South-east Asia
where zoning has lead to special spaces, which attract foreign investment, technology transfer
and international expertise. Thus non-contiguous spaces get administered differently with
“graduated” or variegated sovereignty”. “As corporations and NGOs exert indirect power over
various populations at different scales” there are “overlapping sovereignties” that mark this
environment.

Sharma (2006) presents another important argument in this vein. Her work shows that
there is a co-mingling of the old welfare type of rule with the newer forms of neoliberal
governance in terms of empowerment. State power on the ground often seems to traverse in
complicated ways that reflects local realities, multiple histories of development and democratic
institutions and diversity in the relationships between the state and its citizens. State institutions,
in Aradhana Sharma’s work, work closely with non-state organizations. This reflects global
neoliberal trends that seek to “detach or autonomize entities of governance from state institutions
by spreading the art of self government” in order to move the burden of development from the
state to social bodies. However, she also argues that, “the contemporary Indian state cannot
fully relinquish its development and welfare functions because its legitimacy rests precisely on
such functions”. Furthermore, activism, welfare and empowerment initiatives remain a powerful
corrective force against the negative affects of neoliberalization/globalization. Gough (2000)
suggests that these issues acquire a particular complexity in the global South as compared to the
North. He argues that there is a wider range of historical and institutional factors involved in the
politics of the South and a dynamic “state” whose position in social, economic and political lives
cannot be assumed apriori.
The other responses to these changes in the welfare state have come from scholars like Biehl (2007). His work focused on the HIV ridden populations of Brazil show that rather than a top-down form of control it could be understood as a “market–based biopolitics”. He proposes that the government is not using AIDS therapies as techniques to govern populations and manage bodies rather “poor AIDS populations acquire temporary form through contested engagements with what is pharmaceutically available. The political game here is one of self identification and it involves new economics of survival”. He argues that populations get loosely tied through medicine, disease and health into diverse relations with the state, which is, “pharmaceutically present but by and large institutionally absent”.

In my own work I found that the notion of the welfare state continued to hold ground and shape the interactions with other stakeholders in many important ways. There was a clear sense amongst most government players that drug users required medical attention and social support. Drug users were considered by the state as an important bridge population at the risk for spreading HIV. They were a public hazard and the control of the infection was key to securing the health of the larger citizenry. The state was able to lay claim to the position of primary sovereign authority to initiate as well as sustain the large public health HIV enterprise. It was able to bring together a large number of players, give direction and build new structures for health. I show that this was not necessarily a top down type of model but rather a more managerial role occupied by the state.

The harm reduction paradigm was also reflective of a new form of governance that was more dispersed and disaggregated in the institutional and social networks. It was now coordinated and consolidated within non-state institutions, communities and even individuals (Sharma & Gupta, 2006). Citizens were encouraged to self-govern their health and reduce risk.
Unlike other health issues, drug use involves a significant assertion and application of individual choice. Drug users were thus to be held accountable for their behavior and placing others at risk.

At the same time the state recognized that substance abuse was an issue of national security. Both narco terrorism and narcotics trade were significant threats and the government was clear about using punitive action to control, segregate and discipline ‘dangerous’ drug users. Governed by the political, economic and social pressures, I argue that the state adopted and occupied multiple positions at the same time. It transformed its role in relation to these various non-state actors and evolved with needs on the ground. Despite claims that the state was losing its relevance within the current neoliberal climate, my work shows that the state tended to incorporate many different and contradictory frames of functioning; it continued to exert influence and shape the lives of its citizens in powerful ways.

As questions of the state and health are placed at the center of my inquiry, it becomes important to understand some of the global discourses of public health that have shaped the trajectories of Indian state’s participation in harm reduction.

Public health: tracing its impact on the Indian state.

The traditional drug treatment sector in India is dominated to a large extent by the private/NGO sector. This is not surprising considering that the Indian health care system is the most privatized in the world (Phadke, 1994). 83% of health care expenses borne privately i.e. 2/3rd of Indian households rely on the non-governmental sector for health care according to the National Family Health Survey (International Institute of Population Sciences, 2009). Health is not a constitutional right (though other constitutional elements are interpreted in lieu), within India, though Article 41 and 47 of the constitution include provisions for the well being of its

---

50 When I refer to private providers it includes to non-governmental organizations, local trained birth attendants, traditional healers etc..
citizens. Citizens tend to seek private health care to address their everyday illnesses. They only depend on the public health system for major health needs or long-term hospital stay. Ramesh Bhat (2000) in his analysis of the Indian health system shows that shrinking budgets have impacted the way the Indian state is able to attend to secondary and tertiary care. Low budgetary allocations have created several imbalances. P.C. Sharma (IANS, 2010) of the National Human Rights Commission describes it thus:

There is a paradoxical situation in India. On one side, we have super specialty medical centers, which cater to the needs of patients requiring specialized and speedy treatment and on the other hand, a very large number of our population remains deprived of basic medical facilities and healthcare.

India adopted the declaration of the Alma Ata Conference (WHO, 1978)\textsuperscript{51} as evidenced by its National Health Policy (NHP)\textsuperscript{52} of 1983 and promised to provide comprehensive, universal, equitable and health care services for all. However, there were several gaps in the actual implementation process. Most countries found this broad notion of community responsibility and participation as impractical, expensive and expansive. Over the next few decades instead it was the concept of “selective primary health care” which was instead advocated; the focus shifted from communities to funding agencies with experts. The Indian

\textsuperscript{51} It brought the primary health, at the center of global policy agendas. It proclaimed ‘health, as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 (enshrined in the slogan Health for All by 2000) of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.’

\textsuperscript{52} It focused on primary healthcare infrastructure, close co-ordination with health-related services and activities (like nutrition, drinking water supply and sanitation), the active involvement and participation of voluntary organizations, the provision of essential drugs and vaccines; qualitative improvement in health and family planning services; the provision of adequate training; and medical research aimed at the common health problems of the people (WHO, 2009).
government also primarily pushed vertical programs that addressed specific aspects of health needs such as ORS, breastfeeding and immunization (Hall and Taylor, 2003).

The mid 1980s saw a significant global policy shift towards a “new public health movement”. The essence of this movement was enshrined in the Ottawa Charter. It attempted to go beyond bio-medical understandings of disease towards a social and environmental conception of health (Rhodes, 2002; WHO, 1986). The Charter continues to guide policy and discussions around public health to this day. This development coincided with the emergence of HIV/AIDS and parallel to which harm reduction began to grow as a community based pragmatic strategy that focused on drug users needs (Stimson, 1995; Des Jarlais, 1995). Despite these changes in the global perspective, conditions within India remain largely unchanged. As discussed before, the punitive NDPS Act came into force during this time. Addiction treatment was mainly abstinence-based and restricted to hospitals and detoxification centers. Harm reduction was not even considered in the public radar within the country.

The late 1980s saw the global markets reeling from the “oil shock”. This period of economic downturn left most developing nations floundering. By the 1990s India was pushed to adopt structural adjustment policies; the government was forced to cut spending on social sectors especially health and education (Panchamukhi, 2000; Baru, 2003). The percentage of people in India below the calorie norm of 2400 calories increased from 65% in 1987-88 to 70% in 1993-94 (the height of SAP); allocations to health sector declined from 3.3% to 1.7% from pre reform period to post reform period; investment on health infrastructure also saw a decline during this period (Panchamukhi, 2000).
World Bank’s World Development Report (World Bank, 1993) titled “Investing in Health”53 reflected this global change. Significantly, the report introduced the concept of Disability Adjusted Life Years (DALY) as an index of health. By combining health years lost as a result of premature mortality and years lost as a result of disability it sought to provide a more calculable measure of health. ‘An important source of guidance for achieving value for money in health spending is a measure of the cost effectiveness of different interventions and medical procedures- ratio of cost benefits i.e. DALY’ś’ (World Bank). The report squarely linked improved health to economic benefits or human capital development rather than social development. Most importantly it advocated a lesser role for the government, shifting the burden of health provision to private providers and the individuals themselves (Hall and Taylor, 2003).

This report marked yet another shift in the paradigm of public health creating severe challenges for the poor and marginalized to receive adequate care, especially in developing nations.

Anjana Kothari a senior health consultant with the Futures Group provides some perspective on these changes:

In the last 7-8 yr, (the) shift is towards privatization… and that is one of the marked shifts in the history of health systems in India. We are seeing the introduction of insurance systems being promoted in a big way in the last couple of years. Government opening its insurance market to private players- a package deal with the focus on privatization. For a very long time (the government did not) respond to changing needs. Now they thought the way to deal with it is to open the market and allow private providers to come. You have states like UP and Bihar, who found it so hard to manage the PHC and Community Health Center they just contracted it out to the private providers.

---
53 Bill Gates claims to have been greatly impacted by this report.
We have private players that have outsourced little things like annual maintenance contracts to private providers; sometimes they have outsourced the whole management of the PHC to private providers. Other times just like specific things like maintenance and supply, laundry, which we don’t think are such big issues but they are very big issues. Most of the hospitals if you see—if you analyze the data from National Family Health Survey, what people complain about is long waiting hours, bad treatment lack sanitation most of our hospitals don’t have a system for hospital waste management.

As the Alma Ata deadline of 2000 approached it became clear that India like other developing nations, was far from achieving its goals for “Health for all”. In 2008, WHO released the World Health Report, titled “Primary Health Care- Now more than ever”. This most recent return to primary health care (including concepts of equity, social justice, participation, health system approach and social determinants of health) is far more comprehensive reflecting a broader impetus to bring people to the center of all global health programs. However, there are still considerable challenges in terms of engaging communities, involving governments, civic society and multi-lateral partners. For India in particular this shift is reflective in the National Rural Health Mission (NRHM) 2005-201254 (Ministry of Health and Family Welfare, 2005). The policy aimed to strengthen the primary health system in the country.

While India adopted many of the global policy mandates on paper, the actual impact of these frameworks on the Indian health system is less easy to describe. Often there was a lag or a dissonance between global policies and the response from the Indian government. In this analysis, I found that HIV acted as watershed moment for the country. India quickly recognized that to both combat the illness and participate in this changing health industry it needed to align with international agendas and actively adopt globally accepted models, strategies and

54 The National plan of action aimed to improve the health care delivery system of India.
discourses. Kothari and other stakeholders highlighted that this new age of contracting, insurance and health systems management that are clearly signaling other new changes in India.

Through this reading of health and welfare in India, I have tried to place harm reduction within the broader discourse of global public health. The historical shifts in public health helped to generate heterogenic health strategies in India and most significantly helped to create enough traction for the successful adoption of harm reduction by the state. The re-contextualization of drug treatment, within harm reduction and HIV was partially shaped by these public health traditions. They have helped to reorient the conversation about drug users, grounded in values of human rights, social justice and community participation.

**Government structures of care for drug users.**

Every state that signs up to the Political Declaration at this Commission (on Narcotic Drugs) recommits the UN to complicity in fighting a catastrophic war on drugs. It is a tragic irony that the UN, so often renowned for peacekeeping, is being used to fight a war that brings untold misery to some of the most marginalized people on earth. 8000 deaths in Mexico in recent years, the destabilisation of Colombia and Afghanistan, continued corruption and instability in the Caribbean and West Africa are testament to the catastrophic impact of a drug control system based upon global prohibition. It is no surprise that the Declaration is unlikely even to mention harm reduction, as it runs counter to the primary impact of the prevailing drug control system which, as the past ten years demonstrate, increases harm (Kushlick, 2009)

Barely a year after the introduction of OST, the Indian delegation, composed of members of the Ministry of Revenue, took a clear stand against harm reduction at the International
Commission on Narcotic Drugs\textsuperscript{55}. Since licit opium production continues to be a high revenue earner for the country, drug policy in India continues to be monitored by the Ministry of Revenue. Even though harm reduction interventions have gained prominence in the last few years very little advocacy work was carried out (by either NACO or Ministry of Social Justice and Empowerment) with the Revenue Ministry. For most health experts in India, who have fought long and hard for harm reduction, this international statement was a reflection of the failure of India’s health policy apparatus to co-ordinate their response to drugs and HIV. These very contradictions were the hallmark of the drug treatment sector in India.

In no place was this more visible than in terms of the overall structures of care provided by the government. The government department promoting harm reduction efforts in India is the Ministry of Health and Family Welfare (MOHFW). Established under this Ministry is the National AIDS Control Organization (NACO), which is directly responsible for all harm reduction activities currently within the country\textsuperscript{56}. State AIDS Control Societies (SACS) \textsuperscript{57} which are autonomous bodies, at the state level and District Aids Prevention and Control Units (DAPSU) at the district level are the decentralized bodies that manage HIV prevention and by extension harm reduction work in the country. As I have detailed before, only a small proportion of drug users are at the receiving end of harm reduction services. In fact, abstinence focused services continue to remain the mainstay of the Indian drug treatment sector.

\begin{footnotesize}
\textsuperscript{55} CND is the central policy-making body of the United Nations in drug related matters. It also monitors the implementation of the three international drug control conventions and is empowered to consider all matters pertaining to the aim of the conventions, including the scheduling of substances to be brought under international control.

\textsuperscript{56} Altogether 33 Union ministries and departments of the Government of India have mainstreamed HIV/AIDS prevention in their day-to-day functioning and thus have special programs.

\textsuperscript{57} SACS boards have representation from key government departments, civil society, trade and industry, private health sector and networks of people living with HIV.
\end{footnotesize}
To understand these intricate dynamics I went to visit one of NACO’s chief program officers Dr. Alkesh Kumar. He explained to me that despite NACO’s leading role in the harm reduction work in India, it was actually severely constrained in its functioning. NACO had to work within the broader framework of the NDPS policy and in conjunction with the Department of Home, the Narcotics Control Board, Ministry of Social Justice and Empowerment (MSJE) and the Planning Commission. This of course did not include working with the dozens of international organizations and NGO’s that are partners on a variety of projects with the government. The government i.e. NACO, Dr. Kumar pointed out was now spending a majority of their time managing these various relationships, creating funding mandates, developing treatment protocols, training peer workers and generating the structure within which harm reduction could work.

The Ministry of Social Justice and Empowerment (MSJE) is the nodal ministry for drug demand reduction, prevention, assessment and treatment. Despite the growing momentum to support harm reduction MSJE has largely stayed out of the domain of harm reduction. MSJE’s interventions focus on abstinence policies for the wider group of substance users i.e. alcoholics, non injectors as well as injectors (MSJE, 2009). However, their role in the overall drug treatment environment cannot be undermined. Under MSJE, it is the National Institute of Social Defense (NISD) that undertakes all critical tasks related to drug treatment. There are about 251 drug treatment centers supported by the Ministry of Social Justice and Empowerment during the year 2008-2009. These centers, located all across India, provide abstinence-based rehabilitation services to drug users (MSJE, 2008)\textsuperscript{58}. A senior bureaucrat with MSJE Mr. Basu, explains:

Our focus is to rehabilitate the drug users in their own profession and lead a normal social, personal and family life and we also address a much larger audience – we not only

\textsuperscript{58} Many NGOs on their contract were blacklisted for non performance last year, this list was widely circulated.
target injecting drug users we target all those who are using drugs – we also focus on social family integration- we take focus on withdrawal, counseling and vocational counseling, behavioral change, yoga. We are in demand reduction … so we are not supporting any drug taking behavior – our approach is to rehabilitate them and abstinence… so we are not supporting any (author emphasis) drug taking behavior.

Ministry of Health Family Welfare (MHFW) also runs 122 de-addiction/detoxification centers across the country (MHFW, 2011). These centers adopt a medical model of addiction and mainly focus on addressing the physical symptoms of drug addiction with an abstinence focus. Given the burgeoning numbers of clients that require drug treatment services these government run programs are clearly unable to cover the vast majority of clients. Hospitals and private de-addiction clinics aside there are hundred of NGOs, international bilateral and multilateral organizations as well as foundations and international NGOs that are also providing drug recovery services in the country.

During my fieldwork period the government was in the process of streamlining the services, identifying gaps or duplications and developing standards of care. International organizations and NGOs played a significant role in service delivery. To further understand these state and non-state stakeholder relations I will now undertake a more in-depth examination of these arrangements.

Public–private partnerships.

It was coming to the close of my fieldwork in India and I had been invited by to attend a two-day consultation titled “Developing Advocacy Strategy for IDU Living with HIV- the way forward”. Supported by FHI, Avahan and INP+ it was one of the first forums that was placing

59 The contemporary medical model attributes addiction, in part, to changes in the brain's mesolimbic pathway. The medical model also highlights that addiction may be the result of other biologic, psychological, or social conditions. Within the disease model of addiction, a genetic predisposition is believed to be present.
IDU issues at the center of the HIV struggle. Over the course of one and half days over fifty different organizations working with IDUs, including civil rights groups, HIV AIDS groups, international organizations and funders shared, argued and discussed a whole host of concerns related to IDUs. The Consultation aimed to develop advocacy strategies for injecting drug users living with HIV in India. At the end of the Consultation they planned to put forth a strategic plan in front of the government to inform their policy for IDUs.

As I stood in the reception area of the conference hall during a break from the morning session, I could easily pick out the UN representatives dressed in vibrant expensive silks and well cut suits, chatting in dulcet tones in the corner. The large contingent of drug activists and NGO personnel dressed in more casual clothes formed a stark contrast sharing hugs, making loud jokes and exchanging cigarettes. Besides these two groups there were public health specialists, government officials and members of civic society organizations. This third group was harder to pick out and were clearly also more flexible in their social interactions.

NACO’s senior bureaucrat Amrita Pandey had agreed to come during the final phase of the meeting to learn about the consultation’s outcomes and present the government’s point of view. Later that afternoon dressed in an elegant silk sari Amrita Pandey walked in, accompanied by her colleagues. I was surprised to see the entire room stand up to receive her. It was a significant gesture of respect and awe not often seen in relation to government officials, who were often perceived as obsolete and irrelevant. After intently listening to the report from meeting and making notes she opened the forum for questions. The queries were focused on the inefficiencies in the system, the lack of availability of medicines, delays in providing testing equipment, lack of government supervision in critical care and the future of harm reduction in India.
Unlike the usual bumbling and unaware government official Ms. Pandey fielded the questions deftly displaying both insight and critical awareness of issues. She was both open to critique and cautious in her responses. Quite like a modern CEO she drew on up to the minute information from her colleague’s laptop and her own Blackberry. Towards the end of the discussion she spoke authoritatively about the modern role of government. She was clarified that NACO was keen to support the NGOs’ work, visit project sites to make sure they deliver services and co-ordinate with international agencies. However, she pointed out that it was the role of the NGO’s to act as a third eye and make sure that these procedures are being followed; NGO’s had to help in providing services and become the “eyes and ears” of the government on the ground. The Government, she pointed out, must now focus on managing technology, materials and people; rights and advocacy related work were considered beyond the purview of the government. Despite Ms. Pandey’s clear demarcation of such a division of roles, it was never as easy to point out these differences on the ground. I often saw an overlap of roles, funding structures, opinions and a criss-crossing of agendas.

Today, there are a dizzying number of international organizations that have become involved in the fight against HIV and by extension in some form involved in harm reduction work. These non-state or “private” organizations are in most cases part of hybrid structures of governance with the state or “public” stakeholders. Such alliances are broadly labeled as public private partnerships (PPP). PPP’s have become key to running large-scale public health programs and harm reduction in the sphere of drugs and HIV is no exception in India. Within harm reduction there are many different types of PPP models currently functioning in India. First, there are Government funded and NGO run programs providing services e.g. Ashray was supported by NACO and Delhi State AIDS Control Society. Second, there are UNODC
supported projects that are largely demonstration projects or research pilots that also provide
OST and other harm reduction services. Third, there is Government and UN supported
collaborative efforts to provide harm reduction services. Fourth, there are harm reduction
projects run solely by bi-laterals, international funding agencies and global organizations. Fifth,
NGOs also are often times providing one or more harm reduction services within their larger
mandate (There are other types of alliances as well, which I have not covered in this section).

Steven Rao one of the leaders in People Living with HIV movement in India suggests
that now it almost ceases to matter who provides the services, public/private. But what does
matter is that “it should be providing a good service to the common people – accessible,
affordable, free...”. The Government, he claimed can negotiate and help make it profitable for
private players to enter the health care market. For Mr. Rao and many other NGO leaders the
“post HIV” development sector was about opportunity, seeking alliances with all kinds of actors
irrespective of ideology. I wondered about this ethical suspension where all actors were
claiming to be equal partners in the noble fight against this deadly disease. Were my ideas about
difference, discordance and diversity outdated in a world that was about harmony and
functioning? To understand these interactions between the stakeholders I identified three key
areas - policy construction, program planning and donor coordination and development of harm
reduction expertise (technological and knowledge based support).

I studied the construction of NACP III policy to understand these state and non-state
interactions better. Anjana Kothari, who worked with the Futures Group, shared with me her
experience of coordinating multiple stakeholders during the shaping of NACP III. The third
installment of the HIV policy was “developed through a major consultative, participatory,
inclusive and transparent process” Bahuguna, 2005 retrieved December 2010). In an
“unprecedented move the government threw open its doors to its citizens to critique the flaws of India's existing National AIDS Control Policy (NACP) and offer suggestions to strengthen the third phase of the plan, NACP-III” (Bahuguna).

The National Government constituted a Planning Team that included consultants from various sectors to better identify address current gaps and further decentralize the response. The Planning Team established fourteen thematic working groups, which included representatives of the Government, private sector, development partners, academics, scientists, and implementers including civil society organizations and networks of people living with HIV/AIDS. In addition to these consultations, there was a structured e-forum through which stakeholders contributed their inputs. There were other consultative meetings held with communities, community based organizations as well others who may not have had the opportunity to contribute to the policy development. Over the course of many months NACO involved hundreds of stakeholders, NGOs, community leaders and civic society participants to engage in one of the largest exercises in participatory policy building. Even though there were several issues during the course of this policy building process, it was an impressive feat given the complexities of such a large nation and the constituents. It also allowed these groups to understand the policy structure and composition.

There were many areas of the policy that generated concern and debates, for instance the length of OST support for drug users and the scope of services provided under the rubric of harm reduction. However overall, most stakeholders viewed the process of policy construction favorably. It showed the willingness of the government to consciously and creatively engage with the non-governmental, transnational, civic society and community based groups in shaping the national agenda. Furthermore, the transparency and involvement of civic society created an
open loop of communication and discussion rarely seen within policy circles. The expertise of these non-state stakeholders combined with their financial influence helped to increase their voice in this policy process. The state continued to remain the main player in policy development but its inclusive approach was a significant shift from previous efforts.

Next, I studied the arena of program development and donor relations. HIV had brought a whole host of players into the field and naturally there were hierarchies, both in terms of scale of their involvement and the budgets allocated to the program in India. At the top tier are global organizations such as UNAIDS, UNODC, WHO, World Bank, Bill and Melinda Gates Foundation, Clinton Foundation, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), UNDP, UNFPA, USAID and now PEPFAR (President’s Emergency Plan for AIDS.

---

60 The Joint United Nations Programme on HIV/AIDS (UNAIDS). UNAIDS is the main advocate for global action on the epidemic. It brings together ten UN agencies including UNHCR, UNICEF, WFP, UNDP, UNFPA, UNODC, ILO, UNESCO, WHO and the World Bank. The mandate of UNAIDS in India is carried out through the Joint UN Team on AIDS and the Theme Group on HIV/AIDS, with representatives from each cosponsor. UNAIDS works closely with the Government through the National AIDS Control Organization and other key partners including State AIDS Control Societies, civil society, the academia, the private sector etc. (UNAIDS, 2009).

61 United Nations Office of Drug Control & Crime in South Asia (UNODC), in partnership with the Ministry of Social Justice and Empowerment, is working towards mainstreaming HIV/AIDS and drug abuse concerns in the ongoing programs supported by the government. A majority of UNODC, ongoing and completed projects aim to prevent the spread of drug use and related drug-abuse-driven HIV transmission, especially among vulnerable population (UNODC, 2008).

62 WHO’s Country Office in India (WCO-India) has a long history of supporting several programs of Ministry of Health and Family Welfare, Government of India. The Country Cooperation Strategy (CCS) developed by WHO India for the period 2006-2011 forms the basis for delivering technical assistance in collaboration with the Government of India, the states, development partners and civil society. When the National AIDS Control Program was launched, WHO assisted the government in the formulation of strategy and plan for the implementation of prevention and control activities (WHO, 2006).

63 In 1991 the Government of India and the World Bank expanded their collaboration in infectious diseases control programs, and by 1992 the first National AIDS Control Project was launched with a World Bank credit of $84 million. For the second phase of the National AIDS Control Program, a World Bank credit of $191 million was provided. The Bank has worked closely with the Government of India and other donors in the preparation of the third National HIV/AIDS Control Program (NACO, 2007, retrieved December 2010).

64 The Clinton Foundation (CF) established its program in India in the year 2004, working very closely with NACO in partnership with UNAIDS. It supports the efforts of the government in care and treatment program for people living with HIV/AIDS. The Foundation set for itself a target of supporting treatment for 100,000 HIV/AIDS patients by 2007. Towards that goal it helped in training of private doctors, providing CD4 machines and technical consultants to NACO specifically for GFATM implementation. Clinton Foundation has made available high level of training for the Government of India by periodically bringing large number of technical experts from around the world (NACO 2007, retrieved September 2010).

65 The Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM) is an international health-financing mechanism, which is committed to accelerating the reduction in morbidity and mortality caused by HIV/AIDS, TB
AIDS Relief). In the next tier are bilateral agencies such as AusAid\textsuperscript{69}, NORAD, DANIDA, DFID\textsuperscript{70}, SIDA and GTZ\textsuperscript{71}. Followed by this there is an entire spectrum of smaller groups, charities and foundations that have their own agendas and funding pools. In addition there are foreign Universities, community organizations, civic society groups, churches, missionary organizations and a whole host of other unorganized actors as well as informal groups that are keen to participate in the unfolding AIDS drama.

\textsuperscript{66} UNDP’s role in HIV was fairly minimal until 2004, except a few programs with NGOs, private sector and positive networks. By 2005, UNDP set up its HIV/AIDS Unit. It received support from DFID for the initiatives to control trafficking and HIV/AIDS. It has also initiated specific programs/studies around health insurance and macro-economic impact of HIV. Under NACP-III, UNDP has offered financial support to NACO for expanding the mainstreaming initiative at the level of NACO and SACS (NACO 2007, retrieved September 2010).

\textsuperscript{67} UNFPA supports countries in using population data for policies and program to reduce poverty and assist in providing quality reproductive health and family planning services. The UNFPA Fifth Country Program (1997-2002) of $100 million was the organization’s largest assistance program worldwide. It was designed to reflect agenda post International Conference on Population and Development (ICPD).UNFPA Country Office has established case management services for Reproductive Tract Infections (RTIs) and Sexually Transmitted Diseases (STIs). It works closely with the primary health care centres and laboratories. Currently, UNFPA has three major interventions: promotion of condoms for dual protection, provision of RTI services at primary health centers and community activities to orient panchayat members on HIV/AIDS (NACO 2007, retrieved September 2010).

\textsuperscript{68} USAID implements HIV/AIDS prevention, care and treatment as part of the President’s Emergency Plan for AIDS Relief. Efforts include HIV prevention in high prevalence states and among high-risk groups, and care and support to children infected or affected by HIV/AIDS. The program focuses on reducing HIV transmission through behavior change communication among vulnerable populations, however does not support harm reduction. In 2004, USAID scaled up care and support activities. The CDC provides technical assistance and training to NACO in HIV/AIDS control and prevention. Until 2009 USA maintained a ban on federal funding for needle and syringe exchange programs (NACO 2007, retrieved September 2010).

\textsuperscript{69} AusAID has an agreement with UNAIDS for the South Asia region, under which it supports several regional initiatives including an HIV/AIDS program for the Northeast region in India. The key priority sector for Australia’s aid program in India is health, and it includes HIV/AIDS, education, and water and sanitation (NACO 2007, retrieved September 2010).

\textsuperscript{70} Department for International Development (DFID), India supports the Government of India’s efforts towards achieving the poverty reduction, health and education sector in the past couple of years. These are national program primarily financed by the Government of India but with a variable counterpart share from state governments. Support for the HIV program has moved from projects and direct support to the states in the 90s to a program approach and support for the national program under NACP-III, where DFID is the first donor to go for pooled funding. DFID’s experience in the five states in the initial years contributed in a large way in influencing national policy and the formulation of future phases of the national program (NACO 2007, retrieved September 2010).

\textsuperscript{71} GTZ’s HIV/AIDS program operates within the framework of the National AIDS Control Program. It facilitates dialogue with industry associations and civil society groups to promote more effective services and products for HIV/AIDS prevention (NACO 2007, retrieved September 2010).
Anjana Kothari provided some insight into the way these different actors came together.

She shared that in the beginning:

The problem in the donor coordination meeting was that you had 20 people or 10 people from the UN organization, you had people from Swedish CIDA, Canadian CIDA, World bank, global fund, DFID, all sitting around the table and not being able to take any decisions and come to any agreements. So one of the first things we did was, we introduced an entry ticket approach- any entity bringing 10 million dollars or more per annum towards HIV program will be part of the donor co-ordination at the national level. Put people of the same funding level together, their stakes are similar, they want to see value for money, they want to see result, so they are much more focused on what are the results, so to remove the discrepancy in the expectations of various players we introduced. It was also helpful to make the different units work together.

In 2004 Government of India requested smaller bilateral donors to discontinue their support or channel it through the UN or NGOs. Larger donors (Global Fund, World Bank and DFID, but not BMGF) were asked to channel most or all their funding through NACO.

Programs that outside NACO or SACS are now expected to use the NACO reporting system. India a late signatory to the Paris Declaration on aid effectiveness adopted ‘the Three Ones’ principles (one Agreed Action Framework, one National HIV/AIDS Coordinating Authority and one Agreed National M&E System). Such efforts at harmonization can place constraints on

---

72 Of the smaller bilateral donors that provided funds for HIV, Canada and the Netherlands pulled out in 2004, and AusAID and SIDA supported a regional NACO office in the North East through the joint UN program there.
73 Resource needs for NACP-3 are estimated at US$2.8 billion. Less than 2% of overall expenditure is through Official Development Assistance (ODA), but for HIV the percentage is much higher at 65%, if the World Bank credit of 10% is counted as a government contribution. Approximately half of the funds for NACP-3 are channeled through NACO, including those from GOI (US$715 million), Global Fund (US$446 million), World Bank (US$281 million credit) and UK Department for International Development (DFID) (US$202 million). The UN system has committed over US$80 million to NACP-3 (partly through NACO). Bilateral donors and foundations support the national strategy, largest being the Avahan project (US$356 million) supported by the Bill and Melinda Gates Foundation (BMGF) (UNAIDS, 2009).
innovation and reduce possibilities of NGO initiatives that are not “mainstream”. There are also concerns “about the cost-effectiveness and sustainability of HIV interventions that become overly donor dependent, for example, free treatment, special HIV link workers and financial support for PLHIV” (UNAIDS, 2009).

Despite all this talk about equality and aligning of agendas significant differences and tensions existed among these actors. These differences became even more pronounced when I began investigating the arena of implementation. Stakeholders were often keen to work in specific regions, the allocation of which was made through much compromise and negotiation. Anjana Kothari shares the Director General, NACO during these meetings would say:

We want to continue maintaining the focus on 150-160 category A districts (high prevalence of HIV), so then she would open it up saying we want consistent action, in all the category A districts and then people (external stakeholders) would offer how they want to support it, where they want to support it. So which of the donors can provide support for which of the districts.

The other forms of donor co-ordination were related to financial management and balancing budgets. At the state level the donors would map out the districts and areas they would focus on. The state government’s were then advised by the center not to spend as much funds in these areas but ‘redefine their role’ in these regions. If a new donor would come in they would thus have to adjust their interests based on such divisions of power and responsibility. Anjana highlighted that these negotiations were often difficult, biased and uneven. Certain states received more importance than others. Anjana pointed out:

When HIV started, it was initially stated in a couple of north east states and then down south, so many donors wanted to work in these areas – so the government also responded
with the standard public health approach- focus where the issue is, so that’s where they focused. In my understanding when the BMGF entered into the country, they put up almost a parallel structure, even though there wasn’t a written agreement with NACO for a very long time (they have it now). But at the state level they tried to work out districts with SAC (State AIDS Control Organization)- because they had a very big program. The funding of the BMGF was equal to funding for NACP II and only focusing on 6 states and only on prevention, so that was a lot of money. This gave opportunity to show how different approaches can work in the country at scale they were not one of pilots that the UN typically does, which then they find very difficult to replicate. But they did things at scale and …however it meant that at the field level (experience of care, structures) there were concerns around the way funds were being spent. If you have a doctor whose is getting 2000 and another getting paid 8000, its going to make a difference …the way NACO responded to this was coming up operational guidelines and operational guidelines- lot of times was spent in the first year of NACP III- was spent in shaping operational guidelines- and as you know these are legal documents. So operational guidelines standardized the approach as well as costing. Now that still does not prevent extra budgetary support from doing their own things but now its more a good will gesture- its more and more tendency to fall in line with what NACO has prescribed.

The differences between government supported interventions and privately funded ones, as evidenced above, created an inequality in terms of services and resources. The government recognized the dangers that such a differences in investment can make- both on and off the field. In order to address this difference the government began the process of organizing all services under a similar protocol.
The state also recognized that there are certain tasks were better when left to the private sector. Kirtana from UNAIDS shares an example:

If you are talking about condom promotion in the context of HIV, you could just put the condoms in the primary health center and hope that people would use it. But you actually have a social promotion and mobilization around condom promotion, so you find ways that the condom reaches that last outlet – people are able to access it. So you are supporting your health system through a partnership, which could be with Hindustan latex or with any other company (that has expertise in social marketing). We’ve had experiences in states where we have been able to increase the use of condom manifold through private intervention. I am believer of the public health system because that is what the common man will use in rural areas and even urban areas. I agree that a large number of people go to the private sector but I think when you are looking at services per se. There are certain services that are better managed by the private sector and I think we have to find those niche areas to support the public health system.  

Abhishek Gupta with HIV AIDS Alliance highlights:

There is a give and take which is happening where the government is to some extent trying to influence donors mindsets and where their money flows, but at the same time, the donors, because they are getting a seat at the table are beginning to negotiate with the government about what the approaches should be and what the government needs to think. So I think the relationships will probably mature in the next 5 years of NACP III. Where I think one would see probably a more rounded response from the point of view of

---

74 Another example she shares is the in Gujarat where Reliance Industries has taken over the public health care centers in certain areas and are running it a more efficient manner. She specifically pointed out that ‘private’ today could include civic organizations, health networks and even community organizations all of who were important partners in this fight against HIV.
the government.

Finally in the arena of expertise development, international agencies like the UN played a crucial role in providing the technical support to the government as they developed protocols and frameworks of functioning. Kirtana Singh, head of HIV programs at UNAIDS shared that their own role as a global organization had seen such a transition as the program had grown and evolved:

What one is seeing is that apart from sustaining what one has started, you can see a lot of initiatives being taken on by NACO, on expanding the existing program, put up initiatives or proposals to expand that and really make it a good quality program…(thus) they are working with people like Dr. Sunil Seth (an independent drug expert), UNODC is bringing in international experts-so is Gates foundation- We recently had a meeting with DG (Director General) on the larger program. And her request to UNODC was that all I need from you is support for scaling up the OST program- drop everything else you are doing, that is important but not so important but support us on this.

Kirtana highlights that the UN agencies played an important role in ‘packaging’ the model in such a way that it became acceptable to all parties concerned. Sahiba Kaur of UNODC notes that UNODC has been able to juggle and work with both Ministries of Social Justice and Health with two opposing viewpoints. Given that the larger mandate of UNODC is demand reduction their natural allies were the Ministry of Social Justice and Empowerment, however with time the momentum shifted towards harm reduction and their participation in this newer paradigm has become more significant. Some NGOs and public health specialists feel that this type of ‘dual’ position of UNODC actually works against the harm reduction movement whereas others highlight that the entire sector of drug treatment seems to straddle both perspectives-
abstinence and harm reduction all at once.

UNODC also partnered with Government of India to take over the DFID supported OST sites and “prepared” them for a smooth government transition. Sahiba Kaur shared, “UNODC helped the government to do evaluations of all these sites, to see which ones they could take over and which ones were just not providing any services”. UNODC also became a conduit through which funding for these sites flowed until the accreditation process for these sites was completed. Rajat Dhingra, a senior technical officer shared that their role was to make sure these sites met the NACO guidelines on targeted interventions for injecting drug users “and provide catalytic support in absorbing these sites under NACO’s own NACP III policy”. The “preparation” of these sites also includes “a lot of training and capacity building for the implementing staff so that includes doctors, pharmacists and support staff”. UNODC has established an additional learning center on OST with AIIMS (India’s leading government hospital), they have also established such centers in other south Asian countries where OST projects are active, thus supporting governments to generate more research knowledge on the issues.\footnote{One of the key research projects launched by UNODC is a Rapid Situation Research Assessment to understand the impact of harm reduction programs.}

Dileep who worked with Ashray (NGO), shared his frustration about the importance given to these international agencies, “only about three to four years ago they (UNODC) were totally against harm reduction and (now) suddenly they barged in, they started hiring consultants, started publishing manuals on harm reduction, OST with methadone, OST with Buprenorphine”. This was a crucial issue of contention with NGOs who had often worked longer on the street than these UN “experts”. UNODC has helped to develop ‘tool kits’ for Buprenorphine maintenance therapy, needle syringe exchange and other harm reduction strategies; these tool
kits became precursors to the Government of India’s own training modules. UN’s role was crucial in knowledge generation, research, documenting, training and development of expertise has brought with it global standards of care, evidence based practices and shaping of more transnational model of harm reduction\(^7\).

Sahiba Kaur was clear there was a definite “comfort level” between the UN and government. They worked with the Government on many projects, trainings of peers and workshops, she says “we invite them, they invite us, essentially we go through the government, they sign on our project documents and agree to partner on projects. The interaction with NACO and MSJE has been good and been constant”. This trust is most evidenced when the Government reaches out to them for both information and perspective on different issues.

Sahiba shares some examples:

When the government comes and says look can you provide us with the information or give your comments on this document or can you organize the evaluation for us by independent experts… so I think we are seen as a partner, we are seen as a ‘valued’ partner, also as someone who is unbiased. So I think it has been quite good and even now especially on the Buprenorphine front its been quite good and last year NACO wants to do a pilot on methadone as well and so they approached us and said look you prepare us a concept note and send it to us because we want UNODC to do the pilot so I think that sort of the sign of trust and understanding I think the relationship is good.

UN agencies were taking the national lead in supporting government efforts to legitimize harm reduction. They were seen as a ‘neutral’ agency not aligned to any one particular government department. As a transnational development organization, with great social

\(^{77}\) It is important to note that quite often these UN publications involve NGO and government officials. Also there is this large deficit about knowledge about harm reduction, which UN officials are helping address.
currency in the development sector, their sanction was helpful for NACO to maintain credibility. NACO understood the political hierarchies and was consciously seeking these ties. For the UN this relationship was critical to their presence in the country. Kirtana from UNAIDS highlighted that the HIV program is all about partnerships- “between government, non government and donor agencies (UN and other bi laterals), I think it is really very strong, which defines the future direction- which is also helpful”.

From the government’s perspective the response towards such collaborations was much more guarded. Sankalp Sinha a technical officer for NACO felt that despite the talk of collaboration there was quite a lot of ‘competition’ among the UN agencies to prove their expertise. He also pointed out that these organizations there were considerably distanced from ground level realities, government officials on the other hand, were more keenly aware of these issues. There was similar hesitation voiced by Dr. Alkesh another government bureaucrat of NACO. He claimed that the international organizations were driven by global shifts in agendas and were often keen to address specific project oriented concerns. In contrast to this, the government was aware of these global foci but successfully shaped its policy in response to the community’s needs.

Bi-lateral organizations often collaborated with the UN agencies and the government on projects and participated actively in the macro policy environment. These relationships were strongly governed by factors such as the host country politics; European agencies tend to be more open to harm reduction as compared to the U.S. government and this impacts the types of programs they fund in India. The economic interests of each country and the relationship with the Indian government also impacted the nature of their participation in the harm reduction programs. The relationships between these organizations would change as their investments
within the country changed (increase or decrease). Cross cutting agendas, bargaining and collaborations complicate this policy environment.

**Non-govermental but governmentalized.**

NGOs have traditionally occupied a key role in drug treatment and in the broader development sector in India. As discussed earlier in this chapter some of these NGO’s were pioneering harm reduction efforts even before the government became involved in this area. Both within India and globally NGO’s have had an important role to play both in the development sector but also more specifically in the drugs and HIV sector.

The evolution of NGO’s in India was marked by a growing disenchantment with the Indian state, which despite its socialist leanings was failing to meet the needs of its poor and disenfranchised citizenry. After independence India was keen to build a strong nation built on the promises of social justice, peace and equity. However by the 1970s and 80s it became evident that there remained stark inequities partly the result of skewed government policies. Severe critiques were levied against the ‘trickle down’ modality of growth and development that served to only support the industrial and urban sectors of India (Nandy, 1987; Shiva, 1989; Kothari, 1988).

During these years the country saw the resurgence of Naxalities (violent communist groups) and other Maoist groups. They adopted a revolutionary stance against perceived injustices and building from a peasant base and community focus they challenged the status quo. At the same time there was also the rise of other non-political groups that began to fight for a variety of social concerns, these included charitable organizations, religious and civic bodies as well as community organizations. Non-governmental organizations began as an offshoot of
these institutions and over time developed a unique space of their own, ultimately becoming a significant site for social and political activities within the country.

Under this new harm reduction regime the role of the NGO has developed into a service provider primarily. Roughly over 500 NGOs are currently involved in the drug treatment sector (FINGODAP, 2006 retrieved 2010) and close to 130 NGOs are linked with the government to provide harm reduction services. With the support of international agencies the government now ‘outsources’ care-giving functions to NGOs quite unlike other public health models. The government recognized that in most cases NGO’s were well versed in harm reduction services and was keen to partner with them (due to their prior experience in running their own programs or expertise gained by managing the pilot projects launched by international agencies). NGOs also possessed the necessary skills to mobilize communities and understood the needs of the communities far better than any other organization.

This collaboration with the NGOs was both beneficial and problematic. Experts argued that NGOs found it difficult to balance their ‘care-giving’ functions with their advocacy functions. As a result, I observed that the NGOs were submerged under the everyday problems of service provision and did not have the time to address systemic concerns. However, unlike before NGOs were now given a seat of importance on the “policy table”. Their involvement in trainings, development of promotional material, research and protocols are some of the ways that the NGO’s are being incorporated into the processes of state care model.

Abhishek Gupta, a HIV expert from HIV/AIDS Alliance provided some additional perspective on the nature of these NGO-government relationships:

The NGOs are much more in touch with reality, much more representative of the voices of the community and therefore all the several issues which relate to individual agency and
rights is something which the NGOs are constantly advocating with government for so whether people are not getting treatment, whether harm reduction is not being accepted at the community level, if testing kits are not available, substitution therapy is not available… those are the kinds of things NGO are fighting for besides providing services. Now very often the government is aware of these issues but needs to be reminded of these issues on a constant basis. I think today the government is far more open to hearing various voices from the field as it was say 5-10 years ago and I think that has also happened because of the evolution and the maturation of HIV within the country and the increased realization of the dependence on NGOs and on (patient) networks to be able to deliver the programs.

I mean the government cannot do without the support of the NGOs as simple as that and that message is far more clear now within the government than it was earlier. So I do think that there was a little bit of opening up from the government side though still they find it hard because you know it’s a constant criticism of their own program, their own thinking their own strategies, which are also often determined by various political agendas and foci- but at the same time the only way to influence them is through the voice of the people, through the movement, which is what the NGOs bring to the table so they are forcing the government into corners very often and winning small battles every now and then.

Dr. Alpana Deshpande of the WHO shared the benefits of having NGOs in the mix of service provision. She pointed out, that unlike the bureaucracy that has its “own system in place, they are accountable to several other agencies, they have their auditors…the NGOs function in a much more flexible and unregulated environment”. This adaptability is essential for a successful
community level program. Government programs were more likely to face restrictions, NGO’s on the other hand much more flexibility. Dr. Alkesh from NACO, however claimed that quite often the NGOs ‘had the heart but not the head’ i.e. they were not trained to provide the multiple types of social, psychological and medical services needed. He felt that even a simple program such as needle syringe exchange required expertise, planning, and management, which was often lacking in the working of the NGOs.

While Dr. Deshpande from WHO supports such a government and non-government partnership, she argues that the state must contribute more heavily in the health sector and “NGOs need to be made more accountable they need to work around sustainability and equitability of the partnership…” To address some of these gaps in knowledge and practice, NACO had begun trainings, workshops, developing protocol for interventions and even a process of accreditation for the NGOs and NGO workers.

I had the chance to participate in one of the training sessions that was conducted by NACO. The State Resource Training Center provides most of the training for the partners of harm reduction; they had in turn outsourced the task to Alfred Da Cunha, a peer worker from Sahai. Many of the NGO’s that the state had partnered with were either following an abstinence-based program or were not specifically trained to provide services to drug users. NACO thus had the daunting task of not only educating them about harm reduction but also about drug use in general. However, NACO did not have enough in-house experts that had the time or enough field experience, hence was ironically hiring from within the NGO community to educate other NGOs.

During the training session Alfred gave detailed instructions on the intentions of the new model of harm reduction. He told them that the focus of harm reduction was not to
eliminate drug use but more simply to avoid HIV risk. The motive of the training was to standardize care and eliminate the idiosyncrasies of their local cultures of therapy and recovery. I noticed that the bulk of the training was focused on convincing the workers about the usefulness of such a model, since there were many skeptics and long-term Narcotics Anonymous followers among the peer group. Advocacy functions were given less importance as was seeking connections and networks within the community to support the drug user beyond recovery. Finally, the training was heavily focused on documentation, accounting and auditing their time on the field. There was a clear sense that with the involvement of the government, the NGOs had to become more accountable and record keeping was key to this process.

While the NGO’s considered themselves experts in the field, these trainings functioned to “re-educate” them in the technical processes of a national program; drug treatment in the community was clearly now being “disciplined”. With Bill and Melinda Gates attempting to transfer their projects to community-based organization in a few years, the stakes are indeed high for training these community drug treatment organizations.

Kirtana at UNAIDS highlighted that the training of these community level organizations was a key challenge for the national program:

In Mizoram, they had no clue- they didn’t know what an outreach work worker should do, what a peer educator should do, they did not have a doctor or nurse. That kind of handholding is really intensive and I am hoping that this year and the next year there really would be a good structure in place to strengthen this program because we know that one can reach out to the last person through NGOs and CBOs but you do need closer support for these groups and you do need consistent monitoring. NGOs are normally set up by a person, who is committed who’d like to do something for the community, but
beyond that you are looking at a program that is complex… you do need a lot of support.

And that really is the challenge right now NACP III.

Dr. Khom identified similar issues “One of the things that didn’t work is that you have well meaning NGOs coming up lots of them really committed to health – but with little idea about or understand about the harm reduction issue itself”. He argues that most drug treatment organizations come with the philosophy of abstinence “so for them it takes a long time to switch” to harm reduction. He also identified that some NGOs are church based and have moral concerns about harm reduction. He acknowledges that most NGOs have very little monitoring and quality control and with greater focus on accountability and evidence, NGOs will have to improve their functioning in order to continue to receive support. He feels that one of the reasons the government has been slow in expanding the harm reduction program is the lack of capacity of both NGOs –the implementing partners and the inability of states to provide adequate training and support.

I am saying there has to be minimum system in place- storage of drugs, make sure how the Buprenorphine is kept properly (the rooms, temperature), distribution, entry, screening follow up – all these things have to be in place – now I don’t think in many targeted intervention locations are very confident- that is one side, the other side is how many of the SACS officials are conversant with this to be able to follow it up properly what temperature it has to be kept, what is the supply chain system, follow up system so they are slowly going slow on that. I think we need to push further…

NACO has also been impressive in bringing a number of regional NGO’s to the center stage thus increasing their visibility and exposure, while at the same help to forge alliances
across groups. However, building consensus was not an easy task, there were crucial differences among regions and the NGOs.

I had an opportunity to understand these differences during one of the meetings that I attended during my fieldwork. The meeting was focused on the rights and needs of the injecting drug using population. Over twenty-five harm reduction NGOs’ were attending the session from across the country. The discussion was centered on setting priorities for a policy document that would represent the key needs of IDU’s. The divisions between the NGO’s became clear quite early on. Older organizations from the northeast and from New Delhi were keen to push for second line of ART medication, better testing facilities and a larger focus on OST programs. These organizations were involved with harm reduction efforts for about a decade and were keen for more advanced services and structural changes. The newer organizations were keen on support, training and better coverage of their clientele; many of these organizations were from the South and Western parts of the country. Issues like stigma and discrimination remained important for all NGOs across the country, except in the northeast where drug users are usually more accepted. However, in order to bring about long-term change all NGOs recognized that HIV and harm reduction needed to be “mainstreamed” in the Indian public health care system. Kirtana from UNAIDS pointed out:

Until you integrate this program with the larger health program HIV will still be struggling. It needs a different focus as well because of the stigma and other issues but at the same time it must be a part of the state health program. Otherwise it will remain this vertical program implemented by NGOS and CBOs – there is this huge pressure to scale that up; the capacity to manage that scale is not completely there in many states so it is
not an easy situation to be in where a large part of your program is sitting with NGOs and CBOs.

Abhishek Gupta from HIV/AIDS Alliance also concurred with this view:

We need to sort of merge the entire HIV response within the national rural health mission, so in which case this vertical response to HIV may actually change which means you may not have the small NGOs working at the grassroots level as much as they are working now, there will still be a Non governmental component to the response but probably not like today- tomorrow it might be led by the government machinery the health machinery, which today is in shambles.

**A booming business of health.**

The underlying philosophies and logics of care based on my fieldwork also represented often seemingly opposing and antithetical worldviews of the diverse stakeholders. The ideals of human rights, equity and social justice were clear remnants of the global paradigm of public health and harm reduction and had found their way into the Indian policy and intervention sector. In addition there was a clear focus on the “economics of health”, with an emphasis on greater efficiency, investments in areas of high returns models of health related more clearly on productivity. These tensions shaped the daily decisions of harm reduction policy and more crucially trickled down to the practices of harm reduction as well.

To understand these unique dimensions of harm reduction I turned first to one of the largest funders and policy influencers in the Indian harm reduction circuit. After many phone calls and emails I was finally able to secure a meeting with Kanika Ghosh. She was the young dynamic ex-management consultant from New York who had returned a few years back to lead and shape the Gates Foundation multi-million dollar initiative within India.
The Gates Foundation is one of the largest funders of public health programs not only within the country but also across the globe. They contributed close to 258 million dollars and more recently added another 100 million (Bill and Melinda Gates Foundation, 2009, retrieved September 2009). Their approach to health, thus, influences and frames not only their own programs but also those of their funding partners including the Government of India. Hence, their perspective towards both health and overall development is important to understand in any analysis of the harm reduction programs in India. I was slightly surprised to learn that our meeting would not be held in some plush office in south Delhi but instead within the freshly renovated government offices of the NACO. While the larger government building was dilapidated, the AIDS offices were well designed, airy, with their walls adorned with colorful posters and some local art.

Kanika spoke authoritatively about the role of Bill and Melinda Gates in India, “our work with the government was to help the government wherever we can and wherever we were asked to. An MOU was signed in 2006 for the Avahan/Gates Foundation to provide technical and managerial support to the government to scale up some of its high risk programs”. She highlighted that both “adhoc and more formal support was provided as a part of this MOU, including secondment of staff over to NACO, we have helped them with guidelines where required we have provided training as required, modules in all of the above areas”. But it was not always like this:

When we came in people were actually denying we had an HIV epidemic and people especially the government was very very leery of us as an organization- but close working with them and also proving what we have actually done has helped put the
credibility of our organization and hopefully the methods have spoken for our themselves in some ways. I would rate our partnership in nothing short as strong.

Kanika also importantly detailed the role and trajectory BMGF adopted when it came to India:

In terms of the Government we didn’t start working with the government, we made grants directly to NGOs and continue to do so- however the foundation’s policy in India or policy in general is not to replace government or market or not to crowd any of them out, it is really to be catalytic investors…we are not permanent funders …we know the money will run out one day, we know the foundation corpus expires 50 years after their (Bill and Melinda) death. So we started investigating (whether) the natural owners of the epidemic could take ownership and adopted two strategies, one is to transition our efforts back to the government and to transition our efforts to the community itself they will then demand these services than be recipients of the services so community mobilization is the linchpin of all of that.

Kanika was clear that their effort was to develop a program that would work on a large scale and effectively curb the epidemic. She shares that their effort was and continues to be largely focused on not as much proving the harm reduction model, which has been already demonstrated to work, but instead launch at the scale where it can have a strong impact on India. In an interview that Kanika gave to a Global health blog she draws a strong parallel to private business enterprise. She pointed out:

It’s similar to any business model that you can find in the private sector, where there’s a focus on the customer as the beneficiary of the services being sold – or delivered in the case of health. In the private sector that’s buying toothpaste; in the public sector it might
be the impact in terms of lives saved. In the context of HIV prevention in India, the recipients of prevention services (sex workers, men who have sex with men, injecting drug users) need to be part of the delivery, as peer workers (a “sales force”) and be leaders of community-based organizations delivering the interventions. So the question is - Are you able to design for scale? Do you have a clear denominator? Are you focused in your intervention? Are you integrating across your value chain even within one area? Are you measuring everything you do, which is a very critical piece of any good business? Then you think about executing for scale, what does that mean, operationally and tactically? Are you organized to the point where you can implement on a large scale? Large businesses do not just implement in one little place, otherwise they don’t make enough money. Similarly, with impact, I think you want to have a greater span.

Clearly this position of the Gates Foundation was exemplified in first the nature of their funding and activities since they had entered the country. Their focus was on high-risk groups, in areas of high prevalence, using globally accepted models of treatment, and involving the affected community in all areas of program implementation. With a heavy emphasis on creating structural infrastructure such as testing facilities, clinics and drop-in centers as well as on ‘softer’ infrastructure such as creating a trained outreach/peer staff, developing accurate mapping of the concern and establishing linkages with community organizations.

Critics of the program cite many issues with their approach- from the ideological i.e. the Gates Foundation has used an business model to approach public health to the economic, i.e. high salaries and technical investments did not necessarily make a difference to the people on the ground (Flock, 2009). Globally these criticisms are being increasingly voiced by a small number of public health activists and civic leaders. Their claims that the Gates Foundation is largely
pushing technical interventions, without addressing more structural and cultural contexts has been soundly refuted by the Foundation. Both Government of India and public health specialists in India have responded to these critiques very cautiously- highlighting the needed for continued support- highlighting the complex and interdependent relationships between these stakeholders.

Over the next few years Avahan (Gates Foundation’s India office) will be slowly transferring many of its projects to Government of India. In fact, some public health specialists note that there was a clear “scaling down of role from an implementer to packaging the learnings’ from Avahan” from 2006 (Rao, 2010). There are also concerns about structural and functional capabilities of the State Aids Control Organizations and their ability to manage as well as monitor these Avahan ventures. In addition the incentives to staff and investments in the program of Avahan led programs is far higher than the publicly funded health programs of NACO (Rao). All of these point to serious issues in terms of transfer and maintenance of quality. Given Avahan programs exist in some of the highest at risk regions with most vulnerable groups, this transition has greater implications for the overall harm reduction model.

While my fieldwork did not include any direct observation of the Avahan funded project it was clear they exerted considerable influence in the macro policy context. The areas this was most visible was the way most funders and government spent their money, the frameworks adopted towards harm reduction measures and the focus of implemented programs. Prevention for a country like India was key to stop the epidemic, considering the low rates of prevalence and a large portion of the funds went into infrastructure and technical support. This meant needle-syringe exchange programs and OST were getting a good proportion of the funds as they were framed as risk reducing measures as was outreach. However, nutrition, psychological counseling or long-term rehabilitation was either seen as uneconomical or
ineffective in ‘halting’ the epidemic. The Government and other funding agencies also were following such logics and thus there was an overall consensus in such efforts.

Non-injectors and alcoholics were considered less risky groups despite prevailing knowledge about their high-risk behaviors and health vulnerabilities. Harm reduction programs, according to Avahan literature, was subsumed under the “business of prevention of HIV” and the emphasis according to Kanika Ghosh was on the creation of an “aware consumer”, getting an individual “who otherwise did not care about health to care about health that’s some of the biggest benefits”. Kanika highlighted that this process also involved:

Creating demand for services especially in HIV prevention for sex workers, men who have sex with men, and injecting drug users. These populations are marginalized, they’re underground, and they’re very dispersed. Also, creating demand for services can create solutions for sustainability. If a service is demanded by the community then, whether it’s from the government or from other NGOs, funding can be found.

While Government of India, in particular, did not use such a language necessarily there was recognition that health investments must be made in areas where there was ‘evidence’ of returns.

**Generating a paradigm of harm reduction.**

The unfolding dynamics of the different stakeholders in the harm reduction paradigm in India have brought forth the highly unstable and fickle nature of the politics that surround this sector. Clearly the state is becoming increasingly involved in the health of drug users in a manner that was not seen before, though it is adopting two diverse routes to secure it.

On one end it is becoming a manager of sorts by delegating many functions, developing expertise and creating a cadre of workers and institutions that are ‘non-state’, to provide harm
reduction services; while on the other hand it is re-investing in public health in more of
traditional welfare state model to provide care for its general citizens, of which drug users are an
important segment. No doubt the approach to health has also evolved in this process, with
greater emphasis on evidence base practice, research, risk management, economic evaluations
and creating a more aware, responsive, choice bearing consumer.

However, this development was far from even or cohesive, multi-stakeholders each
with their own perspective on care and health were creating many competing discourses within
the harm reduction paradigm. There was also a great range of service quality, lack of adequate
monitoring/supervision, disruptions, corruption and delays – making it difficult to necessarily
advance any overarching model that was reflective of any one particular ideology. Halmshaw
and Hawkins (2004) highlighted that many international organizations support or channel their
funding through government intermediaries, a trend clearly seen in India. However, this can act
as a problem especially as the government may not have the capacity to adequately absorb the
funds and disburse it fairly. In fact these researchers argue that government often suffer from
their own biases and may tend to standardize approaches to the problems instead of promoting
innovation and independence of community based organizations. In the case of harm reduction
in India all of these trends were visible especially as the government tried to build a new
framework for drug treatment and health and remove local difference. The balance between
adopting a basic minimum standard for provision of services and providing a conducive
environment for new strategies to emerge was difficult and not well executed in the contexts, that
I observed.

Bilateral agencies and international organizations though often at the cusp of new
trends and developments from across the globe, lacked street credibility and knowledge of the
local culture of drug treatment. While they were using NGOs and community based organizations to overcome this gap, it left big questions about who could be considered the ‘real experts’ and what type of cache did expertise bring with it? NGOs in particular were being pulled from their anti-state and advocacy positions to almost become service arms of the establishment. Their own cultures of therapy was now being rewritten in a new language of risk and pharmaceuticals- their participation in the model entailed a revision and re-visiting of their old methods of recovery. This era of accountability was important especially in a sector that has remained unregulated thus far. However, in the same vein harm reduction programs were originally most lauded for their flexibility and adaptability, which this new ‘governmentalization’ is definitely questioning.

This interweaving of public, private, government, non-government and civic society was how harm reduction was being built. Administratively, financially and ideologically this paradigm clearly showed that there were no permanent allies or enemies. Though the stakeholders were invested in certain positions with regard to drugs and harm reduction, they were often flexible across a range of issues and were willing to collaborate and work together. In some senses the current climate of funding structures, grants and the very scale of the projects makes it such that no one stakeholder can work alone. Surviving in a system of revolving doors, where new partners entered as old ones left, was both difficult and challenging. In terms of even mapping these diverse groups is extremely challenging partly because these actors keep evolving and changing their roles, alliances and positions. Swidler (2007) discusses these complexities through evolving a multi-level universe of actors that are interacting simultaneously with a diverse set of players and are thinking about boundaries in unusual ways, especially about nested hierarchies and social processes. Traditional categories of local, regional, national, international
and global, she argues will not work very well in these new ways of thinking about harm
reduction and there must be in fact a greater emphasis on interpenetration of actors, permeability
of boundaries and their own roles as well as the way they come to understand the way they
function in the larger global conditions.

But one of the key points that my fieldwork underscored was that despite these
interdependencies and overlapping of roles and responsibilities each stakeholder was vested in
maintaining a separate identity. The Government continued to push its role as a welfare provider
with critical goals of health and well being for all. NGOs talked about the necessity to remain a
watchdog for the people and committed to the cause of communities in the city. Bi-laterals and
international organizations focused on their global legitimacy of being organizations committed
to health, rights and risk reduction. In the reification of their identities as separate and unique
they seemed to almost overlook the everyday practices of governance and disciplining that was a
crucial mark of their relationship.

Harmonization was a key “organizing” concept and seemed to dominate harm reduction
discourse in India. However, I could see that it ended up masking the inherent differences,
peculiarities and discordant world-views, in order to bring all actors together. In this fight for
survival as agendas intertwined, beliefs got suspended and alliances were made. The temporary
and instrumental nature of these relationships do not undermine the impact they had on the
policy and practice front. Dr. Sunil, an HIV expert in the region, claimed:

We are not really tied or bound to any one particular ideology, if it works then we do it.
Abstinence is the ultimate goal- but it seems no one is in a hurry to get there yet, in fact it
is a continuum of care model and one needs to look at it with that perspective. It is a
practical position that one must adopt and not completely buy the idea that drugs do
harm. There is no one who is wedded to one philosophy unlike the west where there
those who believe in harm reduction and there are those who believe in abstinence. He
also claims that the difference is very much artificial and in fact there is no point to the
fight'.
CHAPTER 5: A NEW KIND OF SURVIVAL- LAYING RISK BARE

The city is.
Unwieldy and rough.
It can draw you in and let you die.
Created almost tempestuously, ungrateful city.
Drawing me within and keeping me lost.

My feet touch the ground and feel a prick.
These paths are my home and my maiden voyage.
Time rearranges itself for me.
Building new ways for me to travel.

My hands feel the walls, railings and leaves.
They shiver and coil.
Emotions come and go in this fractured heart
Am I fixed or not moving

Grabbing, shoving, pushing and heaving...let me be.
Diving, pulling, plunging and piercing...let me feel.

(2007,2011)

Broken lives.

In this chapter I discuss the conceptualization of survival within the context of harm reduction. In detailing the contexts and conditions of the two NGO sites, where I conducted my study I shed light on how the various types of harms generated on the street and the responses of a truncated harm reduction treatment paradigm. I argue that risk becomes a category devoid of context, limiting and often even preventing clients from seeking health. By placing the lives and experiences of drug users at the center of my work and demonstrating the daily practices of recovery and rehabilitation I hope to lay out the complicated ways in which harm reduction is extending lives but also reshaping them in new ways.
Usha, 35 years:

I was born in Calcutta, after the death of my mother my father married again. Today the reason I am into drugs is because of my step mother. Till my father would be around the house she would act as if she cared about me, but after he would leave...he wanted me to go to school. I would get prepared to leave for school and then she would say what will you do by learning how to read and write...she would beat me, I would have to do all the work around the house. When I was 12 years old a boy came to stay in the house close by. He would pick-pocket and he would give money to my mother to keep at our house. My stepmother greedy for money- I don’t know what she told my father, but she fixed my marriage to him. He gave my mother Rs. 5000 and we got married, though I didn’t go to his house until I matured.

As days went by I became pregnant and I noticed he would come home late and then soon stopped coming home at all. I found out that he was stealing. Sometimes he would get caught and released. I also realized that he was taking smack. I would feel bad, we had a small child and here he was taking smack. I would sit all night with him as he smoked, I asked him what are you taking, and he asked me to try. One day he came drunk and he had some pills as well, he took a big stick and started beating me- all these marks over my body, and he has only given them to me. Another day, he took a huge stick and blade and placed it next to him and forced me to try smack. He beat me with the stick and then used the blade to make a mark on my neck. After that day I started taking smack. He also taught me how to steal. I would steal in the railway station and use the money for drugs.
The breaking point in the marriage came when her husband started cheating on Usha, fights ensued, culminating in a separation. Her life after the separation was difficult and she finally decided to leave her daughter with her mother and move to Delhi to try her luck. She landed in Nadi Nagar and in some time found a partner. She had two sons with him and continued to use and abuse drugs. She tried quitting by going to a full time rehabilitation center but found it difficult to leave her husband and children for such long periods. Usha was the only woman I met who was on the harm reduction program. She lived in a small makeshift hut on walkway of one of the main roads of Nadi Nagar. She would come each day and take OST medication for herself and her husband. Usha reported that she had all but stopped her drug use though occasionally she would use drugs. She found this type of community-based program helpful, because it meant she could continue attending to her family’s needs. Usha claimed unlike other women she was not a prostitute but instead begged for food and money. She talked about joining a midway home, educating her children and getting a job. When I left she had not made any plans yet to leave.

Dalbir, 49 years:

I am from Punjab, district Amritsar. I have been here in Delhi for at least 8 years. I was a truck driver in Amritsar, from Delhi to Bangalore and from Bangalore to Delhi. Amidst this I had an accident, after this accident I came to Sahai, here I come to tend to my wounds. They are healing now.

My father was in the Air force and my mother a housewife…I have two brothers and a sister. I left my studies when I was young and would go with my uncle to Pakistan to smuggle goods in black. From here we would take betel leaves and alcohol and bring back opium. I was about 14 years old then. My dad tried to stop me but I did not listen
to anyone. I would make about Rs. 3000 each trip. Slowly I started drinking and soon I was taking smack. I had to then leave home, because by then I had started stealing and doing drugs. At that time I had no idea about drugs, that I could lose my home, I could lose my family, at that time I did not know anything.

Dalbir got married and his wife knew little about his drug use. During this time he would sustain himself and his family by driving tourist cabs and later buses. Even during the height of his addiction he continued working, often causing accidents. Dalbir belonged to an emerging high drug using belt of north India, close to the Pakistan border. Drug use, especially injecting drug use rates in these regions have been on the rise in the past few years. Low rates of unemployment, a violent history of terrorism and separationist struggles have left their mark on the youth of these troubled parts. He recalled, “I got into drugs because when I did not get love from my home, that’s why I got into drugs… the environment was also bad, inside the house, the environment outside- there were no jobs. ”

Dalbir was on Sahai’s OST program but had also tried a variety of other recovery options before his current stint in the program. At different points he had gone through detoxification and abstinence focused rehabilitation. While these would work for short periods but inevitably he would return back to drug use. Even though he claimed he was clean, the staff were very sure he was using other substances besides his medication. In the last few years he had lost all contact with his wife and children. He was keen to heal his wounds and return to Amritsar. He was currently living on the street, without any steady job or income. As I was leaving he assured he would be around when I returned.
Survival dynamics.

In September of 2008, I began my work in the communities of Khargapur with the NGO Sahai and in Nadi Nagar with the NGO Ashray, in Delhi. Both these grassroots NGOs at the time were struggling in different ways to provide basic harm reduction services to the city’s poor, homeless and addicted. Despite being located within the national capital region, which has in the past few years seen exponential growth in civic infrastructure and resources, these communities seemed to be stagnating—almost forgotten. They had for the most part been neglected to such an extent, where shockingly even the most basic of services such as water, electricity and sewage were considered a luxury. Drug users, had to struggle even more in order to survive within this larger context of marginality. With poor public health options available, unemployment and exclusion from civic, social and economic resources they were critically endangered.

But when I arrived all of this was slowly changing. A large reason for this change was that a growing number of drug users had begun to receive care and support through the harm reduction services of Ashray and Sahai. These services were no longer emphasizing abstinence or recovery but rather encouraging risk reduction. Over time I came to understand how this perspective engendered a unique kind of survival for the drug users that participated in the program. In the next two chapters I attempt to delineate the nature of this new survival, specifically looking at possibilities, opportunities and limitations that these harm reduction services created for drug users. But before I do this, it is important to dwell on this notion of survival itself and why I chose it over the much more familiar term recovery.

Drug users have for long been a highly stigmatized group, however as I have shown previously, the emergence of HIV brought about a crucial change. As a high-risk group with the
potential to spread HIV, they could no longer be ignored. Drug users were now to be specifically targeted through a variety of harm reducing interventions. These interventions were to serve many purposes – reduce health risks, manage the epidemic and also bring one of the hardest to reach groups into the purview of the state and civil society. Drug users were no longer seen only as patients or criminals but as potentially productive, responsible and health seeking citizens. The mandate thus for harm reduction, was broader than the traditional boundaries of drug treatment and recovery. The term ‘survival’ reflects a more refined understanding of life under this new regime.

Recovery as a term was also rather nebulous and narrow. In some senses failed to capture how I saw drug users negotiate their daily lives. They were no longer within clinical environments leading isolated lives but instead out in the world struggling to navigate the social, medical, cultural and experiential aspects of a harm-reducing environment. Drug users/clients could adopt a variety of lifestyles, both with and without drugs- each of which was shaped by harm reduction services. Clearly this was not a passive or submissive relationship between the providers and clients and nor could be understood in the limited confines of any single environment. Instead I viewed them as subjects who were constantly evolving, managing, at times manipulating and adapting to extend their lives. Survival encompassed this conscious, adept and vital life force that was at the same time unfettered, courageous and perilous. The term survival, for me as a researcher emerged from a place of hope, not of naïve kind but from a deep acknowledgement of lives and wills that were broken yet became fertile grounds for new possibilities. It is this “survival” that I discuss in through my work.

In this chapter, I lay down the routines and practices of drug users who are participating in these harm reduction programs. My focus is to highlight how drug users experience the
specific risk reduction components of the program namely abscess management, counseling, HIV testing and needle syringe exchange. In doing, so I investigate what changes these services bring in the lives of drug users, in their ways of thinking and negotiating their social environment. Most crucially, I reflect on the implications of this risk focus on notions of health and rehabilitation.

Risk inherently is a combination of abstract factors, which render more or less probable the occurrence of undesirable modes of behavior (Pratt, 1999; Castel, 1991). For social workers in India the concern was not as much to solve the addiction problem, as it was to reduce risk for HIV. Drug users, were now to be treated as responsible consumers of services rather than dangerous subjects. Risk ends up focusing on the consequences of problematic actions such as substance abuse and not as much to address the actual problematic of people using substances. ‘Their primary aim is not to confront a concrete dangerous situation but to anticipate all the possible forms of irruption of danger. Prevention promotes suspicion to the dignified scientific rank of calculus of probabilities. To be suspected is no longer necessary to manifest symptoms of dangerousness or abnormality –it is enough to display whatever characteristics the specialist claim can be responsible for the preventive policies towards risk’ (Castel).

Since most of this research on risk and harm reduction was based on western contexts I was keen to investigate its usefulness to understand the Indian harm reduction paradigm. I also recognize that risk, as an organizing approach cannot be done away with. As a social work researcher I had to participate in the process of reinvigorating risk as a concept that would keep it relevant and sensitive to the needs of the most marginalized. I begin this discussion with detailing the overall framework of drug rehabilitation in India. In the next two sections I will
broadly discuss the actual day-to-day experiences of injecting drug users as they experienced risk, harm and these preventive services.

**Displacing recovery.**

Early in my fieldwork I realized, that to fully understand how recovery under harm reduction was working within India, I needed to pay attention to the construction, functioning and delivery of these services. The advent of harm reduction I found had crucially shifted not only the conceptions of health/recovery but also fundamentally altered how rehabilitation services were reaching people. Thus the routines of recovery became essential to understand recovery itself.

Before delving into these dynamics it is important to preface this with a broader discussion of rehabilitation services in India. Most traditional (both government supported and non-government) rehabilitation centers in India run on some version of the Minnesota Model, which is based on the AA philosophy. Usually operated by recovering addicts, these centers often employ workers who lack adequate expertise in the field and possess poor therapeutic knowledge. In fact, with little monitoring and lack of adequate laws protecting clients, the rehabilitation centers at times use questionable practices to force clients into ‘recovery’; many cases of human rights violations have been widely reported in the media. These centers have a standard protocol applied to all clients irrespective of the specific nature of addiction, age, sex or social conditions. The recovery period often involves long stays in an isolated institutional environment (usually three months). Not only is this difficult for the socially disadvantaged

---

77 The Minnesota Model approach (Hazeldon, 2010) is typically characterized by a thorough and ongoing assessment of all aspects of the client and of multimodal therapeutic approaches. It may include group and individual therapy, family education and support, and other methods. A multidisciplinary team of professionals (e.g., counselors, psychologists, nurses) plan and assist in the treatment process for each client. The assumption is that abstinence is the prerequisite. Treatment provides tools and a context for the client to learn new ways of living without alcohol and other drugs.
groups who may have families that require their economic support but also presents a considerable challenge when the recovery period ends and clients must return/adjust back into their community life. Private rehabilitation centers in India are also notorious for extracting huge sums of money in return for their services. With few (free) government sponsored rehabilitation centers actually working and private rehabilitation centers becoming too expensive for drug users to afford, harm reduction services have become the only option for most injecting drug users seeking care and support.

When harm reduction emerged in India, it thus truly represented a new and dynamic model of recovery. It aimed to provide a variety of options, flexible schedules, community based care and a client oriented recovery program. Services were now to be structured around the needs of the clients who would actively shape their recovery. Delivery of services was to be provided largely by peer workers who emerged from the community itself. In contrast to the existing services harm reduction’s promises were indeed enticing and empowering.

Sahai and Ashray presented two subtly diverse models of harm reduction even though they shared many similarities in focus and practices. To start with, both these organizations focused on the same clientele i.e. injecting drug users (IDU). These clients were usually either rag pickers or employed as informal labor; a few clients had regular jobs as clerks, security guards or rickshaw pullers. However a large number of them were unemployed and would have to steal or beg to survive. IDU’s are considered at high risk for HIV and Hepatitis as well other diseases such as TB. The term injecting drug user referred to any drug user who had been injecting in the last three months (as defined by the NGOs themselves and National AIDS Control Organization). This definition was rather vague if one considered the realities on the street. Many drug users, for instance, were known to turn to injecting during times when drug
quality was poor and resume non-injecting routes such as snorting or smoking when drug quality improved. In other cases many non-injectors reported to having experimented with injecting for short periods as well. Further, a majority of drug users on the street were non-injectors (including alcoholics) who were equally likely to engage in risky sexual practices or risky behaviors that increased their chances of HIV and Hepatitis. Risk then, was far more widespread than assumed through such arbitrarily imposed categories such as ‘injecting drug users’. Both the NGOs intimately understood these issues and tried to expand their reach to ‘non-injectors’ as well, but were constrained by both time and funding agendas. Hence their overall focus remained on current injecting users who formed a small but highly risky subpopulation.

Both the community projects of Sahai and Ashray in Delhi were also similar in that, they were based on the drop-in center model (DIC). This model aimed to provide a comprehensive care package for the drug users at a community based site. Besides outreach, all other services were provided at the DIC. A good way to understand the role of the DIC is to view it as a nerve center. On one end it receives all kinds of information, gathers expertise and adopts strategies while on the other end it uses this knowledge to shape people’s lives in the community. Clients came Sahai and Ashray mainly through outreach or referrals. This meant that peer workers played a key role in convincing injecting drug users to engage and participate in the program. Other times injecting drug users heard about the program from current clients that came to the center. The promise of medicines, tea or food, rehabilitation, job placement and recovery were all key motivating factors for clients to enter treatment.

Beside these basic similarities Sahai and Ashray worked slightly differently. For Sahai, the DIC was seen as an entry point through which clients could then access other services and ultimately move towards abstinence. At Ashray the DIC itself, was in some senses, the end goal.
Though some clients were referred to other long-term rehabilitation services if they chose, reducing immediate drug related harm was the main focus at Ashray. This essential difference became more evident to me as I began to see the pathways of recovery charted out for the clients in the two organizations.

Uttam, one of Sahai’s outreach workers, would often cajole the clients by saying, “Come to the center, there you will get needles if you want, medicine to help with your addiction, counseling, HIV treatment…if you like we can also send you for rehab and from there on we could help get you a job”. Sahai was promoted as a one-stop shop, where clients would have the freedom to pick and choose the services they wanted. They sought a long-term relationship with the clients, where the ultimate goal for them was abstinence. Bhagwan Das, a counselor at Sahai emphasized that the main demand many clients’ had was “Bharti kara do” or admit us. All they wanted purportedly was to be admitted into a full time rehabilitation program. The reason for such a demand, according to Bhagwan Das, was that most drug users continued to ‘believe’ that an abstinence oriented rehabilitation program was the best way to recover. Of course, the added benefit of having food and shelter was also an important motivation. Inevitably, Bhagwan Das shared, 90% of the clients either returned from such recovery programs without completing the program or would relapse immediately upon their return. Harm reduction, he discussed, was still a new concept in these communities and not many clients were able to grasp its implications completely. In fact Bhagwan Das shared that in the beginning Sahai would offer regular detoxification services, “so that they could begin to trust us, realize that the organization is doing good work”. Abstinence was valued more than this new form ‘recovery’.
Averting disease, courting addiction: life at Sahai.

It was fairly early in the morning and the doors of Sahai had just opened to admit its first few clients as I walked in. Only this past week I had begun my fieldwork in Kharagpur and was slowly becoming accustomed to the schedules of the NGO, its workers and clients. I noted that Aslam, a thin wiry peer worker, had already begun to boil a huge aluminum container with water for chai. As we sat down for the regular morning prayer meeting, the aroma of hot chai began to waft through waking everyone. Prayer, I came to understand was a key element of the spiritual foundation of Sahai; it grounded each day’s activities. But the hot chai was no less important- it kept hunger at bay and was almost considered the life force of the NGO.

The central room, which housed the clients during the day, was not a large space and usually cramped and noisy. However, during this morning prayer time with only a few clients and staff present, it seemed strangely peaceful. Unlike other harm reduction initiatives in the city, Sahai continued with this tradition of prayer, a hangover from its old roots as a ‘therapeutic community’/drug rehabilitation center. Clive an old timer of Sahai usually led these meetings. He was a recovering drug user and also a devout Christian, which shaped both his prayer ‘sermons’ and his role as a peer worker. The songs they sang in these meetings were usually a mixture of Sahai’s traditional rehabilitation prayers like ‘Ae maalik tere bande hum’ and Christian hymns (Sahai’s head is a Christian and it clearly influences the spiritual element of the organization). I tried to sing along with the prayers that I knew. I saw some clients’ only mouthed the words while others sang loudly and slightly off key. Most of them had shut their eyes and looked asleep as their heads nodded off. I wondered if they had a restless night on the

78 ‘Oh Master, we are your servants; May our actions be such; That we walk in virtue, and shun wrong. So that we laugh as life-breath leaves us. Ironically, the song was first sung in a Hindi film by jailed inmates but soon became a nationally popular prayer.
street. This shabby and nondescript room perhaps offered them temporary respite from the night. The prayer’s tempo began to build slowly. Saif, (NGO worker) had started to drum loudly on the chair and soon all the clients had opened their eyes and sang with gusto, they clapped their hands, their bodies moving to the rhythm. The hypnotic voices and the drumming reached a crescendo and then suddenly everything became quiet. After the prayer ended the atmosphere in the room shifted, all heads turned to Clive to hear him talk.

Clive took this time to share a moral lesson and spiritual teachings and finished the session in a typical AA (Alcoholics Anonymous) fashion asking God for forgiveness for wrongs done. Before ending the prayer Clive informed the group that a couple of Sahai’s clients were in a critical condition and asked everyone in the room to pray for their health and safety. The moment was poignant, as I watched, unable to shut my eyes, transfixed at the weary and tired faces before me- asking God for forgiveness, health and healing. This heavy intermingling of spirituality, AA and harm reduction philosophies was evident in many daily recovery and rehabilitation rituals of Sahai in particular. These discordant bodies were drawn in through a patchwork of these older traditions of rehabilitation programs and newer modalities of care within harm reduction- affect and pharmaceuticalization it seemed moved hand in hand.

After the morning prayers, the staff began to prepare for their day. Kiran, who was in charge of abscess management, began his daily routine - cutting gauze, tearing the lint, washing the equipment, cleaning out gloves (they would usually reuse gloves until they tore) and sterilizing all the instruments. Well built, quick witted and charming, this young Nepali recovering drug user would keep clients entertained as he tended to them efficiently and with dignity. The latter was particularly difficult to do since clients were treated in the main room of the office with no curtains or room dividers. The public was privy to everyone’s wounds -
privacy was a luxury neither Sahai nor its clients could afford. About an hour had gone by and now the NGO was buzzing with clients, a few had already started to line up for treatment of their abscesses. I watched as they lay down one by one on the rickety bed lined with old rubber sheets and a stained pillow and Kiran did his best to tend to these scratches, blocked veins, infected wounds and deep gashes. Addiction left its mark and the decaying bodies were a painful reminder of the life ‘outside’.

Particularly troubling to me was the rate at which clients returned, sometimes for months on end to tend to the same wound. Poor hygiene, continued drug use, lack of adequate medical supplies and inadequate medical knowledge and training of the workers themselves were to blame. However, Freddy, the project supervisor was quick to point out that since Sahai started its services the number of abscesses and their severity had drastically reduced. Drug users were reluctant to go and seek the free services of the government hospitals because of the long wait, poor service and discrimination. Private health care was out of reach for most drug users and a large number of them would simply die because of the lack of care.

One morning a few weeks later Kiran looked over to where I was sitting and asked me if I wanted to see a maggot infected wound. I quickly refused glancing at the client, who himself had turned his head away from his own leg. My refusal was not understood, since a bad abscess usually generated great interest. Clients and staff would gather around the wound just to see the damage. Slightly disappointed at my refusal to see the wound Kiran continued his work, steadily removing maggot after maggot, there were hundreds. As he worked he remarked, “You shouldn’t have ignored the abscess for so many days”. Clive, who had been watching this was also clearly disturbed by the scene, he kept looking over at the client and reiterated, “We are
giving you free needles, take them from here next time you want to inject…and don’t wait for so long before coming here, you could lose a leg like this”.

Abscesses meant failure, failure to reach out and provide enough clean needles that would prevent infection; failure to help drug users transition from invasive to non-invasive modes of using and of course a larger failure of the system to prevent illness or disease. For the drug user it was seen as a failure of a harm reducing life and for those who had transitioned to the oral substitute, an abscess was the most obvious sign betrayal of their adherence to their new medical regime.

During the time Kiran tended to abscesses, Bhagwan Das as well as Prakash Singh had begun their work in the counseling room. The two worked well together in providing a whole host of services to the clients. This included taking case histories, pre and post test HIV counseling to drug users, assisting clients transition from needle syringe exchange programs to OST or detoxification/rehabilitation, talking with family members, conducting sessions with clients of the DIC and supporting with clients on ART.

Due to confidentiality concerns I was not able to witness these counseling sessions but would indirectly discuss them with both clients and staff. These sessions seemed to primarily convey two messages- HIV prevention and freedom from an addictive life style. Every potential new client was told to come to the center and make an ID card and meet with the counselor. The ID card served as a reference for all future interactions with the staff and NGO. The counselor uses this first meeting to also take their case history and develop a rapport with the clients. Due to time pressure these interactions often were short and without much privacy. Prakash, due to his AA orientation encouraged clients to explore detoxification and rehabilitation options whereas Bhagwan Das on the other hand promoted OST more fully. But both
counselors recognized that substitution medication was most effective with new clients as it helped keep withdrawals at bay and supported them through this toughest phase of recovery.

The other key emphasis of counseling was on HIV testing. Almost every client was ‘encouraged’ to get tested. Funding mandates dictated that the NGO must test as many ‘risky’ clients as possible. Clients were then given basic information about HIV and its risks before they go for their “khoon ka test” (blood test). Usually Victor would accompany clients for these tests and help process their results. After the test, post-test counseling is conducted with the clients. Since most clients are not aware about HIV, one of the main tasks for both the counselors was to explain the nature of the disease itself. Prakash Singh, for instance, would spend considerable time explaining how HIV can be contracted and spread, what it does to the system and the precautions each person must take to maintain health. Clients who tested positive were especially encouraged to either move away from drugs completely or at the very least move to OST. The process was slow and it would take many sessions for clients to fully understand the implications of their disease. Most clients continued some form of drug use and failed to maintain adherence to ART regimes. During the course of my fieldwork period approximately 60 clients were on the OST program. Close to a 100 clients were on the needle syringe exchange program and around 20 clients would come each day for tending to their abscesses or seek counseling for various issues.

The clients on OST would be encouraged to spend the day at the DIC itself. The essential purpose for this was to keep them away from drugs and street life. At times Sahai would conduct sessions with the clients on issues of HIV, risk and addiction. However, during my time at the DIC these sessions were few and far between, usually the clients would spend their day watching TV, chatting and sleeping. No food was provided by the center and clients
would often complain about this oversight. Freddy, the project supervisor, told me no funding agency was willing to fund a nutrition component and clients had to seek food for themselves. By around 4 pm the DIC would shut down and the staff would spend the rest of the day finishing paper work.

After clients had completed six months or more on OST Sahai would encourage them to taper their doses and move to an abstinence treatment program. In fact it would even have regular detoxification sessions to prepare clients. Sahai’s own abstinence program was facing financial troubles and thus clients would be referred to an outside program. One of the other incentives given to clients for moving out of OST was the referral to the midway home. The midway home was run by Sahai and helped drug users to find jobs in local factories and offices. Clients from Sahai’s various programs would be sent there after they had been stabilized on the abstinence programs.

Ideally the harm reduction model was designed to help drug users transition from the needle syringe exchange program to OST and finally towards an abstinence treatment but this rarely occurred. Clients would often move back and forth between these steps – stopping, relapsing and re-starting. As clients rotated in and out of the DIC, it was clear that reducing harm was not enough. In fact, Sahai was in no way, shape or form ready to meet all the demands of the clients completely. Drug users on the other hand seemed to show little faith in the state systems- whether it was health care or judiciary. They were outcasts, stigmatized, left forgotten in the corridors- suffering and death then did not seem as the exception but the rule. Over time, I began to see how this hopelessness with street life and larger systems continued to plague what happened within the NGO itself. As drug users tried to piece together their lives
through the limited resources provided by the NGO, the role of the absentee state seemed to only become more apparent.

**New realities of recovery: life at Ashray.**

After completing three months at Sahai I began my fieldwork with Ashray in late November. Ashray had two offices in Nadi Nagar and I would alternate between them to get a complete picture of their services and interventions. While one site solely focused on the OST program and limited abscess management, the other site provided all the key harm reduction services. Ashfaq Mallik, the project manager, during one of our first meetings explained how things worked at Ashray, “I don’t have a fixed schedule, things happen and I have to adjust”. It probably, I soon realized, was the best way to understand the multiple activities that seemed to occur almost simultaneously at Ashray. The day would begin fairly early for the staff and client volunteers who would spend the first hour of each day cleaning and setting up the office space.

In the first site, there were three rooms each designated for a specific purpose- abscess management, administration and doctor’s visits as well as dispensing OST.

In the second site the office was small and mainly used for administrative purposes or counseling. Bhuvan the counselor and Ashfaq the project manager would usually be found sitting here, completing paper work, sorting client-staff disputes, discussing cases or exchanging community gossip. Since the office was small the courtyard in front was used for in house-needle syringe exchange and OST services. On most days one would find Ansari, Umaid and Abhikh (all three peer workers) sitting under the shade of a large and old peepal tree, sitting on old chairs, interacting with clients. Ansari and Umaid were old timers of the program and were in charge of providing needles and syringes to those clients that came to the DIC. Abhikh was much younger and not a recovering user, he was in charge of OST services. The courtyard
served as an important place to meet, interact, share information about the latest police raids, current trends of the drug markets and family troubles. Most often the discussions would be centered on health issues, especially related to abscesses, lack of adequate care, problems with sleeping or breathing and most crucially drug withdrawals.

Rashid and Julie (peer workers) would spend the early part of the morning’s busy setting up the corner room for tending abscesses. Ashfaq recounts:

I still remember the first time I came here there were so many clients and they were dirty, it was so crowded. Now I see them and realize there is so much change in them. Earlier they were so dirty all wrapped in a shawl (lying on the street corner). Even now one can see them but they are at least a little bit cleaner. Even abscesses have reduced a lot. During the days of our previous project almost 80-90 clients would come each day with abscesses caused by injecting. Nowadays that is no longer there…the community people say what magic have you done over them.

Today only about 10-15 clients would come for treating abscesses- a dramatic fall. Despite these claims I always felt that death and disease were on close call. Some time later two incidents occurred, which both challenged Ashfaq’s claims and my assumptions about reducing harm.

The first incident took place a month after I had begun work at Ashray. It was fairly early in the morning and as I was walking down the road that led to the NGO. Sudhir, an elderly client, who I had seen a few times before stopped me. Since most clients slept on this road it was common for them to greet me every morning, just as they would be waking up and doing their morning chores. However, it soon became clear that Sudhir had not stopped me to exchange pleasantries. He looked extremely troubled, “Can you help Amitabh didi (sister)? His
condition is very bad and these people (Ashray) they are not doing anything to help. He will surely die”. Amitabh, Sudhir revealed had severe abscesses in his groin as a result of injecting. He had been lying on the road for the past few days refusing all help. I had not heard about Amitabh but promised Sudhir I would ask Ashfaq and Bhuvan, the counselor about it. He quickly thanked me and left.

Later that morning I got the chance to ask Ashfaq who knew little and quickly deferred to Bhuvan for clarification. Bhuvan in turn turned to Samir, an outreach worker for details about Amitabh. Samir was clearly surprised by the interest but feebly responded that he had in fact seen Amitabh a few days back. He had asked Amitabh to come to the DIC or go to the hospital but Amitabh had refused both suggestions. Ashfaq looked uncomfortable at the report but not unduly perturbed either. He instructed Bhuvan to send ‘someone’ to find Amitabh and take him to the hospital. An outreach worker was immediately dispatched. Bhuvan approached me and said, “You see Gayatriji, someone did go before, but if the client refuses to go (to get help) what can one do…I mean have so many clients…clients who want help…so going behind one person who is clearly refusing it…it is, it is their choice”. Ashfaq added, “See we are here to give the client choices, but we can’t force them- our goal is to show client paths, it is up to them to choose them”.

A few days later I heard that Amitabh had died on the way to the hospital. Bhuvan told me that after much insistence on the part of the outreach workers Amitabh had agreed to go to the hospital. However, en route to the hospital, as he sat in an auto rickshaw he died due to complications. “There already have been 5 deaths this winter and surely more will come. This keeps happening. It is sad but what can we do…especially in cases like this when the client wants to die”, commented Bhuvan. He further added that clients ‘knew’ that injecting in the
groin was dangerous and yet they continued doing so. I was shocked and deeply disturbed, even though I had never met Amitabh, his death represented such a complete loss of faith not only in life, but also in these very systems, that were created to prevent such tragedies. Bhuvan had called on ‘choice’ and knowledge as critical elements to label his death as ordinary. In doing so he had wiped out his own role or that of the NGO, state and other systems that had left Amitabh to choose death.

A couple of weeks later the second incident occurred. I was sitting in the courtyard when I saw a small crowd collecting in the grounds opposite. As I walked closer I could hear groans of pain and the crowd cleared to let me in. One of the clients Ashish was sitting on a torn blanket, writhing in pain. Ashish like Amitabh had injected in his groin and it was severely infected. Barely able to hold his head straight he told me that his pleas to be taken to the hospital were being ignored by the NGO. With Amitabh’s death still fresh in my mind I walked over to Bhuvan’s office to follow up. Bhuvan, contrary to Ashish’s statement, informed me that they were in fact planning to take him once they found the necessary paperwork. Ashfaq walked in at that moment and asked about the commotion outside. After hearing and viewing Ashish’s condition he asked Bhuvan to take him immediately without wasting any more time on the missing paperwork.

As we watched Ashish leave Ashfaq spoke about the intricacies around such medical problems. In most cases of serious groin related abscesses, there was very little the doctors could do at such a late stage. Added to which doctors were usually reluctant to treat drug users and often make them wait for hours before treating them. Surgeries, like those needed for Ashish and Amitabh were also very expensive for the hospital and patients would be required to contribute a certain amount- especially for medication. No client was able to do this and thus
was often sent back from the hospital with some pain medication but without much hope. Ashfaq also informed me that government hospitals would only accept patients if the NGO assured them that a peer worker would be present at all times to assist the patient. For Ashfaq this meant sacrificing one of his peer workers for an extended period of time. A week later, as per Ashfaq’s predictions, the hospital sent Ashish back claiming there was little they could do.

Both of these incidents were for a number of reasons. The first reason was that despite all claims otherwise there were clearly a number of people simply dying because of inadequate care and support. In order to reach sheer numbers individual quality of care was suffering. Second, harm reduction as a philosophy was counting on primarily the rationality of its actors, to choose life over death. But these logics are often not as clear as we’d like them to be, affect, hope, relationships with institutions, trust in the system and agency (of the person) all played a critical role for Amitabh and Ashish.

During the course of the day over 150 drug users would receive needles and syringes and close to 200 were on the OST program. Overall close to 500 drug users received direct and indirect services from both sites of Ashray. One of the main efforts of Ashray was to encourage clients to simply come to the center and develop trust. This had meant the NGO needed to be flexible to the needs of the clients. Injecting drug users unlike other marginal groups are extremely hard to access and due to the stigma associated with their behavior, they often remain at the periphery of most services/institutions. Thus it was important to remain open to their needs and accept them despite failed attempts at non-risky practices.

In the previous two sections I attempted to outline the overall routines and approach of Sahai and Ashray, with a specific focus on abscess management as well as counseling services.
A key component of their risk reduction work was related to HIV-testing, support, counseling and advocacy. I will now expand on these concerns in the next few sections.

**HIV landscape.**

*Voices of the number 9s.*

Mushtaq Rahim, 47 years:

I would work in fairs with light and sound, much later with the camera and then I got into drugs. It was during this period that I met Sahai in 2008. I used needles and syringes during drug use. When I became associated with them then I got to know about HIV and after that I kept sinking. I then got HIV. Then this madam (outreach worker) told me it is important to be careful- I left drugs then… She would explain about the disease, gave us information. She told us, ‘Don’t use each other’s needles and syringes and don’t share’. We used to do it, we didn’t have much information- yes we have used each other’s needles. At that time even the NGOs would not give us needles. We had to buy our own new needles. We didn’t know that by sharing we could contract the disease- we only got to know about this after the check-up.

Born in Uttar Pradesh, a north Indian state in the country’s heartland, Mushtaq grew up in a small village. His story of rural-urban migration, injecting drug use and HIV is one that is fairly common but one which is seldom heard. The HIV movement has found it particularly difficult to reach out to this demographic, which remains hidden and acutely disenfranchised. When I met Mushtaq for the first him I was struck by his gaunt face and his slight body covered in a dirty white kurta and pajamas. He was suffering with throat ulcers, had lost a lot of his hair and was weak. Like many of his peers, he left school at an early age to work with his family and support their income. Charas was a common drug in the village as was alcohol but besides these
he knew fairly little about drugs. When he came to city he first started using smack and then graduated to injecting without realizing the implications completely. “One of my friends told me, ‘let’s go to Kharagpur and get a ‘set’.” I didn’t even know what that was. A ‘set’ has needles, two syringes and other equipment needed for injecting”. These sets to inject are commonly available in the pharmacies in and around the community.

It was through Sahai he first learnt about his positive status. Positive clients in Sahai are called ‘number 9’s’ - a code between the staff to maintain confidentiality and yet communicate about the positive status of the client.

In the village (even) today I am afraid because I have the disease. If I were to tell people back home then they would hate me…there is a lot discrimination (chua chooth). Even if there is utensils then they will say don’t let this person eat from these utensils—give him separate utensils to eat…I have not told people back home because the respect I had (would be lost)... This is the influence of being positive in our lives.

Once he tested positive he was asked to register at the ART clinic in the government hospital. He didn’t do it immediately and only more recently decided to take the step. His CD4 count was around 300 and he told me he was not doing any drugs.

During our next meeting Mushtaq looked much better and sat talked with me for over an hour. Unlike our previous conversation, this time he spoke less about his personal troubles and more about his rights as a positive person.

In the beginning the staff was talking to us very nicely but now this new staff does not care about the client as much...many things have changed now look madam for us HIV people we come in the morning they should at least try and give us food once a day.

There is no help for us- if tomorrow one of us gets fever or catches a cold or gets ulcers –
then they send us to the hospice care facility of Sahai. We stay there for 4-5 days and even if it doesn’t heal they discharge us. Look the government is fully willing to support us (HIV positive people). That day I had blisters in my throat, so I told Clive (NGO worker at Sahai), so he said let’s see and told the doctor. The doctor wrote a medicine that I had to buy from the pharmacy outside. The doctor only said one thing, Mushtaq we don’t have the medicine here, you have to buy it from ‘medical’ (pharmacy), it is expensive …let’s see maybe you could go to the care home of Sahai (reserved for critical patients), I will find out. He wrote the medicine, I did not pay much attention to the prescription (because I couldn’t afford it). Today I asked him if he asked I could go to the care home. He told me he had forgotten. Carelessness is on his part not mine; we are coming here regularly to them. That is what I am saying for us, for those people who live on the street there is nothing”.

The resources that are coming in our name, we are fully getting those resources for example medicines for fever and diarrhea – everything come from there (government).

Now these people come here and do ‘drama’. I brought this issue up with the Delhi Network of People with HIV (a rights based organization for HIV affected people).

They told me Mushtaq you cannot complain alone, bring at least 4-5 people together and place a complaint with us, and then we can investigate. They told us for you people everything comes, now if Sahai gives it to you or not that is a totally different matter.

You positive people should be kept well by the NGO. Who will listen to us?

Mushtaq’s positive body had catapulted him into a new network of care and support. But he soon realized that his positive status could not guarantee him much in terms of food, shelter or even free general medication. As a positive patient, the NGO frowned upon his using needles to
inject. Sahai was keen to keep him on the rolls of the system but found him far from the ideal harm reduction client. Mushtaq, on the other hand, was keen to continue using drugs but also felt that it was his right to receive better treatment options. In, essence he did not see his continued drug use as a barrier to receive better care as an HIV patient.

During his conversation with me he never once mentioned his rights as a drug user. After a few weeks Mushtaq dropped out from the program and we heard he had gone back to using full time. He had stopped going to the ART clinic as well. No one was clear as to why he left. Later in the year when I was out in the field I met Mushtaq busy sorting garbage. He looked even weak, dirty, his eyes were red and he barely looked at me. I asked him what had happened, why had he stopped coming to Sahai. “I don’t like it there, I fought with them”.

Abandoning any pretence of neutrality or distance I asked him to perhaps give the organization another chance or at the very least go to Ashray. Keeping his head down, he continued to sort garbage and said nothing. I realized my time with him had come to an end and now he wanted me to leave.

**Government Labs.**

It was going to be one of my first visits to the ART clinic, where I had planned to meet Victor (Sahai staff) to understand the mechanics of HIV testing within the government hospital. This large hospital was located a few kilometers away from Kharagpur. It was both dilapidated and depressing from the outside. Old rusted iron gates led into a large compound where patients seemed to occupy every square inch of the compound. Many of them had camped out on the lawns with sheets spread out, lunch boxes and water jugs on display, as if in preparation for a long stay. Children had found a small corner to play and families seemed to basking in the warm sun.
I followed Victor’s precise instructions and entered from the west end of the hospital and was assaulted by the strong smell of antiseptic, sweat and disease. Slightly overwhelmed at the crowds that seemed to be jostling to enter into doctors’ offices I followed the prominent National AIDS Control Organization’s boards to reach the ART clinic. Victor was waiting for me at the door. Tall, broad shouldered with slightly long wavy hair and big bright smile, Victor stood out even in this crowd. Dispensing with the hellos he told me to follow him. In stark contrast to the rest of the hospital, the large room was well lit, clean and air-conditioned. The patients were all seated in comfortable seats and there was little noise or confusion. As the nurse would call out each patient’s name the person would get up and enter the doctor’s office. Structured, efficient, comforting and completely surprising given my experience outside. I noticed that the walls were lined with posters of HIV awareness, support groups, HIV care and referral services.

Victor quickly introduced me to Shahid, Ramesh and Ashok. The three of them shuffled in their seats and flashed brief nervous smiles. I realized they were clearly conscious of their appearance- the dirty and tattered clothes, deep abscesses and unkempt appearance jarred in this scene of middle class HIV patient citizenship. But before I could think about this much more Victor started to explain all the tasks that lay in front of us that day. “Its good that you came today Gayatri, you can see all the steps it takes to get them registered in the clinic”. Shahid and Ramesh had come for their ‘khoon ka test’ or blood test. Ashok on the other hand was waiting for his papers and get registered at the ART clinic. After about ten minutes of waiting Ashok was called in to the doctor’s office, Victor went in with him and after a few minutes came out smiling and led us out of the clinic. Once we were out he asked Ashok, “Did you understand what the doctor said?” Ashok nodded and looked away. Victor took some time to explain
anyway. “Your CD4\textsuperscript{79} count is good, so doctor says you do not need to start ART. But you must take care, eat well and injecting must stop injecting”. “I stopped long back…” Ashok hurriedly replied. Victor was not convinced but told him to come to the center as he prepared to leave.

After Ashok left Errol told Shahid and Ramesh to stand in the line for the blood test, we both left to collect test results from a different floor. Close to 100 people were in line. Some were so ill they could barely even sit and were dragging themselves across the floor. As Victor and I walked up the staircase he informed me that the lab would shut at 11:00 am for tea break. For most patients it was difficult to wait until 2:00 pm, when the lab technicians were “likely” to return. This meant that a majority of those in line would have to come back again tomorrow.

Victor shared:

Clients registered in the ART clinic are given a number – they are given form with the number and if they have the form then they have to go and get the date and the number from another department. So I take the client and go and take the blood samples- according to that file number we will get those reports.

But the cycle of tests, reports and numbers does not end there. Clients needed chest X-rays (to check for TB and other infections), a complete blood chemistry and liver function tests in addition to a number of other tests. Each department gives a different file number and all results are sent to a central collecting department, which is where Victor was taking me.

\textsuperscript{79} CD4 cells are a type of lymphocyte (white blood cell). They are an important part of the immune system. When HIV infects humans, the cells it infects most often are CD4 cells. The genetic code of the virus becomes part of the cells. When CD4 cells multiply to fight an infection, they also make more copies of HIV. When someone is infected with HIV for a long time, the number of CD4 cells they have (their CD4 cell count) goes down. This is a sign that the immune system is being weakened. The lower the CD4 cell count, the more likely the person will get sick and develop opportunistic infections.
We walked fast through a maze of corridors; there was rush to get the paper work done fast before other departments shut down for their tea break. We ignored the signs that pointing to the report collection office and headed in the opposite direction towards the Dental Outpatient Department. The hospital had not bothered to update the signs and this caused delays and confusion for new patients. To avoid these pitfalls, Victor usually collected all the reports for the clients. The report collection office was small room at the end of the corridor. The desk was littered with paper and sagging under the weight of files. I saw files everywhere – falling from shelves, on the floor and on the chairs. Victor confidently entered the room and began to look for his clients’ files. He later confided that the hospital staff allowed only him this privilege. As I looked around the shabby ‘office’ with its tobacco-smeared walls, dirty tiles and scattered paperwork I was struck by the precarious nature of this knowledge collected in this hospital. How could one trust these reports, if at all one found one’s own? This back office of the hospital made a mockery of the entire system of AIDS reporting and knowledge base.

Before we left Victor was asked to sign his name with the patient’s details in a huge file. After getting the doctor’s signature on the reports, we deposited them in another department office. This ‘testing bureaucracy’ was both bewildering and overwhelming to me as a researcher. I could easily understand how patients, especially drug users, would need an ‘expert’ to help them navigate this tricky system.

Victor and I both returned to see that both Ramesh and Shahid were still in line to get their blood work. Victor assessed the situation and decided to talk to the hospital attendant. A quick word later all four of us were ushered in, much to the anger of many of the other patients. We entered a long corridor with six cubicles each occupied by a nurse and an attendant. There are long lines here as well. After about half an hour of standing in the suffocating and crowded
room finally Ramesh is able enter one cubicle. The first two cubicles refuse to draw blood. Victor tells me later that this was common practice. Most nurses found it difficult to find a vein on a drug user, since most of them are blocked due to incessant drug use. He pointed out:

Hospitals-they have their own way of working, they are scared to put their hands on the IDU. It will take a long time- they search for the vein and they can’t find the vein – it’s going to take at least 5-10 min (during), which they could work with other clients who are not IDUs. So this is the main frustration for the hospital also – if they can’t get it they should at least tell the client, hold on and hang on – they tell them go, go. . . then the client comes out and the client feels bad why have I (been) sent back. This means I have to again and give his number and get a new number. (Therefore) I make sure that I go with client and talk to these people and say please...

Then of course is the issue of HIV, which we encounter directly that day. I hear the superintendent look at the clients and talk to another nurse. “On one hand we have to deal with these crowds and then on another ‘these’ people come in…I mean it’s as if we don’t have enough”. She continued in a loud voice talking about positive clients and why should they have to deal with them. Victor tried to step in and talk to the superintendent and could see the crowds growing restless. Both Ramesh and Shahid had lowered their heads desperate to leave. Victor then left the room and few minutes later came back with the young doctor of the ART clinic.

The doctor shouted at the nurses and the superintendent asking one of the nurses to take their blood immediately. Ramesh stepped into the cubicle for the third time. Victor and I watched as the nurse desperately tried to find a vein. She poked him about four to five times, each time I saw him wince and turn his head away. Victor then offered to help find the vein-a routine that is familiar to both Victor and the hospital staff. Victor later told me that nurses in
the past been allowed him to draw blood from the client. He would take the client in the narrow alley way outside, make him sit on the road pavement and sit next to him a search for the vein. No gloves, no sterilized environment and no privacy.

About twenty minutes later all three of us stepped outside, Shahid and Ramesh were holding their arms straight pressing a cotton ball into the puncture to stop the blood from flowing. They joked about the nurse’s ineptitude to find a vein. Victor joined in the fun saying that no one could beat the drug user in finding veins. After the two clients left I followed Victor to the advanced testing center in the opposite building where another client is waiting. As the day reaches an end Victor returned to the ART clinic to submit all reports that he has collected so that his clients can see the doctor the next day. He highlighted:

People from the main ART clinic can collect it (reports), but they are so reckless and careless. (Plus there are) so many reports… its scattered there sometimes the reports are missing so that means my client has to go in for another exam- which is going to be difficult. If the client needs to be admitted and is hospitalized its and emergency then I go in fast- I ask the doctor if he can do it and within 45 min to half an hour I get the report. Sometimes (I even) do the tests before meeting the doctor…its takes more than one and half weeks (for all the tests to be completed. (I have to help them) because these people don’t know where to go – it was the same thing for me but now I know where to go…

It almost seemed like a battle against the system, a battle that sometimes Victor lost. He recounts the story of “my poor Danishq, who expired a few days back”. Danishq, an injecting drug user was also HIV positive. He needed a bone marrow transplant and his hemoglobin levels had fallen dangerously low. The hospital asked him to come back a week later, for reasons
not specified. “After that he became more sick and he was admitted in Sahai’s own hospice care unit, (as his condition worsened), we took him to the emergency. He expired before we can work on him”.

**Getting tested.**

Farah (outreach worker Sahai), Kiran (outreach worker Sahai) and I had left for outreach to the famed Meena Bazar near Jama Masjid (Delhi’s largest mosque). Notoriously known for the large sex workers community (immortalized in folk and film songs), the reality was much more stark than I had imagined. Today’s mission was to take three women or more, depending on who was willing, to get their blood checked for HIV. A long wide road led to the mosque to its right was a larger dried pool surrounded by a large field. One couldn’t tell what it had been used for before, because today it had turned into a large slum settlement. The mosque’s proximity to the city’s main bus and train station meant that a majority of the city’s new settlers found themselves in Meena Bazar. Small tents, temporary houses and small shops littered the area. However since Bakrid\(^{80}\) was a few days away the compound of Jama Masjid was especially buzzing with activity. Large number of tents had erected next to mosque housing hundreds of goats, ready for the festival.

Farah told me that she had already visited them a couple of times before to prepare them (pre-test counseling). She had identified Nusrat as the community leader and had given her the responsibility to round up the rest of the women. Just then Nusrat who had been washing her clothes walked towards us, asking if we wanted water. A small crowd of children and some teenage boys had gathered around us, curious; I could also see some of the men of the community eyeing us suspiciously from their perch on cots, where they played cards. Nusrat

---

80 One of the most important Muslim festival where goats (Bakhri) are sacrificed to celebrate their strong faith in Islam
was barely 28 and the women that she brought with her seemed a much younger (some closer to 15). All the women were sex workers, already had at least one child and lived with either a partner or husband in the community. Parveen told me they would earn anywhere from Rs. 15-20 for each sexual act (below half a dollar). They usually have sex in public bathrooms, in buses, trucks or taxis that are stationed or in their shanty shacks. While many of them did not use injecting drugs, they did smoke marijuana and were at high risk for HIV because of unprotected sex. None of them seemed concerned or worried about the eminent test that awaited them. I wondered how much they understood.

The testing center had a single nurse who seemed to know Farah. Farah informed her that pre-test counseling had already been completed (pre and post test counseling are mandated). I was not sure what either one of them meant as pre-test counseling. But the women were most likely not aware of the implications a HIV positive test would mean.

The women were told to sit and then each one’s blood was taken over much squealing and excitement. Farah informed them that she would give them the results. 2 out of the six women who tested were positive. I asked Farah what would be the next step for these women. She informed me that her main role was encourage women to test, once they knew who were positive, Sahai would encourage them to get registered at the government hospital and check their CD4 count (to measure the strength of the immune system). For other women they talked about using condoms and constantly testing. Current funding restrictions do not allow much work with this group (since the funding is for injecting drug users) and other NGO’s continued to work with them. Rita in Ashray and Farah in Sahai continued to work with these women intermittently often just spending time to talk and share.
Later while talking to Kunal Rathod a project officer at UNODC about the issue of HIV, rights, bodies and gender I asked him the rationality behind such testing. Knowing, he pressed, was important if they didn’t know they couldn’t possibly take any action. Dr. Ambika Kapoor at the WHO felt that for too long “we have assumed that they are ignorant and poor and therefore not capable of any positive behaviors”. Testing allows for individual action. One of the women did act- she came to Sahai looking to enter the rehab for women. After a few weeks of staying there she left, claiming she wanted to return to life on the street.

HIV testing and counseling was started in India in 1997. Under the NACP III all testing and counseling facilities were brought together under the ‘Integrated Counseling and Testing Center’ and today the country has more than 4000 such centers — the largest network in the world. However, according to NACO only 13% of the HIV population is aware of their status. This impetus to test is a part of a larger mandate globally that has in equal parts been critiqued and lauded. On one hand global organizations like WHO, UNAIDS and UNODC highlight that as a result, without testing, many opportunities for increased access to treatment and care are overlooked. Their argument draws on the basic premise that knowledge about being HIV positive or negative will help in preventing risky behaviors and promote safe behaviors amongst people. While on the other hand research evidence on testing as a prevention strategy, shows its benefits to be limited and impacted by gender, class, social norms and public perception (Higgins et al., 1991; Exner et al., 2002; Yeatman, 2007; Biehl, 2007). While there are many methodological and practical constraints in studying the overall impacts and outcomes of testing on actual risky behavior it continues to be promoted as a key strategy for prevention.
The battle for rights and life.

The emergence of HIV, scholars argue, has changed the dimensions of how one understands disease in its totality. It has evolved into a global social/health movement impacting policy, politics, law, human rights and social justice. Despite the diversity of experiences and contexts within which HIV emerges, there are two critical components of which seem to resonate everywhere. The first component is attention on the high-risk groups and their marginalized life conditions that make them most susceptible to HIV. The second component is the focus on patients’ rights to medication and treatment, especially encouraging patient mobilization.

During the period I was in New Delhi I was acutely aware of both of these components and their particular dynamics for injecting drug users. I had begun with questions like - had HIV changed meters of recovery for them? Was there a new form of consciousness that being positive evoked? Did it separate them from other drug users? And most critically how did it shape their survival in the day to day.

HIV prevention and treatment was a critical component of all work within Sahai and Ashray. Funding institutions dictated specific targets for HIV testing, client registration in the ART (Anti-retroviral treatment) clinics and if needed ART regimes. Sahai, I discovered, focused a fair amount of time and effort on assisting clients in this process whereas Ashray tended to let clients take the lead. Even though the NGOs approached their interventions giving primacy to HIV, clients would always identify their primary problematic as addiction. Despite this disconnect most clients were prudent in using their status in fighting for their survival- even though this still meant that their needs were under served. Moreover, to me their worlds as drug users and as HIV positive clients were inextricably linked and it was difficult to separate them.
Being positive meant little without first acknowledging their addiction and being an addict could be no longer seen without their HIV status.

I could see some of these politics at play when Ashray introduced a nutrition component in its program. Ashfaq Mohammed (project head Ashray) had put forth a list of clients eligible for the program. He had informed me that the list prioritized clients who were HIV positive or had TB and Hepatitis. Slots for food were few and such a prioritization was essential. On the first day as the food arrive so did the clients and some community members ready with proof of their ART registration. “We have heard that you are giving food for HIV positive people”, remarked a community member. Ashfaq quickly had to clarify that the program was in fact for ‘clients’ i.e. drug users and HIV positive people. Unhappy at this response, the community person responded “Even we are sick we also need this food…do we now have to take up drugs to be given food”. At the same time many clients who were not on the list, as their condition was not considered critical enough, were equally angry. However, the positive clients were quick to defend their position- highlighting their unique vulnerabilities and their special needs. Ashfaq was frustrated by his inability to provide enough for all of his clients. He recognized providing even a basic essential like food in a poor and marginalized community was a potentially explosive issue.

What became most clear through fieldwork was that the disease of HIV had been able to, like in other global contexts, create a line of services for those impacted by it. In doing so it had created a sense of consciousness within clients about the uniqueness of their condition. Clients were now also ‘patients’ who deserved special privileges not accorded to their peers. Also critical to recognize was the fact that these services were not equally available for all those who were positive, but in fact there were hierarchies, special sub populations based on risk
assessments and the current political focus. On one hand, this super specialization of populations was essential to serve the most needy, but on the other, the ‘justness’ of its approach is clearly questionable. HIV services were attempting to provide exceptional and in some cases an extraordinary type of service for these clients. However the worlds of being positive, being addicts and being marginalized were not far apart as I mention before. As these worlds collided the exceptionality of HIV services were severely undermined often creating contradictions in the type of care clients received. Treatment was then experienced as separate from their lives as recovering drug users generating a fragmented and often split perception of their rights, recovery and health.

The final sections of this chapter address the needle syringe exchange component of the program as well as a discussion on the implications for risk and survival.

**Exchanging risk/ calculating infection.**

Sharing of needles, syringes and other injecting equipment between IDU’s is one of the highest at risk behaviors, recognized to be a primary driver of HIV and HCV (Hepatitis C) epidemics among these populations (Sarkar et al., 1993; Panda, 2002; UNODC, 2008). The provision of clean injecting equipment thus serves to reduce the likelihood of sharing and support their health.

The first formal needle syringe exchange program (NSEP) began in 1983 in Amsterdam, Netherlands for Hepatitis B (Wodak and Cooney, 2005). Today NSEP is considered a critical aspect of any HIV prevention program (WHO, 2003). Such programs are currently operating in 65 countries across the world (Wodak and Cooney). Wodak and Cooney conducted a meta-analysis of 49 studies from 1989-2002 to study the effectiveness of NEP. Overall they found that NEP promoted health seeking behaviors, reduced the likelihood of HIV
infections or other blood borne viruses, increased exposure to primary care and different treatment regimes, reduced injecting behavior.

Ksobeich (2003) also studied the positive effects of NEP based on data from 1988-2001. It also showed that there was in fact a reduction in risky injecting practices and overall positive health outcomes for the drug users. Harm reduction programs that have used the needle syringe exchange and out reach have found benefits, especially for the hard to reach street users (Des Jarlais & Semaan, 2005; Gibson, Flynn & Perales, 2001). Several studies have indicated that users understood the risk of HIV/AIDS and tried to reduce risks by exchanging used needles for sterile ones (Rhodes, et. al., 2003; Ksobeich, 2003; Des Jarlais, et al., 1994). At times NSEP can also indirectly benefit the drug users via ‘secondary exchange’. In such exchanges IDU’s obtain syringes from NSEPs and deliver them to those clients that cannot or choose not to come (Valente, Foreman, Jungue & Vlahov, 1998).

However, there have been a small number of studies where the results have questioned the effectiveness of NSEPs. In studies conducted by Bruneau et al., (1997), Hagan et al., (1999) and Strathdee et al., (1997) the incidence of HIV and Hepatitis C actually rose despite NSEPs. Inadequate availability of needles, the involvement of riskier participants in such programs and the rise of cocaine injection has all been used to explain the rising rates (Bourgeois and Bruneau, 2000; Bruneau, Franco & Lamothe, 1997). Bastos and Strathdee (2000) highlight that for needle syringe exchange programs to succeed other components of risk behavior must also be simultaneously addressed, such as condom use, Hepatitis screening and testing as well as referral to drug treatment.

Research has shown that the relationship between the provision of needles, behavior change and reduction in disease is dynamic and complicated. In fact, a combination of factors
such as adequate coverage, the removal of contaminated equipment from the community, the monitoring of needle syringe exchanges between formal (between NSEPs and drug users) and informal (between drug users themselves) networks and prevalence or incidence of blood borne infections in the community all play a key role in the efficacy of NSEPs (Des Jarlais et al., 1995; Kaplan, 1994; Kaplan & Heimer, 1994; Kretzchmar & Wiessing, 1998).

Currently needle syringe exchange programs are running in Manipur, Delhi, Mumbai, Kolkata and Chennai and have had varying degree of success (NACO, 2010). In a study conducted by Sharma et al., (2003) in the state of Manipur it was clear that unsafe injecting practices were high but risk behavior itself was similar between IDU and non-IDU groups. Lack adequate coverage, paucity of injecting equipment, poor service delivery and residual risk factors like injectors tended to use the same equipment for more than 5 injections and 11% admitted to sharing were crucial factors that compromised the program’s efficacy. With limited resources NSEPs in India continue to face multiple challenges. But there is little research that provides an experiential picture of these programs itself- how services are delivered on the ground and in what manner are they received. My effort was to both enrich this experiential understanding of NSEPs in Delhi and reflect on the implications for health and recovery.

*Public injecting and outreach.*

The needle syringe exchange program was an important component of the harm reduction services at Sahai and Ashray. The outreach staff at Sahai covered Kharagpur and two large communities around it. They would specifically target large open garbage dumps, abandoned buildings, public toilets and the ‘khet’ (field in Hindi), which was at the periphery of

---

81 In the U.S. for instance there was a Congressional ban for decades on the use of federal funds to support NSEPs, which has only been recently lifted. This severely impacted the nature of programs and their coverage.
82 In 1998, the Manipur government advocated the needle exchange policy to halt the transmission of HIV amongst drug users and their sexual or needle sharing partners (Manipur State AIDS Policy).
the community. While the outreach workers had certain set routes they would often deviate if they heard a new ‘shooting’ (drug injecting) site had emerged. Clients would usually tell staff about these sites, since these would keep shifting depending on the conditions within the neighborhood. For instance, once during outreach Gulzar and Mahesh found no clients in their usual spots because of a police raid the previous day. The clients had all shifted their ‘shooting’ spots and gone underground. At other times clients would have to move temporarily if community members were objecting. NGO staff had to be constantly vigilant about these shifts in order to reach their clients.

Ashray’s staff would conduct outreach mainly within Nadi Nagar and focused especially on three big public parks turned shooting galleries in the area, namely Chottu Park, Jaggu park (which had a large Bangladeshi and Nepali immigrant population) and Dholak park (populated mainly by the transgender community\(^83\)). Chottu park\(^84\) is the largest of them all- a large green expanse that extends between the Yamuna river and the main over bridge in Kharagpur. It is the most infamous in the area and it took me just one visit to understand how it had earned its reputation. From the main road the view is blocked by small hillocks. But as soon as I climbed over one of them, stretched before me were literally hundreds of homeless all across the park. It looked like an urban refugee camp, where the city’s unwanted were contained. Almost all of the park’s residents were male and a majority used either drugs or alcohol. During the end of my fieldwork Ashray decided to change its strategy and plant one outreach worker all day at ‘Peti (meaning box in Hindi) market. This was one of the largest metal sorting markets where most drug users would congregate during the day. Ashray found

\(^{83}\) A large transgender community resided in Nadi Nagar
\(^{84}\) This park is so famous that a film depicting its subculture has been made.
that having an outreach worker for at least 12 hours of the day in this heavy traffic area increased their outreach by 100%.

Both Sahai and Ashray had three to four teams, composed usually of two peer workers and at times a client volunteer. These teams conducted outreach with sixty to a hundred drug users each day, except Sunday. The teams would meet as well as interact with clients, provide clean needles and take old ones but most importantly engage and encourage clients to come to the center to seek OST, abscess and HIV related services. During the earlier phases of outreach both NGO’s would also provide bleach and cotton. Providing other paraphernalia like cotton and bleach, have been shown to be effective in reducing the disease burden (Hilton, Thompson, Moore-Dempsey & Jansen, 2001; Bluenthal, Kral, Erringer & Edlin 1998; Vlahov & Junge, 1998; WHO, 2004).

However, after the government took over Ashray’s funding, these additional services were dropped. Sahai was facing severe financial problems and thus had limited its activities. The NGOs also distributed condoms to the clients during outreach and I would notice place a few boxes of condoms with key community members. This way clients or people from the community would have multiple sources and access points. Even though funders and policy makers stressed on condom promotion, outreach workers noted that only a few clients would actually ask for condoms and even less would use/need them. In fact outreach workers felt that clients would simply take the condoms to appease the outreach staff.

During this initial interaction with the drug user, the staff would at times pass out educational material, discuss both addiction and HIV related concerns and connect them with social services; research shows that these are effective strategies for outreach (Heimer, 1998; Des Jarlais, et al., 2000; Bastos and Strathdee, 2000).
Dr. Ambika Kapoor from the WHO highlighted that the latest research suggests that the actual ‘exchange’ of the needle and syringes are less important than the actually flooding the community with enough clean equipment. Dr. Rohan Chatterjee claimed that in addition to lowering HIV rates needle syringe exchange plays an important role in creating discipline among drug users. In fact, this discipline then helps to transition drug users to OST.

The relationship between outreach workers and clients has considerable influence on users’ ability to inject safely (Kral, Anderson, Flynn and Bluenthal, 2004). Ideally, outreach workers were expected to stop and talk with all drug users and inform them about HIV and harm reduction services. As I discussed before, such a strategy was needed, since street users would often shift from injecting to non-injecting modes depending on the availability of their drug of choice, its quality and their financial position. Moreover, many non-injectors were equally at high risk for HIV and other diseases through high-risk practices such as unsafe sex or sharing of drug equipment. However in practice, outreach workers were usually pressed for time would only interact with the established injecting groups. At times, new clients would themselves approach the outreach workers and seek services. Funding restrictions prevented the NGOs from employing more staff and expanding the scope of their work.

Harm reduction interventions are seen as a continuum of care and needle syringe exchange in many ways is considered the first step in this process. Drug users, once having established a relationship with the outreach workers, are more likely for other services and move from harm-inducing forms of behavior to less harmful approaches. I will now detail some of these experiences from my field notes and to provide an in depth and intimate picture of the varied nature of outreach, needle syringe exchange programs and harm reduction.
I set out with Saif, Manish and Mushtaq (client) to observe their outreach activities in Kharagpur. I had tucked my dupatta\(^85\) behind my ears covering my head, mimicking the other women on the street- a deliberate move in an attempt to blend in as well as protect myself from the scorching heat beating down on us. I walked a few steps behind the outreach workers, but I could see that my presence was already creating a lot of interest on the streets. We began at a small public ‘park’ that had deteriorated into a large garbage dump. One had to be careful while standing in this ‘park’, because sometimes people would throw garbage directly from their windows of the apartment complex next door. To enter the ‘park’, I had to jump over a narrow ditch and climb over rubble before I landed on a pile of garbage. The first thing that hit me almost immediately was the stench of decomposing garbage, then I began to slowly take in the ‘park’ itself and the clients – man and matter almost seamlessly molded together. I followed the outreach workers carefully, often looking down making sure I didn’t step on the many needles and vials scattered around the ‘park’.

Fieldworkers are allowed to give out only one needle and two syringes, because of shortage of funding. For most drug users this was barely enough and I saw many of them arguing with the out reach workers, demanding for more. I noticed that the staff would tear the sealed packet of the syringes, before handing it over to the client. The NGO workers told me that this was necessary, because, clients would otherwise sell these unopened packets to make money for drugs.

There were close to ten clients in the park that day. Some were injecting or smoking up, others had covered themselves with torn and tattered blankets and found a corner to sleep in the mounds of garbage. I noticed Sadiq, a young client of Sahai, who came sometimes for clean needles to the center. He was clearly high and barely noticed me. He had brought some rice

\(^{85}\) Indian scarf worn with a long tunic and pants –salwar kameez
and dal (lentil) from the temple and was sharing the food with his friends. Just as we were about to leave Sadiq asked Mahesh to come with him to see Rafiq. Sunburnt, weary, with tattered clothing Rafiq lay writhing in pain in one corner of the park. He could barely speak, eyes red, face covered with flies that he was too tired to push away. Like other drug users around him Rafiq had been injecting for years. Once all his veins on his hands and feet were blocked, he had resorted to injecting in his groin and the day before the vein had become infected.

Both Mahesh and Saif sat down next to him, pushed away the flies and stroked his forehead. Saif then gave a few rupees to Sadiq to get some chai and bread for Rafiq. Meanwhile, they called a few more clients to help them lift Rafiq to a relatively clean and sunny area in the park. They gave a small card containing Sahai’s address and asked one of the clients to run and inform Clive about the problem. Clive and other staff members helped Rafiq get to a hospital later that day but nobody was hopeful.

Static, (February, 2009). I had accompanied Julie, a young and smart outreach staff member and Ismail, a tall and wizened old peer worker, both of who worked for Ashray on outreach. We walked along the main road stopping near bus stops, toilets, between road dividers and small tents that substituted for homes for the street drug users. Each time Ismail would open the beaten up tin box and offer it to the drug users, who would dump their bloody and dirty needles and syringes. He would then open his bag and give clean injecting equipment. Meanwhile, Julie would take down their names, age and ID numbers. I noticed that almost every client gave his or her names as Salim or Mohammed. It was as if we were meeting the same person in repetition. The poignancy of this was not lost on me. The history of use, abuse, neglect, chaos and pain seemed to almost merge into one and another- sharing a name only seemed most appropriate.
Unlike some of the other outreach workers I had observed, Julie would take time with each client asking many questions, “Since when have you been injecting? Do you have a home or do you live on the street? Do you have any abscesses that need to be tended? Have you tried OST? Have you come to the center?” While some of the clients were too drugged to answer, others would briefly talk with her, show her their wounds or ask for specific services. As we walked away Ismail mentioned that during outreach we were more likely to encounter much younger clients as compared to OST. The reason for this he said was simple, they have ‘young blood’, death and disease still seemed distant and therefore these young clients were more likely to take risks.

This comment stayed with me, when I met Ajith a young drug user in Nadi Nagar. I happened to ask him his age. He quietly replied 28. Ajith was a poly-drug injecting user and had already lost both his legs because of abscess related complications. He would push himself on a wooden plank that had attached wheels to move around. Despite losing both his limbs he had not stopped injecting. Ismail handed him the needles and syringes and jokingly commented “For as long as I have known you, you’ve been 28…why don’t you tell us you real age’. Ajith looked up, pocketing the needles and syringes and said ‘Until I have this nasha (addiction) I will always be 28”. After taking the needles he pushed himself across the street and towards the direction of the pusher, while we walked on.

Traces (November, 2008). The mobile and transitional nature of drug users lives mean that they usually carry all of their possessions in a large burlap bag. I never get to see inside it but often I see things that come out of it- old clothes, pieces of broken plastic, newspaper, metal, cups and plates, soap and some times food. I wondered if they left anything behind to mark their

---

86 While the demographic was largely young males in both sites, there were some women and transgender clients (the latter were usually contained in specific neighborhoods).
presence. I began to look for the signs that they chose to leave in the parks, bridges or streets. During outreach, NGO workers would point to these nooks, which were home to some of their clients. In these ‘home spots’, I would find the portrait of Goddess Lakshmi hung from a nail on the bark of a tree (perhaps under which one of them slept), etc. things of their names across a wall, a line of clothes left to dry on the water pipe in which they stayed, a small chulha (mini stove) or a bundle of blankets and bedding stashed under a bush. Small traces of themselves - they had been there, live there, were here.

Many clients would leave behind old injecting equipment- vials scattered, blood stained needles/syringes, cotton balls and bent spoons. Outreach workers would often pick these up commenting about the addicts’ carelessness knowing fully well who slept there. Usually if we would encounter them later on the street they would request them not to leave the ‘dangerous’ equipment lying about. The addicts’ wouldn’t even have to say a word, for their matter had already betrayed them - just like their bodies. These traces would carry from the community into the recovery spaces. Clients who would return their needles-syringes and make an effort to use ‘safely’ in public were trusted and at times even given small privileges (such as more needles, higher priority in the list for medication or detoxification and even opportunities to volunteer within the NGO).

**Sharing lives.**

Injecting behavior in the communities of Nadi Nagar and Kharagpur was not hidden. In fact, it was public and open even though it was heavily stigmatized. Sharing of needles, syringes and other equipment was common among clients- both in Ashray and Sahai. Drug users, claimed that one of the main reasons for sharing injecting equipment was the inadequate number of needles and syringes provided by the NGO. Further, since outreach services lasted
only until the afternoon clients would often miss the outreach worker as they would leave to find work, money, drugs or food. This meant they were forced either purchase clean equipment from the pharmacy or share.

Ajay (client of Ashray) shared his perspective with me about this:

No there isn’t enough needles and syringes being given out here – for one person 4 needles and 2 syringes are needed. I mean the first time I put time I put in 5ml with needle and syringe and suppose it doesn’t go then I would have to use another needle. . . now I wouldn’t have another needle to use . Or suppose my friend comes and he doesn’t have any money so he may say why don’t you give me some so I would take the same needle and syringe and I would give him a fix …its not the case that each time I use a fresh needle and syringe. If there were more needles available then one could save oneself from disease.

In consideration of the international standards set by WHO – a new needle and syringe for each injection, the actual number of needles and syringes given during outreach massively under met the demands. In fact, Sharma (2003) based on a study conducted in one needle syringe exchange site in Delhi, showed that on an average a needle was used twice and a syringe was used 3.66 times before disposal, exchange or passing onto other IDUs. Thus, clearly violating standards of safe use, endangering their own lives and those of the community.

Dr. Chatterjee (leading harm reduction specialist) placed the blame partly on funding organizations and the government that did not adequately account for needles and syringes per drug user. He related this to lack of knowledge regarding prevalence and drug taking behavior. He pointed out, that NGO’s too, felt pressured to reach a certain number of target drug users, with the logic providing the minimum to the maximum. “They must learn how to say no”, Dr.
Chatterjee concluded. However, Clive (staff Sahai) contended that this was difficult to execute in a community setting. He argued that clients would get angry and it could place the entire program in jeopardy, if they began to refuse clients. During my fieldwork period Ashray was lobbying hard with the government to change its guidelines, however the government had not yet changed its stance.

Panda and Sharma’s study in 2006 found that nationally in India most drug users purchased injecting equipment from the pharmacies. They cited a number of other reasons besides limited time and equipment. These reasons included- high drug user mobility, stigma attached to entering a NSEP facility (the person would be then categorized as a drug user), perceived or actual poor quality of injecting equipment disbursed by the program and requirement of different sizes of injecting equipment than those disbursed. Research has shown injecting drug users may avoid needle syringe exchange programs or purchasing from a pharmacy out fear of arrest, drug users are afraid that carrying injecting equipment would place them at legal risk and they would rather share needles at the public injection site (Rhodes et.al., 2003; Bourgois & Schonberg, 2009).

My study supported some of these findings. I noticed that a sizeable group of drug users were indeed mobile- they were in search of better quality of substance or were escaping from the law. This clearly jeopardized their access to free injecting equipment. However, a majority of the clients remained in the area and were associated with the NGOs for years. In fact, older clients would often induct new clients into the program. Stigma attached to entering the NGO was not a major factor in accessing equipment. Most drug users would readily agree to come to the center, since the NGOs were embedded within the community for a long period of time, the clients were comfortable and would freely move in and out, accessing a variety of
services. However similar to the study by Rhodes et al., (2003) and Bourgois & Schonberg (2009) I found that clients were fearful of arrest and on days of an imminent police raid they would disappear, not accessing any service. The local police were well aware of the work of Ashray and Sahai and would usually leave the clients alone. In fact, Clive and Muquim told me that the police were not keen to arrest drug users, since then they would have to deal with their withdrawal symptoms as well. The police only arrested clients in case they suspected theft or if a community member complained. The other times raids were usually conducted to ‘clean up the streets’, but things would return to normalcy in a day or two. During the course of fieldwork however clients would at times complain of being brutally beaten by police personnel but they had little recourse.

Panda and Sharma (2006) highlight that injecting equipment can cost up to Rs. 5-6 each time and when one multiplies these costs over the month- they can be very steep for a user living on the street (more than the cost of food). A large number of street drug users were engaged in some form of informal labor like rag picking, metal sorting, recycling, rickshaw pulling or working in marriage parties as temporary staff. A majority of the drug users would live on the streets i.e. either in the ghats of Yamuna or within the radius of the three big parks. Most lived without a roof, some within old abandoned buildings, inside broken water pipes, under makeshift tents and trees. Therefore with limited resources there was precious little left to spend on new/clean injecting equipment.

The final aspect of sharing behavior was the street culture of using itself. At the interpersonal level sharing needles with friends or partners was often seen as a sign of trust and intimacy and may prevented drug users from using sterilized injecting equipment. Rakhi found it natural to not only buy drugs together with her partner but also share with him. Ajay, Dalbir,
Mushtaq and Santosh all spoke about buying and sharing drugs with friends. While most of these groups were all male, sometimes a female partner or a transgender would also be a part of their circle. Usually, those who contributed the maximum would take the first hit and others would follow. Drug users who are unable to inject themselves, and 'hangers on' who 'contribute nothing to the acquisition of the drugs, are often the last to use the needle and at the highest risk (Bourgois, 2009).

Clients in my study reported that often did not know who was positive and it did not feature significantly in their drug taking/sharing behavior. A few of them commented that if they knew about their HIV positive status they would allow others to inject first before injecting themselves. Being positive then did not necessarily stop sharing especially when clients were in severe withdrawal. They reported wiping the needles/syringes with a cloth, washing it water and even using saliva to clean. These findings reflect other research studies that have found drug users often had misinformation about the status of asymptomatic HIV infected people, inadequate knowledge on how to cleanse needles effectively and lack of awareness of one’s own HIV seropositivity (Bryant & Treloar, 2006; Perngmark, Vanichseni & Celentano, 2008; Golub et al., 2007; Loxley and Ovenden, 1995). All of these factors impact sharing behavior and increase the likelihood of infection. The fear of being known as HIV positive person was another barrier against safe injecting practices (Golub et al., 2007).

Sharing of injecting equipment was a part of the larger ethos of living and surviving on the streets of Nadi Nagar and Kharagpur. Limited availability of equipment, management of withdrawal symptoms, NGO policies, legal and funding barriers, fear of arrest, poverty, misinformation and lack of alternatives were crucial in shaping this risky behavior. As I began to understand how they participated in these harm reduction programs, I began to reflect on these
‘risk – creating environments’ themselves. Survival it seemed was negotiated through navigating these multiple risky conditions. In the final section of this chapter I discuss my understanding of this risky survival.

**Reframing risk and the making of survival.**

My chapter began with the stories of Usha and Dalbir and it only seems fitting to end this chapter with their lives. Both were the quintessential clients of Sahai and Ashray- poor, struggling with recovery, unemployed, unsure of their (HIV) positive status and clearly lacking adequate support to bring any lasting change in their lives. They continued to use drugs, share equipment and pieced together an existence through many risky not to mention often illegal and problematic practices. On the face of it, harm reduction seemed to be failing to deliver on its promises. Not only were clients like Usha and Dalbir frustrated with the system, but also saw little change in their own lives. However, as one looked closer the implications and transformations were far reaching.

The daunting numbers of HIV had placed the Indian public health sector under great stress. It had become important to launch a program that was ‘at scale’ and fairly swift, to halt the epidemic. India thus followed the global model and engaged with groups that were considered most ‘at risk’. High prevalence rates of HIV, Hepatitis and other STD’s within these ‘high risk’ groups reinforced the need for such an approach. Risk, was a calculable and relatively reliable measure to divide the populations and implement programs. However, risk in its essence, was not supposed to be a stable or bounded category simply applied for designing interventions. It was clearly based on multiple assumptions, context specific and governed by a number of uncertain factors. Despite these limitations of ‘risk’ as a notion, has gained enormous
social currency and reigns as the dominant form of organizing and providing HIV services across the world and now in India.

My fieldwork also showed that indeed a greater focus on risk based assessments and interventions had coincided with the emergence of a neoliberal approach within the social sector. However, the conditions were considerably more complex. While on one hand India saw the growth of a neoliberal approach to many social concerns it has not necessarily lead to a dewelfare state as is assumed. In fact, while ideas of economic efficiency, markets and profitability have entered the social sector, the government especially in the case of HIV prevention has continued to engage, invest and implement many welfare and social justice oriented programs. Further, in most developing nations executing harm reduction services the public health systems are almost non-existent and privatization of health care occurred far before the advent of neoliberalization. Re-investment in HIV services has some scholars would argue forced the government to re-evaluate its entire stance on health. Despite controversy about whether HIV has invigorated the entire health sector or not, one thing was clear –there was an intermingling of neoliberal and welfare approaches. Sharma (2008) points out, this uniqueness or ‘exception’ (Ong, 2006) to neoliberalization’s totalizing influence can be seen in many spheres of development in India.

In the specific case of harm reduction this has meant that older welfare ideals of health, influence of the AA model of recovery and the presence of rights based movements shape a ‘risk-focused’ environment. Risk, was clearly perceived very differently by the clients than by the service providers themselves. Risk reduction services were focused on reducing HIV infection and mainly through a focus on individual behavior. However, clients responded to the services in the context of their overall lives. For clients, HIV infection was less of a risk to their
immediate lives, than getting access to food, shelter, and medication or most importantly avoid withdrawals. Risk to them was embedded in their needs and desires, which often did not reflect the same rationalities and logics that harm reduction services employed.

However, these risk-focused interventions had opened a realm of possibilities that were not available until now. Clients who were the most marginalized and neglected were now the center of services, HIV had brought their plights to the notice of policy makers and service providers. More than quality, it was the sheer availability of services itself that was remarkable and gave these drug users a fighting chance. Risk had thus opened the chance to survive but not necessarily in the ways it had imagined.

Survival for a majority of drug users now meant becoming visible to service providers, government institutions and social systems. By this I mean that for a long time drug users were hidden- both fearful of authority and treated with apathy by civic institutions. Harm reduction, with its focus on access, outreach and engagement was bringing the drug user back into the fold. In fact, the drug users themselves were learning to seek out help in different forms. However, this new induction did not necessarily mean that drug users were being disciplined into productive, responsible and rational subjects (Rose, 2007). The resource poor setting with limited staff permitted only the bare minimum surveillance and enforcement of discipline.

Clients used services in somewhat a judicious and agentive manner, to suit their lifestyle rather than conform to the services. Clients would adapt these services into unique forms of harm reduction for themselves, creating a plethora of harm reducing lifestyles. For instance, they would take needles from the program and share it with only their partner; they would access Buprenorphine from the Opioid substitution program and clean needles from the center to inject safely; they would even take ‘breaks’ in their injecting cycles and go into
rehabilitation programs to rejuvenate their bodies. They seemed to be applying the basic principles of risk reduction in diverse ways to maintain their bodies functioning. They had found a way to make this new system adapt to them.

Keeping target numbers enrolled in the programs meant that NGO’s could not refuse them services and this meant drug users retained a fair amount of flexibility. Moreover, with an equally strong rights based philosophy and overarching influence of AA, the harm reduction environment was operating under multiple pulls and influences. Care was limited and services deeply fractured- clients more than anybody else in the system intimately understood this. Health had to be sought through and within this patchwork system and not despite it. Instead of a continuum of care model, my work shows that harm reduction was a cyclical model of survival. It re-constituted both risk and health constantly generating new modalities of being a recovery subject in India.
CHAPTER 6: PHARMACEUTICALIZATION OF HEALTH

It flows inward and outward
Through me and on the street
It leaves its trace quietly.

I cannot remember when it began
I keep these keepsakes of injury
Drawing it out will erase
Old memories.

Bottled up inside this pill
Can it really be the same?
It is not of the street
The same DNA
But more polished in its affect.

They tell me I am ok.
Now, with the pill.
Traces are few
But the injuries remain.
(Moorthi, 2011)

Pharmaceutical survival.

In the previous chapter, I outlined how a unique type of survival was being shaped through risk-mediated practices. This risk regime was the result of a new focus on efficiency, calculation and containment of the HIV epidemic. Though injecting drug users were now able to access a number of harm reduction services, my work showed, these services were conceptualizing risk very differently from the drug users own experience and their engagement in risk. Moreover, the drug users continued to struggle with recovery as these interventions were unfolding within a larger milieu of apathy and impoverishment. In response, the drug users were creating unique expressions of risk reduction that often did not follow protocol. Further, the
presence of rights based struggles and older models of recovery such as AA, continued to exert their influence on the nature of survival.

In this chapter on clients’ lives I will specifically focus on the drug users experience of Opioid Substitution Treatment (OST). The introduction of OST was (as discussed earlier) an important turning point in the development of the harm reduction model in India. It was introduced, on a large scale, after much struggle on the part of NGOs and international organizations. However, larger conditions of poverty, stigma and paucity of infrastructure were endemic to these drug users lives and impacted how OST services were delivered and received. I intend to examine how this increased pharmaceuticalization introduced a specific type of ‘care’ environment and explore its efforts to promote recovery.

I also return to the notion of survival, but this time engage with the form and shape it takes under OST. Survival, was clearly now conceived for these drug users via the chemical introduced to support it. As drug users battled for health and healing they were, I argue, being constituted into ‘pharmaceutical citizens’. This term has recently gained much attention within the sphere of medical anthropology to understand the growing dominance of pharmaceuticals in shaping health, disease and rehabilitation. The pharmaceuticalized existence, of course cannot be examined or understood without the context of the pharmaceutical industry that produces, supports and proliferates such a life. Most crucially, some scholars argue, governments or states are increasingly replacing care, therapy and social institutions with provisions of pharmaceuticals (Biehl, 2007; Petryana, Lakoff & Kleinman, 2006). From the perspective of citizens – pharmaceuticals are seen as life extending technologies, and are often used to center demands from the state. The most obvious example of this strategy, in recent times, is the social movement for free Anti-Retroviral treatments for HIV across the globe.
In the case of harm reduction in India, the growing focus on OST and provision of pharmaceuticals to sustain recovery has raised many questions - what does survival and health look like under this pharmaceuticalized regime? What does such an intervention reveal about the nature of relationship between the state and the citizens in the sphere of health? How does social work respond to such developments and shape its perspective?

The promise and possibility of becoming stable, less risky recovered and responsible is now increasingly the focus of harm reduction intervention in India. Pharmaceutical interventions are seen as a solution that not only can resolve addiction but also socially re-integrate potential clients/patients. At the same time there are clear boundaries about who can and who cannot access these medications - as decided through risk profiling of the populations. OST medication in India is still restricted in terms of coverage, especially when compared to the larger drug addicted population excluded from this service. OST is provided by a single pharmaceutical company and heavily subsidized by the government. Since the legitimate market is still small we do not see the same kind of politics of ARV - around access to medication, competition and struggle to gain legitimacy within patient groups. In fact, the main focus until now has been to increase the reach of the pharmaceuticals across India. I argue, similar to Biehl’s (2007) experience in Brazil, the condition in India is such that, this pharmaceutical intervention is not really a tool to govern/discipline bodies. Instead, drug users are temporarily drawn into relationships with NGOs, the state and other bodies that provide pharmaceuticals. Drug users are governed by their instinct to chart out a survival and pharmaceuticals have become a crucial way to negotiate their existence.

As social workers it becomes important to understand what are the new ways in which citizens are managing their lives and the forces that shape their behaviors. Pharmaceutical
citizenship is an important theoretical concept that helps to make sense of these new conditions where pharmaceuticals attempt to take over care and health. In the next sections I detail the government protocol around OST and compare it with the actual experience of OST on the ground. Further, I detail the transgressions and politics surrounding OST. Finally, I comment on the issues that govern the unique survival generated through such an intervention.

**Government pharmacopeia.**

The Government Manual for Buprenorphine Maintenance Therapy (OST) describes the program in this manner,

OST involves replacing the client’s drug of use with a medically safe drug. For instance, an Opioid such as heroin, which is considered unsafe (it requires repeated administration through unsafe/hazardous route) is substituted with a medication (such as Buprenorphine) which is safe, and administered through oral/sublingual route with a longer duration of action. The medication used in OST helps in achieving an opioid level in the body, at which the client does not experience either withdrawal or euphoria (‘high’). As OST helps in achieving a comfortable level, the client stops using injecting drug, thus preventing the potential harm of contracting HIV and other diseases transmitted through injecting route (e.g. Hepatitis B, Hepatitis C). While on OST, clients do not require to spend all their time looking for their next ‘fix’. Thus, they can be engaged in other activities including counseling and group discussions, which help also in delivering Behavior Change Communication. In addition, there is also an improvement in the psychosocial status of the clients, leading to an overall improvement in quality of life.
In the 1990s, Buprenorphine, a partial agonist synthesized from the product of poppy, was a commonly abused substance. It was easily available without a prescription at the local pharmacy under the trade name Tidigesic. Drug users realized that it had a low risk for overdose and was relatively cheap. It fast became the drug of choice for many street users. In fact, till date it continues to be one of most abused licit substances in the country. The government in an attempt to prevent abuse of Buprenorphine pills removed it from the shelves of pharmaceutical shops, however ironically enough they continued to stock the liquid form of the medicine, which was easier to inject. While it is illegal to purchase Buprenorphine without prescription, a healthy black-market for the medicine exists. Both Nadi Nagar and Kharagpur are over populated with small pharmacies that sell most licit drugs without prescriptions to drug users. Addiction is heady business in these communities.

The threat of HIV changed the dynamics on the ground- drug users were now risky property. Ashray was one of the first NGO’s in the country to suggest a ‘modal substitution’ and not a drug substitution as ‘harm reducing’ solution. Hence, instead of promoting methadone maintenance- a common pharmaceutical substitute in the west, drug users were simply encouraged to switch the mode of using Buprenorphine, i.e. from injecting to oral use. Owen (NGO head of Ashray) argued that this modal substitution was more efficient for two main reasons. First, to replace Buprenorphine a partial agonist with methadone a full agonist seemed ‘counter-intuitive’ –it would be increasing addiction rather than reducing it. Second unlike

---

87 The opiate µ receptors are believed to be responsible for most of the analgesic effects of opiates and side effects like dependence, euphoria, depression etc.. Buprenorphine binds very strongly with the µ receptors preventing other µ receptors from binding. Concurrent use of heroin will not give any additional euphoria. When Buprenorphine is discontinued, a withdrawal syndrome is developed. The withdrawal features are similar to morphine; however, the features are not very severe. They include nausea, sweating, drowsiness, headaches, disturbed sleep and constipation.

88 Mukund, a client at Ashray informed me that when a ‘new’ drug user goes to these pharmacies (or chemist shops as they are called) they receive a ‘starter’ kit- Avil, Buprenorphine, syringe and needle. The shop keeper may even show you how to inject.
methadone, Buprenorphine was locally produced and therefore a cheaper and more viable long term option in terms of treatment. A modal substitution, it was believed, would help clients to graduate from invasive and dangerous forms of consumption to safer methods.

Research shows that substitution programs are effective in that there is greater retention of drug users and less unemployment, criminal activity and deaths of drug users as well as more economical in terms of costs of drug treatment (Gibson et al., 2008; Zaric, Barnett, Brandeau, 2000). Methadone programs in a variety of community contexts have been successful in helping to stabilize the drug user and promote long-term recovery (Sacerdote et al., 2008). Today marketed as Addnok by Rusan Pharma - the only Indian formulator licensed to manufacture and distribute Buprenorphine, it is available .2mg, .4mg and 2 mg sublingual tablets89. It is also available in India as a mixed tablet of Naloxone and Buprenorphine. This is done to prevent the misuse of BP through injection, as this combination causes severe unpleasant withdrawal symptoms (not providing a high). Buprenorphine is then according to the government, the medical establishment and the NGOs a safe, non-euphoric, stabilizing pharmaceutical treatment for addicts. In fact, almost every stakeholder I met hailed OST as the single most significant development in addiction treatment. My experiences in the field however challenged some of these assumptions and highlighted the complicated stakes of this intervention.

An unending wait.

It was during outreach that most clients first heard of this ‘dawai’ (medicine in Hindi). Even though most clients are familiar with Buprenorphine as a drug, its status as medicine is something that is not as well understood (will discuss in detail later). I noticed on many occasions outreach workers would tell the clients to come to the center, where they would help

89 During the period of my fieldwork only Buprenorphine was given as an Opioid substitute, however since then methadone has also been introduced in some centers.
them get over their ‘nasha’ (addiction/drugs). When they did come to the NGO they would usually be told little about the medication itself except for its ability to remove withdrawals and help them stop abusing.

Tukaram, a thirty-five-year-old drug user, recalled his first interaction at the NGO Sahai:

They told me this (drugs) is not a good thing. If you eat this medicine then you if you do drugs then it will be useless, in fact there can be some opposite reaction. The medicine tastes sweet. There is no difference (between drugs and medicine itself). I felt no discomfort – well for one or two days I definitely felt uncomfortable, medicine is less and I was using drugs much more… in fact in my feet I felt some amount of pain. After 2-3 days they increased the dosage of the medicine and then ‘continuous’ slowly the pain went away. Now I want to get out of this, I have a daughter.

Tukaram had begun using in his 20s. He had planned on helping his younger brother who was involved “in some bad company…however in trying to change him for the better I myself went the wrong way”. He told me, it wasn’t easy to get on the list for medication, in the first place:

I (first) came here 2-3 times(Ashray), they didn’t give me anything, they kept telling me to come this day, come that day, so I went back to using drugs. For about 2-3 days I kept doing this – sometimes they would say come on Monday, but then I couldn’t come on Monday because I got some ‘jugaad’ (slang Hindi term for hustle) and then I tried coming on Tuesday and Wednesday and they told me to come next Monday. Then one day I went to Ajmal (coordinator of Ashray) and told him that I was feeling really ill, so he told me there isn’t enough medicine (here) why don’t you go to Sahai. So I went to the counselor at Sahai and told him how I felt, I told him my problems and he started my
medicine. So I gained courage at that point. Otherwise I would have broken down… I had actually broken down.

Tukaram had silent tears streaming down his face as he narrated his struggle to get medication. “With the medicine everything good is only happening nothing bad is happening. When I was on drugs then only bad things were happening. Now only good (things are happening)”.

Slots are limited as funding requirements limits the number people who could get medicine. Both Sahai and Ashray had a policy “waiting”. New clients on most occasions (unless recommended by another NGO worker or were in severe withdrawals) could not access the medication on their first day. They would be often asked to come back and wait. This waiting period was seen as a test of their interest in recovery, but more significantly it became a test of worthiness to be on treatment. Showing their patience, regularity and ability to adjust to the system (which was often arbitrary) were key facets of a model client—a client who the NGO could trust would adhere to the treatment protocol and not use the center’s resources to tide over a difficult time.

Over my time there, I saw many clients get angry, anxious and desperate—resorting to begging for treatment as they ‘waited’. This waiting period could last anywhere from 1-7 days. The staff informed me that such tactics used to move them in the beginning but now they were used to it and realized that the clients were ‘using/playing’ them. Neither government harm reduction literature nor public health documents recommend such waiting periods. The waiting period was a useful tool for practical reasons. For instance, if the NGO did not have enough slots for medication it was a possibility that during the ‘waiting period’ an older client dropped

---

90 Some clients would come to center on days when they could not ‘hustle’ enough money for buying drugs. They would show interest in the program but often drop out after a few days.
off and the new client was given his/her slot. By making the client wait- the NGO workers argued at least the client was (potentially) keeping away from the drugs for that period of time. Overall a majority of the clients seemed to cycle in and out of the system on a regular basis- waiting, joining and quitting (repeat).

**Kneeling patients- Pharmaceutical Transgressions.**

After morning prayers the in-house staff would quickly begin dispensing the substitution medication, knowing fully that many clients were showing signs of withdrawal and would not hold up long. I would usually sit next to Clive, Brian and Atif in the dispensing room most mornings to observe this Opioid/Oral Substitution therapy (OST) at work. The three NGO workers would sit behind a large old wood table close to the entryway. The table held all the dispensing equipment – strips of Buprenorphine, a steel spice masher to crush the pills, as well as the registers and files to log client details. A small locked steel cupboard on the extreme left corner housed all the medication- its keys were guarded zealously by Brian. There were a few chairs for clients in front of the desk but usually the staff, community members or the doctor who consulted at the clinic occupied them. Thus, clients who would come in to take their medication would end up sitting on the floor, right next to the small narrow bed used for tending abscesses. A small table with medical supplies and boiler to clean medical equipment was wedged between the main door and the bed. The peeling yellow walls were covered with a few HIV posters, an old mirror and a wall clock, given by a client- that never seemed to work. The medium sized room was always buzzing with activities of dispensing, abscess management, and record keeping but it was also a hub for socializing among clients, staff and community members.

To receive their dose of oral Buprenorphine clients needed to present their ID cards, this also contained the dosage taken by each client. Almost every day two-three clients would
forget or lose their ID cards- a phenomenon common in both NGO sites. A fight would ensue between clients and staff, as the NGO workers would usually refuse to give medicine. The ID cards Muquim (project manager, Ashray) told me is not only necessary for records but also imposes discipline, hitherto lacking in their lives. As an added incentive, it also legitimizes them as patients/clients of the NGO. The police was less likely to harass them if they showed their ID cards (knowing that they were undergoing treatment) and they were likely to receive better treatment in hospitals and access other social services.

The NGO worker would usually place the assigned dosage of medicine into the spice masher and crush it into a fine white powder. This powder was then poured onto a small piece of paper. The drug user was asked to bend down or would kneel on the floor as the NGO worker poured the crushed contents directly the client’s gaping mouth. The clients were not allowed to touch the drug physically at any point. However exceptions were made for certain clients. At Ashray, the procedure for medicine giving was similar in style to Sahai but given the large numbers and lack of space or time, the pace was much faster. Anil a thin wiry chain smoker would sit at the register to note names and check ID cards, Kalyan a young novice with little experience was made to smash the pills and pour it into the clients’ mouths. Usually a third NGO worker stood at the door, directing traffic and making sure the clients had swallowed their entire medicine before leaving.

Don’t eat or drink anything for at least 15 minutes before you want to take the medication’. ‘Don’t smoke your beedis’. Keep your mouth shut, don’t try to talk while the medicine is in your mouth’. ‘Look straight and keep your hands where we can see them’. ‘Open your mouth wide, wait let me check properly’. ‘Don’t make a fuss, don’t
come too close- I will fall ill, close your mouth and cough, if you must’. ‘No we don’t have any medicine for fever, ask the doctor to write you a prescription’.

These dictums, given by workers, were common in both the NGOs. It kept clients reminded of who they were- ‘untrustworthy and risky subjects’. Day after day as I sat in Sahai and Ashray I would watch this drama unfold with literally hundreds of drug users who would come for their daily medication and leave.

The kneeling- open mouthed submissive drug user, to me, has in certain senses, become the new symbol of ‘recovery’ of harm reduction in India. An ironic choice considering the broader ‘rights based philosophy’ that harm reduction experts claims drives this paradigm. However, I also recognize that this symbol of a kneeling subject is unstable and extremely fragile. For instance, whenever the clients got a chance they would remove the Buprenorphine, store it for injecting later. Jamal an aging client was one such rebel. He had become such a nuisance for Ashray that it was comical to watch his arrival. Tall, almost 6 feet, matted hair, with a ratty bag that included all his belongings he would walk in and produce his ID card with great flourish. Anil looking up immediately smiled and loudly said, “Look who has arrived, everyone be alert, this one always leaves with medicine”. Kalyan chimed in, “Don’t you dare show your ‘kaalakari’ (smarts) here”. Then turning to me he remarked, “We have try to explain to them so many times that this is medicine, it must not be misused, but do they listen... We are tired, no matter how much you explain it to them, they just don’t understand”.

Jamal looked at me his eyes twinkling and his thick beard seemed to be hiding a smile. As he sat down on the bench waiting for the medicine to dissolve I looked over at the workers-all three of them- Anil, Kalyan and Raghu (the third worker on duty) were staring at Jamal waiting expectantly, nobody moved as they watched him swallow, hum and smile intermittently.
Jamal tried to check for something in his pocket and all three workers jumped at him to stop and sit quietly. After five minutes of such non-stop staring, another client walked in and their attention got divided, Jamal recognizing the opportunity, put his hand in his mouth and took out the medicine, storing it in a small piece of paper. After giving it another ten minutes Jamal got up to leave. Raghu asked him to show his mouth- all clear. Raghu was not satisfied and began a physical pat down asking him to empty his pockets. Kalyan joined in as they checked every little scrap he was carrying, even asking him to open his bag –rifling through his belongings. By now a few other clients had also come to watch, as were the nurse and some of the outreach staff. Throughout this humiliating experience Jamal kept smiling. They finally did find the little folded piece of paper with the medicine. Once outside Jamal and other such ‘rogue’ clients would carefully remove the stored contents, dry in the sun, mix it with another pharmaceutical like Avil or with smack (street name for heroin) and inject it right back into their bodies. A triumphant Raghu a large man himself pushed aging Jamal out of the center. Kalyan let out a string of Hindi abuses as he shouted at him for being so ungrateful. The entire NGO came to a standstill- Jamal was being a made an example and everyone was made to watch. A week later Jamal convinced Muquim (project head) to give him another chance and returned back as a client. Jamal story was hardly unique, many such Jamals’ came and disappeared during my time at Ashray, however practices of medicine giving, stealing and injecting continued. The return of Jamal to the system was inevitable as were his attempts to misuse the drug.

Ajay, a client from Ashray who also told me that he regularly stole and injected medicated Buprenorphine. Mukund an immigrant from Nepal had lived in Delhi now for many years.
I try to take it out, if I can then great if not…the days I have friends (who are using) or I am sorting garbage and I make enough money to buy my medicine. But I don’t take chances here. I first look around and then see that I don’t steal in front of any and every client. I want the respect of the staff to be maintained, so that as a result of one- another person doesn’t lose respect. So that they (client) don’t say why do you let him go and not us.

He was almost certain that he needed to steal dosages to keep the withdrawals at bay. Ajay was at all times careful of what he revealed to me, making sure that no one heard us. He seemed to be more concerned about losing face (for himself and the NGO workers) than necessarily acknowledging the conditions that prompted his misuse. His experience (both corporeal and psychological) of OST was very much grounded in this community and these NGO worker-client dynamics- it was this life politics that were the techniques of his survival.

Uma who I had met on the very first day of my fieldwork at Ashray, also echoed similar sentiments. She had stood out not only because she was the only woman coming to receive medication (in both NGOs), but also unlike her male peers she was allowed a ‘take home dose’ of Buprenorphine and bypassed some of the bodily disciplining of OST that I have previously described.

I don’t share only sometimes- these people (Ashray) don’t know that I still use, they think I have left drugs, so why should I get a bad name, so when others are using…My drug use has become less as a result of the drugs (she uses the word ‘nasha’ both for the medication and her drug use), without it would be a wasted away- because of it I stay all right, I don’t have any problem.. I can do my work. When I was using drugs I wouldn’t even like getting up until I had my drugs, but now look at me I look fine, I get up at the
right time. I do all the things that are needed to be done, there are no problems, no worries- no need to do ‘jugaad’, medicine is good.

Both these clients highlighted how the appearance of recovery was as important as recovery itself. In fact, recovery under harm reduction was more akin to managing their drug use in controlled ways rather than addressing inherent issues surrounding drug use.

For Uttam a fifty-year old tailor who had started abusing drugs almost twenty years ago, his harm reduction treatment was a part of a continuum that carefully wove use and abuse with his desire to be considered ‘treatable’.

I had heard about this organization in Kharagpur and felt it would be beneficial for me to join , there is benefit…but again after one month I left them and after one and half months I ‘relapsed’. Then I fell back in the hole again and again I returned to Pawan (counselor Sahai) – I talked to him and started my medicine again. From that day until today I have been on medication (he started coming to Ashray after Sahai’s project site changed). I tell Raju (counselor, Ashray) brother increase my dosage by two pills he tells me he will do it on Thursday, sometimes Monday …that is why I need to take one and half pills on my own.

Uttam claimed he was too old to completely change and harm reduction offered a comfortable space in-between. He told me:

The experience of the medicine is just like smack. It tastes like opium- its that ‘taste’. After taking the medicine, have some chai then it (the taste) really blossoms - it just seems like as if I have just taken ‘nasha’ (drugs). Besides that it has helped stopped a lot …medicine makes the person stop engaging in bad things. Now that I have got my medicine , now I can relax and quietly talk to other people. I don’t have (to worry about)
money, I don’t have jugaad (hustle) or that I have to go and pick pocket. If I had to go for work (legal or illegal) then I wouldn’t have been even able to talk with you, my mind would be flitting from here to there…now this medicine it doesn’t allow the mind to move here and there, only in one direction the mind moves- towards food or home.

Harm reduction had opened the possibility of using drugs without remorse, guilt or stigma. However, there was ambiguity of what was this status that it had acquired in their lives. Without necessarily labeling these transgressions as relapses as they did in the previous abstinence paradigm, drug use was now seen as a part of their lives a chemical that sustained life, made it normal and livable.

Bharat was considered an ideal client and a success in many ways for Sahai. Six feet tall with a slightly long and curly hair and a big beard this lanky man would be at Sahai’s offices just as they opened the shutters and leave only when the staff left. Usually quiet but when he spoke his booming nasal voice garnered everybody’s attention.

Someone told me that sometimes you pick it up and sometimes u drop it , why don’t you go to that organization they give medicine. It was about 10-12 years back …in the beginning they gave me a medicine and then the whole day I felt drugged – I said well there is nothing better than this – it’s a free drug. I became linked with Ashray – I would take the medicine, mix it with Avil and …then pull it in the syringe, then mix it like (makes a motion as if he is shaking the needle)- mixed it like this and then inject the 5ml in my bloodstream, then again after 2-4 hours I would do the same again. Then I started seeing that many boys, some had put the drugs in their groin, some had lost their legs – their hands…their groin was bursting. Then I became scared and said I have to leave this.
After five years of injecting I decided to go for rehabilitation. I stayed in the rehabilitation center for about one and half months.

But once out of the rehabilitation center Bharat started using again. He would earn money by sorting garbage buy a vial for about Rs. 50-60 and some food for Rs.10-20. The day he wouldn’t be able to make as money to get his usual fix then he would inject Buprenorphine. “The staff of Ashray itself would sell the medicine and would be fixing it as well. We would be injecting them and they would be injecting us”.

However in the past year things changed dramatically, he decided to commit fully to the program at Sahai and had not abused any drug (except taking medicated Buprenorphine). He was also willing to try rehabilitation again.

I am telling the truth, I am sick, I am tired and without any aim –stealing, jugaad, stealing things at night, getting beaten up, not getting food. I left my household and am living under the bridge – I have broken down completely, now I want medicine in a regular way in the mouth. So when I came to the Sahai they started my medicine. For the past one year I haven’t touched a needle or a foil. I only had the medicine, and in the evening had my food, and gone back to sleep. Then in the morning my eyes open and I straight come to the center.

Bharat like others has found many benefits to this medicated life:

Firstly we are away from crime, I have stopped stealing and all those kind of things. Nor do I have to do so much “jugaad” for instance I had to steal this bag, nor do I need to be in such withdrawals. I know that I have eaten my medicine, I have to eat food and then go to sleep. I have that much belief that if I come here tomorrow we will get the drug tomorrow. I don’t have to actually spend money at all. We also get the drug, two three
times we get tea, they talk to us nicely and our time passes – we are away from that life – breaking somebody’s lock, stealing someone’s luggage, stealing someone’s cycle- people are beating us, they are breaking our hands, going to jail…this life is better than that life that I had before.

Over time, I began to understand how these were examples of OST’s most basic functioning at best, while simultaneously OST’s most acute failure. Dr. Rohan Chatterjee a leading harm reduction specialist (heading a large government harm reduction program in the city), met with me to discuss these transgressions and how he saw harm reduction’s function in the addicts’ daily lives. He told me he was very aware that clients often misused Buprenorphine and even abused other substances with OST. But he argued that their (NGOs/medical establishment) main effort was to reduce harm, even if it was for a small number for a short period of time. He pointed out that statistically if one were to calculate, even if one drug user did not share one time the possibility of reducing HIV was multifold. While it seemed to be shortsighted at first glance Dr. Chatterjee argued that for a country like India where people did not have any experience with OST, the act of coming to a center to receive medication itself was a radical move.

With family we have had 2 contrasting response some family perceives that these are addictive medication, doctor you are not helping my husband or my son and there are people whose families are thrilled- that my husband is now well he gives me money from his earning 80% of his money.

These drug users, in that sense were not a failure but recovery in progress. Every day the drug user had less chance of sharing because he received closely monitored doses of Buprenorphine and clean injecting equipment, every day he was less likely to engage in criminal
activities since he was getting his drug free of cost and everyday the possibility of him spreading HIV reduced. As a by-product of these rituals he was inadvertently and slowly reducing his chemical dependence, more engaged with some form of civil society and no longer invisible but had become a pharmaceuticalized citizen. In his own facility Dr. Chatterjee had seen many successful patients who had not only stopped using drugs (not dependent on OST) but also had returned to their families and even taken up jobs. During my time at Sahai and Ashray I only saw 3-4 clients successfully transition into such a life, out of the hundreds that came to seek their services.

**Dosage politics.**

Ashray struggled with such ‘rogue’ clients more than Sahai. Ashray’s clients told me, that this was partly because only recently had the protocol around medication changed in this site. Previously, all clients would be given take-home dosages, clients were used to misusing the pills as they were without supervision. ‘The clients have been spoilt by such practices and it becomes difficult when we try to enforce some discipline’, Muquim told me quietly when I asked him about these shifts. Clients like Ajay were also quick to inform me that the staff was selling Buprenorphine strips in the black market.

Earlier we would do outside drugs and we would get these drugs as well. I mean if our dosage was two pills then openly we could get as much as we wanted (via the black market). But in the middle what has happened is that the dosage has reduced now they are only giving us one pill. The number of pills has reduced and also they are being crushed, so we have to go outside and find pills for injecting. In the middle when they would give us medicine it wasn’t enough so one had to go outside and search for more medicine. The amount they give us is enough but what to do its force of habit and
secondly a drug user must use drugs there will never be a day when he/she will say reduce the drug, the drug user will always think that this is less- what one is getting from here, he will want to do more drugs. The drug user will never say I want less medicine, reduce my dosage… he will only think that one day I had this dosage I did not have any enjoyment so today I need to fix (in addition to the medicated dose) so slowly it will keep increasing. But I do feel what they are giving from the point of view of the NGO is enough. In our minds we keep thinking that if we do more drugs then we can work more, so we then we pick up more drugs.

It was an allegation that was brought up on many occasions including by some of the Ashray staff members themselves. For poorly paid staff this was a lucrative side business. Even if clients felt they were not being given enough medication, they assured me they could easily procure it via the black market. The lines between licit and illicit were constantly crossed and never clear. Thus, there was a culture of abuse that seemed to link the community and the NGO. Injecting drug use was not only a public fact, but in some senses nurtured through these NGO channels of unlimited availability and misuse.

One of the easiest ways to gauge clients’ adherence and compliance were the rate of abscesses. If injected oral Buprenorphine could block veins and cause severe abscesses. Hence if a client on OST came to the center with abscesses it was evident that not only was he/she continuing to inject, most likely abusing medicated Buprenorphine. As compared to before, abscesses have drastically reduced and in most cases they are attended to, more quickly.

Closely linked to this ‘undisciplined behavior’ of misuse of medicine was the issue of dosage. Both in Sahai and Ashray the issue of dosage was mired in controversy for a variety of reasons. Universally clients complained that their dosages were inadequate and their effect only
lasted for 24 hours. NGO workers on the other hand assured me that the doses being given were adequate to manage withdrawals for at least 72 hours. There were no set criteria for deciding the dosage- it was usually a collaborative process between the doctor, NGO worker and the client. In some extreme cases (SOS), when the doctor was unavailable it was the NGO worker that prescribed medication.

At Sahai at about two in the afternoon the center’s doctor would arrive on his old green moped. Dr. Choudhary, was a balding middle aged physician who had been working for Sahai for a number of years. He would usually amble into the center, open the newspaper and demand a cup of tea before opening a single client file. Flipping disinterestedly through the charts he would begin with the most ‘serious’ cases. Glasses perched on the edge of his nose, legs crossed he would ask “Kya dosage okay hai? Koi mushkil to nahi, sone mein?” “Is the dosage of the medicine okay? Did you have any difficulty sleeping?” Jairam a relatively new client to the center had just begun the OST treatment and he wanted to increase his dosage. Clive (NGO worker) had informed him that only the doctor was allowed to change dosages. Thus, Jairam was here, clearly nervous, he mumbled quietly that he was in ‘tootan’ or withdrawals. The doctor assured him that it was likely his body would face such difficulties-especially since he had just shifted from injecting to oral use. Jairam looked unsatisfied with the explanation and then reluctantly talked about his lack of sleep, difficulty in concentrating and not being able to work. The doctor at this point looked over to Brian and Clive – as if asking for some form of confirmation about the authenticity of these symptoms/conditions. Clive looked over at Jairam and said “The whole point of coming here is that you reduce drugs not increase them. You will have some difficulty in the beginning but it will soon become okay”.
The doctor now clearly keen to move to the next patient increased Jairam’s dosage slightly “I am increasing it by two pills”. He did not tell Jairam the potency of the dosage, the effect it will have on his body or the future course of the medication. Jairam, satisfied left his chair for the next client. This type of collaborative prescription was common. Doctors often relied on the NGO workers to provide a patient history and determine the client’s trustworthiness (necessary to maintain adherence) or condition. However, since dosages had to be managed in response to client’s physical needs, the client was an integral part of this prescriptive process. In most cases the dosage that was assigned was started low and then based on the client’s physiological state, adherence to regime and behavior increased over time. Even though there were major differences in the types of drugs abused, the length of abuse and nature of addiction, most clients were given the same starting dosage. Depending on the clients’ condition the dosages would then be tapered in the coming months, with an aim for achieving a drug free status. Clients often found the initial dosage too low and would face withdrawals, which prompted their return either to full blown drug use or using other illicit drugs simultaneously. For clients the number of pills mattered as much as the actual the strength of the pill itself. Hence NGO workers had to make sure they conveyed the strength of the pill as well as the number clearly to the clients during each interaction (especially if there was going to be a change). Most clients in Sahai were constantly encouraged by NGO workers to reduce dosages-maintenance, as a concept, was not encouraged.

Ashray, in comparison, tended to focus less on abstinence as a goal. In fact, a significant group of clients were taking medication for over 5 years. During the course of my fieldwork however, Ashray workers shared that their policy of maintenance may undergo a change. Until Ashray was funded by private /bilateral donors they were free to dispense
medication as long as they deemed fit. However, under government funding they faced certain restrictions. Government policy stated that after 9 months dosages must be tapered off. By late 2008, after massive lobbying from the NGOs, this policy was revised and extended to a longer period (approximately to 18 months or determined case by case). Government actors who wanted clear timelines of recovery and were daunted by the prospect of funding medication in ‘unending’ fashion.

Often dosages were also reduced because there was a delay in the medicine supply chain. Other times the NGOs were fearful, that the funding for the medicines would cease, since most contracts with the government were six months long and those with private funders lasted for one year only. This sudden withdrawal of funding could potentially create a situation where the drug users, would be left without any support or medication. Hence the NGOs would often create a buffer of stock to protect against such future shortages. At other times there were during periods of plenty, NGO workers would encourage drug users to increase their dosage- so that they would feel ‘comfortable’ enough not to use other drugs. These shifts in availability, perceived shortage and thriving black market generated ambiguity in terms of what was adequate dosage or medication.

When dosages would be reduced clients would get extremely agitated, angry and sometimes even get violent. Withdrawals to Buprenorphine, clients told me, were far worse than any other drug they consumed. For many clients the medicine provided them with certain stability and even a slight shift in their pattern would have major repercussions to their street life. On one such day the medicine had been delayed at Ashray. One by one clients had to be told that today their dosages were going to be cut in half. Both Anil and Kalyan had been especially patient with clients- trying to explain that the medicine had simply not arrived from the office.
While some clients took the news calmly, others clients like Raju became very angry. “This is our right, you are here to serve us…how can you do this, stop our medicine suddenly”. Anil tired of the explanations began shouting, “What can I do, I am only an employee here…” As the morning wore on the situation remained tense. Many clients refused to leave the center premises even after collecting their ‘half dosage’. Muquim (project head) had to specially address the group and force them to disperse. The staff clearly outnumbered was scared about their anticipated response. The clients seemed to calm down once Muquim spoke with them. Over the eight month period of my stay this happened twice, Muquim told me that these rare occurrences were ‘tests’ for the clients and the staff as well. “There could be a riot here, if we one day decide to stop giving them medicine. There are too many people who are dependent on it”. Muquim was right, in some senses these clients had stopped imagining their lives without the medication and any threat to its regular supply was seen as a clear threat to their sustenance.

Abuse of OST was intrinsically linked not only to under dosage, lack of social support and easy availability of drugs but also with the inherent act of drug taking itself. As Salim (client of Ashray) explained it to me, “We miss the prick of the needle”. The needle prick, the abscesses and the sores reflected a semblance of normalcy, continuity and even nostalgia for these ‘overused’ bodies. It gave them a sense of control on the drug and themselves. Thus, even if though, injecting medicated Buprenorphine did not provide the necessary affective response (because of the new chemical combination) and led to abscesses, the act itself was an essential element of their lives. Abdal Khan shared, “When you prick it goes into your body, then (you know) that yes we have felt the drug…for an injector this is his/her identity until the needle doesn’t prick…” For drug users scoring, preparing and using were deeply entrenched rituals and activities of their day-to-day drug life. However, now they received measured and crushed
doses of their drug as ‘medicine’. Moreover, clients were not only prevented from touching the medicine but also stopped from manipulating its form - some clients would request to be given the tablets whole as they preferred it to crushed powder. Drug taking, was then not only the disease- exterior and alien, but over time, had come to represent who they were as people. It defined the textures of their lives and how they understood their roles in society.

I have drawn out the various aspects that made up the ritual of medicine taking and the processes and practices that surrounded them. In this final section, I attempt to highlight the kind of survival, health politics and medicalized recovery that governs drug users’ existence today.

**Surviving through a new kind of recovery.**

The provision of oral Buprenorphine in a medicalized setting was intended to help drug users move away from harmful injecting use and keep them away from criminal activities as they were assured the dose of Buprenorphine. OST, according to the government was to serve only as a transition point, from where drug users could move to rehabilitation services and ultimately live a ‘drug free’ life. However, my ethnographic work showed that the experience of OST on the ground was a much more complex process- affected by a number of conditions that generated new modalities of survival.

**Recovery talk.**

Pharmaceutical medicines have managed to bring the notion of measurement into the understanding of recovery and more broadly living. When asked about their stage of recovery clients would often answer in terms of the dosage they were on-.2mg or .4mg etc.. Lesser medication meant they were doing better than before- abstinence remained the gold standard of a recovery lifestyle. The length (time) of recovery was also broken down in terms of medical dosages not in terms of psychological breakthroughs (as was common under the AA/NA
models). Talk about recovery, is now significantly different as well. Largely spoken about only in these indices of dosage with amount of medication as the only indicator of well being. Drug users have quickly began to emulate the local harm reduction experts and use the language of measurement to speak about their health and addiction. Pharmaceuticals have single handedly manage to remove other idioms of recovery and health- leaving the psychological component an important core of the addictive life untouched.

Social support or health care assistance was also now measurable in new ways. Reduction in medication became a critical indicator to measure the quality of care and clients would argue that their rights were being violated. This model (as discussed above) allowed the client to participate more fully and actively in the management of his/her medical recovery. This was quite unlike the heavily psychologically focused model, where the doctor/counselor was the only expert. Armed with their years of expertise in managing their drug dosages, this new management of medicine is far more familiar than any psychological framings of their disease. They would often make demands to increase and even reduce dosages depending on their condition and doctors had to listen. However, government guidelines and NGO interventions clearly carry traces of a historical medical model of doctor and patient, which are also uniquely Indian in its texture. Doctors, within the Indian context are seen as key authority figures and patients do not necessarily participate as vocally in their treatment. In fact, patients’ class positions play a key role in the status they occupy in this interaction; marginalized groups such as drug users have never occupied an equal space in this medical arena. Submissive bodies, bowed heads and unquestioning agreement with establishment continue to reign medical interactions across the spectrum of health, not only in the sphere of addiction. While inherently problematic, the medical model offered harm reduction a way to legitimize this new and radical
model of intervention in local communities. It helped to situate something unfamiliar through a more familiar relationship. Most critically, this was to serve as an important break between the drug (Buprenorphine) and the person, between addiction and medication and between a private concern and public health.

**Ambivalent medicine.**

The government framing of the consumption of medicated Buprenorphine is significant, as it tried to shift the conception of this drug from the ranks of illicit, addictive and pleasurable to the platform of legitimate, controlled and emotionally abstracted. But as my fieldwork progressed it became clear that the easy availability of Buprenorphine in the black market was undermining these official efforts of separating Buprenorphine as an illicit drug from its guise as a medical intervention.

Lovell (2006) describes this movement of ‘addiction pharmaceutical from the site that legitimizes it (the treatment context in which its commodity status is downplayed before its status as a pharmaceutical tool or a medicine) to an informal illicit network (the drug economy where it morphs into a symbolically charged dirty commodity that escapes market and state regulatory mechanisms)’ as pharmaceutical leakage. She highlights that ‘what distinguishes a good substance from a bad one is not inherent to the substance itself; it depends on the effect sought, the quantity taken, the means of administration, the frequency of the practice, the context, individual vulnerability, all of which are highly symbolized. The ability to differentiate between poison and remedy, to generate a dialectic between these two poles of the pharmakon, depends upon the lay knowledge and scientific knowledge that circulate among drug users’. Lovell points out that is not the drug itself, but the knowledge about the drug, value judgments
attached, information provided by health practitioners and the indigenization of pharmaceutical knowledge (Kleinman, 1986; 1988) that ultimately governs its use/misuse.

This confusion between medicine and drug was most evidenced in the terms of reference used by drug users. They often continued to refer to Buprenorphine as ‘nasha’ or drug very rarely calling it ‘davai’ or medicine. Uma was clearly very aware of these differences and what they would mean for her recovery:

When you do drugs you don’t feel like anything else, when you are facing withdrawals then you are having problem, your mouth starts to burst, tears start rolling down your eyes, you start feeling lethargic and. However, now when you have one pill you don’t tend to feel too much. Its not like I don’t use drugs at all sometimes I do fix medicine—once or twice in a month …I know that for so many days I was doing drugs and I was unwell. Now I need to have this medicine—it’s important that is why I take this medicine. Medicine— for disease, if I think of it as drugs and consume it then my mind will lose control – that is why I am unwell I am taking this medication.

This slippage in language also translated to their very consumption patterns as well. Clients were after all taking the same drug except the conditions surrounding its intake differed vastly. This difference in perspective made a great difference in how they used/abused the medication/drug. I argue that the abstinence paradigm created a break both in their consciousness and their actual material life—separating or purging the drug from the body, while harm reduction promotes a continuity in experience – where neither the body, the senses nor the consciousness realize any vacuum or shift. Thus previously clear lines of recovery and use are made muddy.
While clients understood the legitimacy that the NGO provided pills gave them—protection from the law, acceptance by society and social currency to negotiate their concerns in other civic institutions (hospitals, social service organization etc.), they also claimed that the pills were a way for the government/NGO to keep them addicted and controlled. The medicine they recognized only helped to keep their addiction under control not help address multiple concerns that surrounded their use. Dalbir (client) told me:

The withdrawals to this medicine is even more than smack. By taking smack there is not as many withdrawals- you don’t want to work, your limbs hurt, you don’t feel like eating…as soon as you eat the medicine you start feeling hungry as well, you start to drink more water as well. We get the medicine in the morning and then we keep sitting. he says it works for 48 hours but not for 72 hours. They are lying to us because after that you do need the medicine, withdrawals for the medicine keep coming back – mouth starts to burst, you are in a bad condition. I don’t want to take medicine all my life, I want to leave this as well. Because we have to come here on time we can’t even go to work- we come here straight to eat the medicine. One has to leave this slowly slowly – you can’t be eating this all your life.

This ambiguity between medicine and drug was deeply implicated in the way they conceived of their current recovery and future life. Almost every drug user that I interviewed viewed drugs use as problematic and painful. Shahnawaz, a client/volunteer at Sahai was struggling with recovery often relapsing into full blown drug use. At almost fifty his struggle with drugs had lasted almost all of his adulthood. His grown children and wife had all but given up hope. “In this its not like one gains anything, man always loses and loses- loses everything, loses his land, the respect he has in society, things…one doesn’t gain anything. His thinking is
like that he gets peace when he gets his drug”. Drugs were not neutral they had caused grievous harm to their lives –loss as a theme was recurrent in their renditions of these addicted lives. It was not merely a loss of material things but a loss of control over their bodies and most significantly a loss of hope. Dalbir in one of our last conversations had this to say:

Any drug is bad, no drug is good. Because of it one loses their home, their friends, their relatives, one loses everything. Drugs breaks a person, first it breaks the family members, then it breaks relationships with relatives...any relatives that would come by would say he look a ‘smackiya’ (local term for smack user), hide your things. He will steal your things. One has only negative impacts as a result of this, no benefits, everything is broken as a result. Drug use is a disease – you do drugs and it gets over. There is no correct time for eating and drinking- if we get food then we eat it otherwise mostly we drink tea. Tea chases away the hunger. Drugs are a bad thing, they are not a good thing. This we only find out when our lives are ended.

Thus, Buprenorphine once an injectable, illicit, pleasurable and unsafe drug despite the government’s best efforts never completely moved to the platform of neutral, safe and non-euphoric. Ingrained in its very bio-chemistry, medicated Buprenorphine has a more fundamentally organic intent- delinking the drug from its uncontrolled past. However, it continued to carry traces of its previous life as drug users time and again referred to its ability to provide comfort, familiarity, suffering, pain and pleasure. Therefore the government’s re-framing of Buprenorphine as a neutral agent that leads to neither withdrawals nor euphoria is, in practice impossible to conceive for drug users. In fact, it was perhaps this very feature that made the intervention successful and led to high adherence rates. Further more, at the macro level, pharmaceutical substitution functions in a system where drug use continues to be seen as a
criminal activity with a heavily punitive approach (as harm reduction approach remains a minority). In fact, the government’s welfare arm continues to support abstinence-based programs. This contributes to social context within which drugs remain as problematic and negative.

This unclear position of Buprenorphine and its inability to fully shape recovery as a rights based, choice induced and progressive public health strategy, produces a chemical survival that retains a transitional and artificial quality to the life it sustains. Drug users are already implicated ‘pharmaco-subjects’ not only in terms of consumption but also in terms of how their identities, values and behaviors are heavily shaped by this activity. OST is attempting to shift their identities, values and behaviors by inserting an old abused substance into a new ‘drug system’ (I use the term system because the drug use is organized around institutions, rules and ideologies). However, it is not a mere reframing of the substance that is at stake, but by rearticulating the role and position of the drug user; it is in fact a repositioning of survival or living itself that is at stake. No longer must life be thought of devoid of substance, but instead life is in fact measured through the meter of substance. As ‘pharmaco-subjects’ enter into this new system the pharmaceutical is no longer seen as alien or synthetic but instead is seen as integral to the continuation of life- personal and organic. As healthy life becomes inseparable or dependant on a pharmaceutical life, it will slowly blurs the difference and shapes a unique subject for whom survival exists only within these parameters.

**Empowerment or Dependency: Excavating the drug subject.**

As I was coming close to completing my fieldwork in India, I continued to grapple with an essential question about what defined this harm-reducing drug user. Was he/she a choice making individual or a dependent subject? Were harm reduction services encouraging
empowerment or were these drug users simply making day to day choices to survive? These questions of agency, dependency, freedom, rights, choice, discipline and governance seemed to be at the heart of the harm reduction project. In this final section of the paper I attempt to tackle some of these key concerns.

For a majority of this chapter I have drawn from Foucault’s theoretical body of knowledge that in some senses is less concerned about individual agentive capacities in local spaces and more concerned about the affects that disciplinary forms of power have on social bodies. Even Foucault’s notion of biopower and the related literature on citizenship links the growth of omnipresent knowledge, expertise with these drug populations, leaving less space to reflect on local activism, rights focused struggles and innovative efforts to chart out a living. Finally, using Foucault as Bourgois (2000) writes, can at times lead to a paralysis in thinking about practical concerns, which are the focus of practitioners and disciplines like social work. Therefore, my effort is not only to understand more theoretically how drug users are being shaped but more practically what can we as social workers do in making the services more supportive of drug users’ needs.

One of the biggest concerns around OST and more generally with pharmaceutical substitution is that this form of treatment continues the individual’s dependence on drugs (Holt, 2007; Bell, Dru, Fischer, Levit & Sarfraz, 2002). However harm reduction supporters argue that by replacing street drugs with medically provided substances under supervision, clients are more capable of acting in responsible and rational ways. The quandary was evident in my fieldwork context as well. As I described before, drug users and NGO workers alike would question this very dependency and yet had few options to independently seek a stable life style (Bell, Dru, Fischer, Levit & Sarfraz).
Some scholars have rejected an either or stance and instead shown the range of strategies and behaviors that clients’ tend to adopt—leaving the question of empowerment or dependency almost unnecessary. Gomart’s (2002, 2004) work in the methadone clinic highlighted how freedom and constraint can be viewed from the perspective of drug users who are trapped in their own addiction. Despite the freedom the drug users’ lifestyle provided, for most clients’ in the field it held little meaning. Without being connected, related and functional within a societal context, autonomy was almost useless. This notion of attached autonomy was cleverly used by the clinic to harness drug users into behaving in less risky ways. In my fieldwork setting while such an approach was missing, it was clear that clients were unwilling to passively submit to the restrictions of the NGOs. They would manipulate, divert and use Buprenorphine in different ways than expected yet at the same time wanted to remain engaged with the NGO itself. These tactics to remain independent but connected and resonate with Gomart’s findings. Ning (2005) also has commented on these issues on her work in a methadone clinic in Canada.

This was similar to my own findings in the field, as I have reported before. Given the cultural focus on abstinence and a chemical free life, this dilemma is fully understandable. For Holt it was important for practitioners to acknowledge the clients’ efforts for ‘controlled and strategic use of methadone with other drugs to maximize both treatment stability and the maintenance of pleasure’. However, considering the political climate under which most harm reduction programs operate, this might be difficult to achieve. In his work Holt suggests that treatment should attempt to encourage clients’ decision making on one hand without a fear of dependency and increased responsibility on the other. It is a delicate balance between fostering reflexivity and independent action as well as success in the treatment, though the
latter can inadvertently “induce fear of losing that independence and capacity for action” (Holt).

While reflecting on my own fieldwork experience these suggestions are indeed important and useful. Within the Indian context medicine taking for treatment of addiction is still a fairly new phenomenon. But the clients were clearly facing the same challenges as outlined by the researchers above- in adopting the treatment regimens fearing both dependency and loss of control yet recognizing its potential for leading stable lives. Similar to Ning’s clients, the clients of Ashray and Sahai were clearly agentive in their compliance, realizing that their ‘good behavior’ could help them survive in a context that was mostly hostile to their needs.

At the same time in India there was a strong rights-based movement around HIV services, which promoted the right to OST (among others) for injecting drug users. In fact, active drug users were involved in service provision, advocacy and management of OST services. Hence unlike the western contexts, there was less of a sense of being controlled or disciplined through treatment. The two NGOs that I studied were also community-based organizations with long histories of working with these groups. All of these factors greatly influenced the nature and perception of OST in the community. The right to OST medication was being spoken about in the same vein as ARV treatment and several drug users were advocating for expanding the programs to new areas and increasing dosages since most clients were given the bare minimum. The fight in some senses was for increased pharmaceuticalization rather than reducing its reach. Further, as the OST programs move to the next phase, there will be a greater emphasis on the empowerment of communities. In fact, the goal is to transfer a majority of these harm reduction services to community led
organizations. The question of dependency becomes even more important to answer in such conditions.

Overall, this effort to understand who drug user is being shaped to become, is a complicated one to answer. I do argue against some scholars, who cite that harm reduction’s goals to empower its participants could be understood as another way to discipline them into responsible subjects. Agency and empowerment, I recognized, were clearly more than concepts for NGO’s like Sahai and Ashray, who pride in harnessing and creating human potential within their clients. Their ideas of empowerment were far from singular, empty or unchanging. The two NGO’s accepted both- a wide range of harm reducing behaviors as well as clients who would relapse and return to drug use. Their belief in the clients’ ability to change was in some senses unflinching, courageous and refreshing and not centered around disciplining rogue populations. Ironically, this belief pre-dated the harm reduction model, and actually was a core principle of their philosophy as community based drug rehabilitation centers that drew inspiration from not only philosophies of AA but also religion, human rights and community action. It is not clear how these ideas will evolve as harm reduction is adopted by other agencies that may or may not share similar values. But what is clear, is that harm reduction more than any other model of recovery and rehabilitation draws on the precarious but powerful belief about human potential, freedom, values and most crucially the ability to transform.

Whose deaths matter and why? Is harm reduction renewing the hope of those who live? Can this new focus generate a greater likelihood of survival? What are the parameters by which we judge our impact? Drug users in effect represent one of the most marginalized categories. Their lives have little political and social significance in most spheres- rendered
important only through their potential to spread disease and harm. My effort in this chapter has been to show how they gain political and social significance, piece together their survival and generate new forms of living. Survival for drug users and other diseased groups is in the process of being re-crafted and re-defined. The potential of pharmaceuticals, to increase the chances of survival for drug users, is undeniable in India. As drug users learn new ways to manage and negotiate this pharmaceutical regime, in the absence of other forms of care, it is more than their health at stake. To fully understand their implications one must take into account how these inorganic substances are entering bodies, voices, values and actions.

Social workers can no longer remain outside this dialogue, especially in countries like India, where they are a crucial liaison between different stakeholders. As social workers, we need to engage with the implications of this pharmaceuticalization, at the same time not lose sight of our core beliefs in our clients and their potentialities.
CHAPTER 7: MODELS, MUTANTS AND EXPERTS

Tin boxes, papers, codes, bags, medicines and cigarettes.
Clean and organized.
Foil, spoons, cloth sacks, medicine and cigarettes.
Dirty and lost.

Just revealing enough.
Bruised but not broken
Undone and unfinished.

With them and them...both and none.
Rebels disciplined
Fighting for the same side.
(Moorthi, 2011)

‘I would go back 7-8 years when Sahai was switching from the abstinence program to the harm reduction approach. Most of the guys were working at the head office…and here careers are made and people are made…(it is that) kind of thing (here in) Sahai. So the group that was working, they were very committed people, working 16 hours a day, 14 hours a day…in the course of time, it was observed that all work and no means of entertainment…was making people to go for a major relapse. So that was the time when they started – weekend parties and all that…apart from that they would buy a small bottle of liquor for themselves, have a few drinks and chill out and this was the weekend.

Then next day they would come all pepped up and ready for work, (work) the next week and (again) they would slog for hours. So here it was seen that they need some means of ventilation- now it was not like harm reduction black and white on paper, prevention of HIV and all of that but it was like a practical stuff where a person who is coming out of drugs, hard core drugs and is trying to main stream himself, re-integrate in the mainstream society, there he needs some kind of you know…say push or some kind of a support…social support has always been there but this kind of support, where he would feel good about himself...’ shared
Alfred Da’Cunha, a peer worker from Sahai. For Alfred, harm reduction was ‘what he did’ and not ‘what he lived’. But Alfred was a part of a small minority of peer workers who chose not to experiment with harm reducing measures. Over the course of my fieldwork I noticed many peer workers using alcohol and even drugs. On most evenings, a few staff members at these NGOs could be seen drinking and sometimes even using. They claimed this choice was made consciously and after much consideration. Harm reduction had reduced the shame of seeking treatment but had also allowed alcohol and drugs to legitimately enter the sacrosanct space of the treatment center itself.

As Alfred and I sat one evening discussing my project, he shared with me the stories of his peers, many of whom, had got grand opportunities to work for larger organizations in South Asia. However, after a few months they inevitably returned- emotionally broken, out of control, broke and often deeply entrenched back into the world of drugs. These peer workers, Alfred pointed out, were unable to “control” their drug use, despite claims of being “harm reductionists”. Their experimental use would usually lead to “relapses” and soon “full-blown” using behavior.

When I began this project I thought I knew where the lines between abuse and harm reduction needed to be drawn but watching these peer workers use substances tested my own perspective on this issue. The impact of harm reduction in the private lives of peer workers, who were the very harbingers of this movement, was both extremely poignant and baffling. It was easy to see that such conceptions of harm would seem containable under a system of risk and public health, but here in the nooks and crannies of peer workers’ lives it got to be both convoluted and confusing. Until now, my dissertation has dealt with harm reduction policy and
its implications for drug users. This final data chapter focuses on the lives of peer workers who were in the middle of it all.

The precariousness of their lives underscored the potential of harm reduction to shape a new type of recovery, while at the same time alerted us to the ever-present danger of completely losing control. Peer workers, I argue, became “models” for their patients. They demonstrated the possibility to control drug usage, assert rights and take responsibility for the community’s health as much as their own. Also peer workers, I show, were experts of the street and the larger system. They were able to navigate the complicated institutional and non-institutional pathways to create possibilities for a healthy life. These multiple identities gave them what I call a “mutant form”, which meant that they were unable to completely inhabit any single role of patient or service provider, they remained constantly adrift never completely rid of their addictive lives and struggled with the ethics of their profession while at the same time trying to survive. As I detail the lives of these frontline workers I explore the boundaries of recovery, empowerment and its implications for long-term health. In engaging with these issues my chapter also addresses questions of social work ethics, that these peer led models of interventions bring forth, especially in terms of legitimacy of care, professional ethic and ethics of care.

**Organizing care.**

The challenging task of running the day-to-day programs of harm reduction largely fell on the peer educators or as NACO labeled as the ‘foot soldiers’ of the program (NACO, 2008). NACO defines a peer educator (PE) as a ‘person from the high-risk group who works with her/his colleagues to influence attitude and behavior change. PEs are responsible for providing information on HIV/STIs, harm reduction, and promoting condom use and other risk reduction
materials among colleagues/peers, which ultimately results in building peer pressure for behavior change’ (NACO). Peer education is especially useful since most high-risk behaviors are highly stigmatized and PEs can ‘build trust and establish credibility with the vulnerable groups; they are a vital two-way link between the project staff and the community; they provide important information about the vulnerable group to other stakeholders and the wider community; they act as a link between the services and the community (for instance, by introducing people or accompanying them to the service facility)’ (NACO).

According to the protocol PE’s must typically serve approximately 40 clients but in practice they often served up to 80 clients each day. This is because there are far fewer NGOs with peer workers than is needed. Their role includes but is not limited to ‘identifying new clients, providing motivation and follow up through outreach services to access OST clinics, assist IDUs with STI, abscess and other related issues; assist in organizing support group meetings and group discussions and helping conduct home visits, and other follow up activities’ (NACO).

NACO also had created another layer of workers called Outreach workers who were above the PEs. They did not have to be current/ex–drug users but needed to be familiar with the context and community as well as be literate. In most cases these workers were also undergoing treatment or were following the harm reduction paradigm. They were expected to ‘identify and motivate IDUs about the harm reduction programs, provide support in registration as well as dispensing Buprenorphine and supervise peer educators. Their role also included conduct follow up and home visits, help establish peer support groups, conduct information

---

91 I have used the term outreach worker, elsewhere in my dissertation to signify worker conducting outreach, and not specifically related to this definition.
sessions and assist the clients in receiving various other referral services among other activities’.

In addition most sites had volunteers who were also from the drug using community and supported the NGO in a variety of tasks such as cooking, cleaning, guarding the premises, supporting the administration, organizing clients, supporting the workers in dispensing needles or condoms and acting as a conduit between the client and the NGO. Volunteers also served as community watchdogs and were often aware of changes in the political, social and psychological facets of the neighborhood and its people. The staff at the Drop-in-center also included a project manager, doctor, nurse and counselor.

Beyond these field level positions, peer workers, especially those belonging to English speaking middle class were able to deftly rise in the ranks of this cut-throat world of the HIV development industry. They ran NGOs or government supported projects, engaged in advocacy and activism, conducted or supported research initiatives, participated in developing policy initiatives and conducted trainings and workshops based on their technical expertise.

Sankalp Sinha, from NACO, stated that most NGOs did not have clarity about these different roles. For instance in the case of the peer educator, ‘the NGO tells them that they are full staff, actually they are not, they are just volunteers and we are actually engaging their time that does not mean they have to be in the drop-in center all the time’. The contradiction in the actual position of the peer worker and his/her assigned role was clearly evident in the project sites.

Even though the peer workers were assigned a large number of tasks they were not given the status of a full time employee. The peer educators were paid below minimum wages, kept on loose contracts and never fully absorbed into the system. Working for an extremely low pay
meant that many peer workers continued to live on the streets next to their old drug using friends and now ‘clients’. As one client pointed out, ‘When the sun goes down they become one of us’. I often observed the tensions that were created as a result of this unclear status of relationships. Clients banking on these street-friendships would ask for favors like more medicine, recommendations for a job in the NGO, better services or special treatment. Peer workers found it hard to balance these social and professional commitments. On one such occasion, a client told me ‘what’s the real difference between him and me…I use so does he…I also know about drugs and HIV…its just he dresses up well and comes here (to work), that doesn’t make him any different from me…’

Peer educators were rarely if at all included in devising programmatic interventions. Their opinions were only sought in specific client related matters or field strategies. Such a distinction in the role of the peer worker created a “de-linkage” between the street, NGO and government, replicating older patterns of disjuncture between the policy and practice arms of the system. It severely challenged the harm reduction model’s claim that it encouraged empowerment and participation.

In the upper ranks of harm reduction workers, especially those involved in the NGO head offices or with bi-lateral organizations the scenario is considerably different. The English speaking, educated, middle class workers usually occupied these posts. This ‘creamy’ layer of workers, have probably gained the most in this process of ‘expertization’ of street level workers within harm reduction. They have been able to parlay their street experience for a position at the decision making table. Many of them now possess a sophisticated understanding of the health discourse, which in turn opened a new career pathway and a lifestyle that was not possible before the advent of harm reduction. While the instability of the development sector due to irregular
funding cycles, and shifting agendas continues to plague these workers, most stakeholders agree that today HIV and harm reduction have created a spectrum of opportunities where previously none existed.

Sankalp Sinha, a technical officer at NACO, was a good example of a peer worker who had been able to rise in the ranks. A drug user for many years, Sankalp underwent rehabilitation and later joined a peer led organization in the northeast region. In the next few years he gained expertise in programming and policy through a variety of projects. His intimate knowledge about drug use, particularly in the region and programmatic experience led him to his current role in the national government’s harm reduction program. Over the course of my fieldwork I had the chance to meet with many ‘career’ harm reductionists and understand their growth trajectory in public health. Their street credibility combined with their programmatic knowledge made this breed of workers high in demand. As a final note about these roles, Sankalp pointed out that not all peer workers had taken the knowledge, funds or experience back to their ‘communities’ of origin. These careers, he shared, had helped launch a chosen few into the global development orbit without necessarily creating a “trickle down” affect that could bring long lasting changes to the local communities.

All in a day’s work.

To understand the breadth and diversity of the roles occupied by peer workers I shadowed a few workers as they went about their day. I now provide a brief glimpse of their lives through some of the pages of my own fieldwork diary.

Karthik Kapoor

8:00 AM: I stand waiting for Karthik’s car to arrive. He is the head of the harm reduction programs for Ashray, and had agreed to allow me to accompany him as he went about his typical
day visiting Ashray’s project sites. An ex-corporate executive, Karthik was on old-timer at Ashray. He prefers to keep his ‘addiction story’ private, but was otherwise fairly talkative on our drive to the first project site at Nadi Nagar.

‘It is important to keep coming (to the project), my presence is very important, there is a style…a culture, which we have always lived and worked with and one of my main roles is that we don’t lose the style, we don’t forget the (way we would) work- that is reason we are the best at what we do. I don’t come and look at records, and all…I know there are people efficient and well versed to see and know what they are doing but…my main thing is to keep the base there, which provides the energy and strength to do this kind of work, otherwise believe me, its not possible. If you go purely technical and say what the plan says and what the budge says you wont survive- you have to have your own philosophy and beliefs that take you forward. Times that are good very rare, always more people coming in, relapse, fall outs, crisis is happening all the time- its never good for them…”

10:00 AM: As the landscape of city shifts from wide roads and tree lined streets to bustling and overcrowded narrow lanes, open garbage dumps and drains, the car slows down; it must now wrestle with bullock carts, overflowing buses and careening cyclists. We enter the project site and in spate of few minutes the small office is cleared of the clients, tea is brought in and jokes are exchanged. Karthik tries to be one of them and yet I can see that Muquim, the project head, is acutely aware that Karthik is the boss and this visit for all intents and purposes is an inspection. I see a steady stream of clients come over some touch Karthik’s feet, while others shake his hand and brightly say ‘Good Morning’. This is quickly followed with an update about how they are feeling, the current dosage of medication and the status of their other ailments.
11:00 AM: Karthik is now busy walking to the other project site, situated a few blocks away, he reprimands the workers on keeping the premises dirty and asks why the room does not have any posters, as was discussed in his previous visit. Quickly Ramlal brings out the dusty but mint condition HIV/AIDS posters provided by the Government. He supervises the workers, who hastily put them up on the ‘paan’ stained brick walls of the center. The posters are in Hindi and English, with pictures about modes of HIV infection and safe use of drugs. The cynical staff make jokes about the posters, clearly not convinced about their efficacy, given that most clients are illiterate or simply did not seem to care about reading them. Karthik informs them, that it was important to ‘use’ the posters and keep the premises in order, since the accreditation process for the site was going to begin soon and each NGO must meet the criterion set out by the government\(^\text{92}\) for continued support.

12:30 AM: A client who wants to complain about the project staff waylays Karthik. The client accuses the staff of stealing Buprenorphine and abusing the drug. A common problem, Karthik assures me; it is an issue he addresses on each visit with no real solutions. He has learnt that ‘flexibility’ is key for the success of such a program, ‘Lets remember that the working population (peer workers) here is also homeless. (They are here at the) same spot after 5 o’clock where the client is, so, if he uses a bit of drugs and alcohol and goes a bit wild we understand that… but we have learnt to, over the years to pin point that the next morning or (the next) opportunity that we get… because its like a constant reminder that (while) working here as a service provider, you need to be a ‘little different’ from the receiving end…there has to be that line. I have to say these guys have come a long way I personally think its good they have stabilized lot more than they were a couple of years back…’

\(^{92}\) Ashray’s staff was involved in developing some of the guidelines for the accreditation.
1:30 PM: After some lunch, we get ready to visit another site located in Jagatpuri. It is much quieter and has only one or two clients compared to the bustling Nadi Nagar project. Hira, an aging former sex worker, an outreach staff member, informs Karthik that there were several problems in the supply of medication and needles. Medicines were often delayed because of blockages in the supply chain and problems with the flow of funding.

2:30 PM: The doctor walks in and was pleased to see Karthik. He too was upset about the delays in medication. Karthik assures him about addressing this with Ashray’s leaders. He also asked the doctor to adjust his timings to suit the clients better and after paying the staff for the month, we leave.

4:00 PM: Upon returning to the head office Karthik finishes preparing for a talk he is going to give at a training session for peer workers, arranged by NACO. ‘Working with harm reduction IDUs is hard area to tap, understand …difficult to work with. (We are now) forming training units, sharing knowledge and expertise with other states within India that have no clue about IDU’s and harm reduction’. Karthik served as a consultant for the Government and spent a large amount of time training other NGO workers and civic organizations. Karthik played many roles in a single day- administrator, peer, friend, boss, doctor, harm reductionist and teacher, often juggling these multiple identities at the same time.

Gautam Kumar

8:00 AM: Prayers had just ended and Gautam, Sahai’s resident counselor was taking notes after consulting with the outreach workers. Always dressed in colorful shirts tucked in a pair of jeans with sneakers, he was one of Sahai’s strongest workers. ‘I have been a peer outreach coordinator with UNODC’s harm reduction program. There I learnt about harm reduction, there I also understood about substitution program- those people who are injecting are
getting injured, they are getting afflicted by HIV/AIDS. To reduce those dangers, first and foremost make sure they are not sharing needles and syringes...after some field observation, I conducted group sessions (to address this issue)...as a result of sharing I knew that some people had (HIV positive) status- they were sharing the needles very easily amongst themselves. First, I talked to those who had (HIV positive) status- you have a responsibility to society. If this disease only spread to you and stopped, then that would be the most smart thing- it is a matter of responsibility to society’. His role as a counselor was to persuade drug users to use safely and if they wanted to quit, he would connect them to the Buprenorphine program. He felt that the biggest problem with all the programs was the fact that after the drug users left the premises, they had nowhere to go but the very same streets laden with drugs.

9:30 AM: An old lady wants to meet Gautam to talk about her drug-addicted son. Gautam asked me to sit in for the session. In a tone barely audible over the din of the center, she shares about her son Sharif. Barely 20 years old Sharif is injecting drugs and alcohol, had already sold many things from the house, lived on the street and refused any help. By the end of the story she had tears and begged Gautam to help. After listening carefully he asked her to bring Sharif to the center. She then asked him if they could forcibly put him in treatment, Gautam explained that the center only accepts clients ‘voluntarily’. He then proceeded to describe the continuum of care model, she seems fairly unconvinced at this ‘new’ approach to treatment.

10:40 AM: Gautam spends the rest of morning writing. Most mornings are spent completing case records and field notes. All funders - government and non-government, have become very strict about paperwork. Until client logs are complete it becomes difficult to gauge the progress made and NGO workers spend a considerable time during the day tracking their
work. In a center like this one, there are only a few literate workers, which burdens them with the task of writing and reporting for the entire project staff. Each client, every interaction on and off the field, sessions, workshops and advocacy efforts— all of it must be recorded, reported, and written out.

1:00 PM: Gautam has tough afternoon ahead of him. Each week, a local rehabilitation center sends their officials to pick up willing clients and take them back to the rehabilitation center. Gautam’s role is to convince, cajole and persuade those clients, who have made significant progress to take the leap forward towards abstinence. This is a hard task, because clients are usually comfortable with their routine and life in the community and unwilling to leave for an abstinence program. ‘There is no system, because we are not the decision makers. Nor are we the one’s making decisions. We ask them what is your problem now and what do you plan to do about this problem. How can we help you?’ Despite all this talk about choice, I find that most clients are encouraged to graduate from the programs. A couple of clients agree to leave, Gautam had been talking them for a few weeks and hopes that they will stick through the entirety of the abstinence program and re-integrate. He was wrong. All quit and return within the month to the community and then to the NGO seeking harm reduction services.

2:00 PM: The rest of the afternoon is spent with clients discussing issues around their ART treatment and HIV testing. ‘We first talk to them about self knowledge…then we hold a session and tell them about the four ways in which people contract HIV. If you have done any of these high-risk behaviors, then you have full right to know about yourself. This test is a volunteer test and is fully confidential…it is also free of cost and you can know about your self’. Gautam is one of main workers who prepares clients for testing and also engages in post counseling. He often co-ordinated between the outreach worker and Victor, who helps clients
navigate the health system. He was also responsible to encourage reluctant clients to seek ART treatment and this is especially difficult, given that many clients are unwilling to give up using. In all of his work he emphasized their rights to choose and shape their treatment. I wonder if he himself is as convinced about harm reduction’s promise as he continues to remain committed to abstinence.

Alfred Da Cunha

9:30 AM: We had decided to meet at a training session for Samarth’s (NGO) workers. This NGO was primarily focused on women’s issues but recently had stepped into the field of HIV and drug use. Alfred, a veteran Sahai staff, was hired to conduct a two-day program to train Samarth workers before they began implementing the harm reduction programs. Besides addressing the basics of drug use and harm reduction Alfred spent time discussing the main issues facing workers during their interactions with drug users.

11:40 PM: He announced a break for lunch and asked my opinion about the training. Alfred identified that one of the biggest issue was the moral stance most ‘non-users’ held against drug use. Now with HIV in the picture these moral opinions and ideas had to be put on hold.

1:00 PM: After finishing with the session I agree to accompany him to a UN meeting, which would include other NGOs also working on harm reduction. Unlike the first half of the morning where Alfred was the expert, here he was very much the recipient of knowledge. Alfred barely acknowledged this type of role reversal, slipping from one position to the other fairly easily.

4:00 PM: Back at the NGO office, he is busy finishing his report for the government, which includes a proposal for training of peer educators. He is one of the few at the office, who has experience in developing grant proposals and thus was often burdened with the task of
compiling and writing. He claimed that with cuts in funding the NGO was barely able to pay him. Consulting assignments, such as the training he conducted that morning, were a means to secure an income each month (he provides a portion of the payment to the NGO). Despite being offered many positions with international organizations he had chosen to stay with Sahai out of loyalty to the organization that had helped him become healthy.

5:00 PM: He got a call from an Ashray worker, asking him to participate in a workshop on advocacy for IDU’s impacted by HIV in the coming week. He confessed that the daily chores of running programs and supervising took away the bulk of his time. It left very little time to address the larger macro pieces of the harm reduction puzzle. However, such opportunities were great to network with others in the field of HIV.

The diversity of roles of Karthik, Gautam and Alfred occupied was not surprising given the way NGO’s have grown in stature within the harm reduction paradigm. Until now NGOs were fairly flat organizations with quite a bit of fluidity in roles and responsibilities. With the entry of NACO and other international funders there have been considerable changes in the system of functioning. As detailed in the previous section there were now clearly demarcated hierarchies of functions within the NGO. Operational guidelines for each harm reduction intervention now clearly stated the roles to be occupied by each type of worker. These roles were largely seen as stable/permanent though it was possible for the workers to rise in the ranks by meeting the new standards of skills. However, given that most peer educators were illiterate and not given any special support to upgrade their skills it was very likely that they would remain in their current role without much progress for their entire careers.

This ‘choice’ to work for an NGO was often made because most recovering users found it difficult to get jobs in the ‘community’- due to stigma, lack of skills and lack of employment
opportunities. Since these NGO positions are limited they are highly coveted but not necessarily always desired. As a result of all of these factors peer educators tended to move from project to project creating an environment of great flux and instability.

**The re-education of peer workers: from the street to the boardroom.**

Jared Richards, a peer worker from Ashray, was one of the few who had been able to successfully navigate the harm reduction–HIV industry and evolve a new persona from a drug user to an expert. I would often end up meeting Jared during my fieldwork at policy meetings and workshops. The few times we met at his air-conditioned office located in a posh south Delhi neighborhood, he was usually either finishing a report or a grant application and at other times preparing to present at an international conference or writing a research article. This was a far cry from the early days of Ashray where peer workers like Jared would spend bulk of their time running programs in the field, looking for funding to meet their budgets each month and working under resource poor conditions. Beyond the superficial change in the roles, a more fundamental “re-education” had occurred. Jared himself had only recently begun to fully process the implications of this change.

‘In 2005 I was at a DFID conference just before NACP III, NACO had asked for help for putting together NACP III, to see if we could raise issues and give recommendations. Not knowing any better I took the M & E (Monitoring and Evaluation) part of NACP III and tore it to bits. (I had pointed out that) all monitoring indicators were geared in such a way to show a reduction in HIV prevalence irrespective of any (actual) reduction...at that conference my standing was that of a minor person working in Ashray and a drug user so, I had other people standing up and saying I have no national integrity and patriotism, how can I say that the figures are wrong for India. I didn’t know the right jargon that time, so no matter what I said it wasn’t
looked at...’. A few months later Jared shared that corrections were made and his point was proved. ‘I never made that mistake again. If I have to make a point and if I have to make that sound credible then I better speak the language they speak in’.

Jared quickly learnt that he had entered a new world where words carried a heavy price tag and the frames of reference were no longer the same. He learnt how to communicate in a variety of settings without leaning on the ‘emotional’ stories of his addiction, making himself now heard as a drug expert. His exposure to international organizations and their experts and his participation in multi-stakeholder projects had a critical role to play in this change in approach. Technology and the Internet in particular, had made information gathering, networking, knowledge dissemination and accessibility to a wide variety of stakeholders much easier, thus also transforming his knowledge field.

Unlike before where ‘being an addict’ was the highest qualification needed, these harm reduction workers were now being given a more formal ‘re-education’. In Jared’s opinion organizations like BMGF, DFID and the UN had done more to ‘professionalize’ the field of social work and support the evolution of peer workers into experts, than any institution or school within the country. These stakeholders played a key role disseminating knowledge through workshops, trainings and seminars. Over 960 new peer workers were being trained to implement harm reduction programs across the country not to mention a large cadre of outreach workers, program managers and health volunteers were learning new ways to intervene and run programs, social work education was indeed witnessing a change. While services like needle syringe exchange and outreach were fairly straightforward other services like OST required an understanding of the medication, its affects and dosage management (even though the doctor prescribed the dosage).
The notion that expertise was earned through an education was actually quite new for this sector, which was used to drawing on instinct, guts, intuition and experientially learning. Also the shift from a more psychological and social mode of recovery, to a behavioral focus meant that these workers had to learn a new language of treatment. The workers were also learning how to record, review and learn from practice in a much more organized fashion; they were adjusting to concepts of privacy, confidentiality, rights and choice; finally they were examining their own practices through frames of evidence and efficacy.

In all of this shaping of new experts, there were two important elements. One was the fact that quite often though the impetus for such expertise came from outside i.e. funders, global organizations and even the government, the people conducting the trainings and disseminating knowledge were coming from within the NGO community itself. Second, despite efforts to completely ‘convert’ the peer workers to this new modality of functioning there were still several traces of their ‘old ways’ of thinking and behavior. For instance these contradictions became quite evident during my conversation with Dileep, a peer worker from Sahai. In order to motivate his clients to remain committed to harm reduction, he used a much older abstinence narrative drawn from the Narcotics Anonymous model. ‘I give them motivation through my own story. I was also a drug user. I used to also stay in the garbage dump. I also have a counselor, he has taught me a path I walk on that road. So I am away from drugs. I don’t push my ideas- if you do this then will change’. Saif, another peer worker, also shared that while he provided his clients options of needle syringe and OST he would also talk about rehabilitation and recovery in a treatment facility. This mingling of abstinence philosophy with harm reduction was common among most peer workers.

Expertise is a fragile concept and in the arena of care, it is often subsumed under much
more complex and controversial concerns of peer workers that are loaded with ethics and values. For many peer workers harm reduction’s promises seemed hollow and incomplete for them. Recovery was still wedded to the notion of abstinence. While they understood the program, they also understood addiction and its temptations. Gautam shares, ‘I know myself, anywhere if I get alcohol after 2-3 days I will start to use again, I am not able to maintain myself…very quickly I will return to my drug of choice’. On the ground this becomes harm reduction’s biggest challenge as many peer workers with long traditions in abstinence-based models combined with their own powerful personal experience are unwilling to fully buy into the harm reduction paradigm.

Involvement of affected groups in service provision- issues of efficacy.

While drug treatment NGOs in India have always used peer workers to provide services the inclusion of active drug users and harm reducers in the harm reduction paradigm is slightly more unique and deserves some discussion. Until now, sobriety was usually considered as a minimum criterion to engage in NGO drug related work. This was done for a number of reasons, the foremost being to have peer workers who were mentally, socially and psychologically equipped to handle the stress of providing care for others. Usually, clients who were able to do well in drug treatment programs and maintain their sobriety were absorbed by the drug treatment NGOs (this was not the case with government run programs).

Harm reduction however, did not place as much stock on sobriety as it did on functionality, responsibility, rights and choice. In this vein, all drug users irrespective of their position in the recovery continuum could now theoretically participate in providing services. Despite this “liberal” position on drug use, I found that peer workers who used drugs were often given less respect and value than those who chose to abstain. Abstinence was still held up as the
gold standard for recovery. This often prevented the peer workers from sharing the exact nature of their use/ abuse of substances, though in most cases the project manager could easily tell who among his staff was “clean”. I will now detail some of my field experiences that explore these dynamics.

On a cold wintery day of late January I was getting ready to accompany Shyam and Jeet, peer educators from Ashray, as they conducted outreach. Packing their old backpacks with clean needles and syringes, health pamphlets, condom packets and notepads for record keeping, they were getting ready for the day. Both were recent graduates of this recovery program and in fact continued to be on the Buprenorphine maintenance therapy. As the morning wore on I noticed that something was definitely amiss with Jeet. His quivering hands, bloodshot eyes poorly covered by a pair of cheap flashy sunglasses, slight slur in speech and frequent tea stops were clear indicators that he had been using. The clients on the street were of course quick to pick up the telltale signs of the body that had used and refused to lie. Yet roles of client and outreach worker seem to be maintained. Not one client outwardly challenged or questioned Jeet as he went about dispensing advice on using, distributing needles, and making referrals. Shyam seemed subtly shoulder a majority of the tasks of the outreach that day – a routine that possibly shifted depending on the physical state of either one of these outreach partners.

Later that day, Muqim, the project manager (and one of the two employees who did not have a drug using history; the other being the counselor) shared his frustration of having to manage ex and current drug users on the program. Muqim recognized the benefits of having peers, given the dynamism of street life. Also certainly the employment helps clients financially, gives them a sense of ownership of the program, and generates a sense of empowerment. But as a project manager, future outreach planning often becomes hard with such an unstable staff. He
was forced to plan day-to-day depending on staff turnout and their condition. Peer workers, he claimed, often did not come in for work at all or did not perform optimally due to their drug use. Muquim would then have to send others to cover for this staff member, hindering any progress made on the field.

Alfred too, on many occasions had voiced such frustration of working with peer workers who were using and thus unable to perform their usual tasks, ‘…at some places harm reduction has also been manipulated… like my colleague, he will not turn up for work and he would say that he is having a stomach bug and then when you call him up at 8 o’clock in the morning he would be sounding drunk so what do you say… that because he is having a hangover that’s why he cannot turn up for work …’

During another afternoon, as I was sitting and talking to Muquim, the project manager, Salim, a peer worker stumbled into the office slapping down his record register on the table in front of us. A minor argument broke out as Muquim reprimanded Salim for rudely interrupting our conversation. Salim, disheveled, droopy eyed and slurring quickly apologized and said that he only wanted Muquim to cross check the data he had spent all morning entering. ‘ Yeh kya halat bana rakha hai tumne’ What have you done to yourself? You haven’t shaved, look at your clothes- go have a bath, wash your face and then come. Muquim, of course functioning strictly under protocol, could not tell him the one thing that was staring us in the face more than anything else- his obvious consumption of drugs. He later told me ‘Kya karein inke saath flexible hona padta hai. Agar strict rahenge tho mere paas koi staff hi nahi bachega’. What to do, we have to be flexible. If we are too strict, then I will have no staff in the project.

Later that week, Ashray’s project manager Karthik was visiting from the head office. Salim’s name came up during the discussion. Muquim just smiled and said ‘well you know how
he is doing…’ Karthik told Muquim that he should watch Salim- ‘We have given him enough chances, if he doesn’t behave…he can leave, he has a choice…why don’t you ask him to go for detox’. Muquim replied-‘ He has been, many times…but I will talk to him (again).’ Karthik getting up to leave said –‘ We have many others, he can’t take this for granted…’ Clients on many occasions ‘knew’ which staff had used and Muquim felt it created a tense dynamic. It not only attacked the integrity of the program and its efficacy but also reduced the legitimacy of the worker in the clinical sense. Even though sobriety itself was not Muquim’s goal, with either workers or clients, the appearance of sobriety was very important so that the clients would respect and listen to the workers. Muquim brought forth a crucial point-clients were used to their ‘caregivers’, doctors, counselors and NGO workers as clean, sober, efficient and in control of their addiction. This blurring of lines not only challenged the old assumptions but created confusion of what this new breed of workers would/should look like.

Sankalp Sinha highlighted that, ‘there needs to be clarity of the ideas of how to use an active user in the program. It needs to be very clear with the program implementer and the functionaries. They say these people are always high they don’t know what they are doing so I mean what can you expect from active drug user but we have also seen NGOs whose program managers are skilled enough to actually not motivate them, to actually make them understand that they are part of this program and they are the best person to go out and give information. If we look back and if we go back the history of drug use scenario not only in India but all over the world when someone starts injecting , it is someone is helping him to start injecting because we don’t know how to inject by our self and in he process we learn, so that’s the peer norm all over the world. When we started injecting we also started learning how to share the injecting equipment with friends...at that point of time if we were taught that it was not good to share
injecting equipment no one would have shared until now. …what we are doing now with the help of peer educators is (that) because he still fixing it now and drug users normally listen to another …very easily( and we just go by one word from another drug user saying that oh after taking drug you take alcohol you get a good kick, without thinking twice people do that)…, so if you can use those opportunities to provide information and people if they can start, positively, start using those information then we can reduce lot of incidents of sharing of (needles)...

Alfred points out that while it peer interventions have many great components and organizations like Sahai were built on strong foundations of peer support. However, when this model was taken into ‘the community where I am a peer but I am surrounded by active drug users, how long can I sustain. It’s the same thing where you have male out reach workers for female sex worker programs and they once in a while go and have sex with their clients so it’s the same thing happening in the drug domain… there are out reach workers and peer educators who are like clean for some period and they once in awhile go and trip, they sit with their clients and share a injecting injection…buy a drug together and trip’.

Due to the problems associated with such using behaviors, Alfred says the organization makes a great effort in choosing their staff. He shared, ‘to select staff members who were outreach workers who would go in the field, we had to pull them out of other programs and then send them for this particular outreach…these were like those strong guys who were like five years...(clean or in recovery) so we had to pull out strong guys …’. In the beginning when one of the staff members would relapse it was considered as a major concern. But now Alfred claims, it is ‘openly accepted’, if a staff member uses, then he goes to the rehabilitation center of Sahai, spends ten days, undergoes rehabilitation, detoxification and joins back. It is ‘like a cycle’, when it happens again they wait and support the peer worker. Alfred calls recovery a
‘process, where one falters, relapses and then recovers and then relapse…’

**Not good enough.**

The ‘peer workers’ are not only the frontline providers of harm reduction services but also the walking symbols of the ‘success’ of the program itself. On one hand, these peer workers must become and often are perceived to be the harbingers of a controlled, if not drug free, lifestyle. While, on the other hand, the peer workers constant return to drug use or failure to reduce harm in their lives reveals not only the dangers of drug use itself but more significantly the fragility of this ‘bio-regime’ as a whole. These ‘not good enough peer subject’s’ are then, at once harm reduction’s ideal front and its most vulnerable or destabilizing link. This tension between the progressive and the risky peer worker represents harm reduction’s own strains within the Indian context.

The peer worker can emerge as a role model/empowered political force only when ‘problematic/continued drug use’ is suppressed or hidden. One cannot be both an active drug user and an ideal public health subject in the current Indian context. Drug use, conceptualized as brain disease or immoral/criminal behavior has forcibly pushed out of ‘normative’ action, thus forever rendering drug users outside society, marginal in health concerns and under-represented in public policy. Harm reduction and HIV have managed to changed some of this, but as peer workers demonstrate reformulation of recovery does not necessarily challenge underlying beliefs of drug use or re-craft justice, empowerment and rights in this context.

Often times the peer social workers may still be using drugs (albeit in less risky manner or using legal pharmaceutical substitutes). Even though this may be the ‘right’ of the worker, it often undermines the position of the peer social worker in the mind of the clients (who still consider abstinence as the ultimate goal). Peer social workers also tend to receive more benefits
than the ‘average’ drug user. This creates tensions and zones of exclusions, which challenge community-building efforts of harm reduction services. Further, harm reduction interventions have not critically challenged broader laws or social structures that shape drug use and recovery (Bourgois, 2000; Hathaway, 2001). Peer workers thus often feel that harm reduction services are temporary solutions to their broader medical, social and economic concerns; for the drug users this crucially displacing responsibility from the state to the community organization and peer social workers. Peer workers become the face of the program, a program, which is not itself completely sure of what it promises and what it can deliver.

Peer workers are an important layer of the harm reduction enterprise, on them rest its success and failures, through them we can study the remaking of subjectivities, contradiction in values, and interaction between old systems and new. While not completely ‘cured’ of their addiction they form the most appropriate backdrop for harm reductionists to demonstrate the success of the program. At the same time as I witnessed the break down of many drug users who were trying to tame their addiction into a steady disease I saw them fail as often as they succeeded. For many peer workers the ability of living without drugs was a goal that seemed to be receding in all of this harm and risk minimization strategies. While they recognized the short-term value of such a program, they were clearly thinking about the long-term dangers of remaining on drugs. Here was the unintended consequence of harm reduction, it had led to the shaping of the subject, who was prudent and rights bearing, but at the same time was questioning the very system that had made such a life possible. The liberating power of the paradigm is not even and not always positive. The pressures and limitations of a overburdened health system, under resourced NGO and partially informed staff creates conditions where there is a race to simply survive rather than discipline or even govern.
CHAPTER 8: CONCLUSION

I am reminded of that place when I hear an old Hindi movie song
Sung in a high pitched voice, straining,
He sat there getting bandaged
We all clapped.
He stumbled down from the bed, combed his hair over, tightened his scarf
As he sauntered into the street singing
We stopped clapping.

I crawl because I don’t know how else to move
The city seems like a war zone
In each passing moment bullets fly
We tend to those who we can.

Battles lines are drawn and then rubbed off quick
Slowly they emerge again
Difference, exclusion and exclusivity
In drawing them in what and whom do we leave out.

There is a place where we walk with care
Because as we walk we break the silence which has remained
Filling the void of noise seems important
But we realize unnecessary.

They remain with me, as a whimper of protest and a vibrant memory
Unfettered fluttering in the sky.
(Moorthi, 2011)

In this final chapter I revisit the key arguments of my dissertation and highlight the implications of my research for social policy and practice. I also discuss the areas for future investigation and further research. Through the course of this dissertation, I have attempted to carve out a number of diverse conversations between the concerns of HIV, addiction, rights, power, governance, citizenship as well as drug policy and treatment. To shape my ideas, I have drawn from the scholarly traditions of social work, medical anthropology, public health and political science while simultaneously engaging with both the issues on the field as well as the theoretical challenges facing social work. Through this multi-layered approach I have raised
questions about the possibilities of life under a ‘harm reducing’ paradigm and the future of health within the developing world.

The game of survival.

My dissertation shows how harm reduction has evolved in the shadow of the dominant abstinence model of drug treatment in India. The terrifying HIV pandemic acted as a crucial precipitating context that pushed the government to respond to the voices of grassroots and international organizations, leading them to ultimately support the harm reduction model. Initially, many critics claimed that harm reduction was poised to fail given its uncertain political status, undemocratic reach, inadequate infrastructure and ill-formulated policies, all of which were considered as major drawbacks. Beating all odds however, harm reduction grew into a program of national repute. Harm reduction was able to adapt to changing local conditions and emerge as a flexible program that engaged multiple actors- both traditional and non-traditional, in a variety of capacities in different regions of the country. It functioned in a loose and amorphous form both at the policy level and on the street. It was in-part transported from the global health paradigm and partly indigenous in character. Harm reduction ended up altering the overall context of drug treatment within the country.

Unlike traditional public health projects that focused on shaping the health patterns of the entire population through a singular and a static model of health, harm reduction approached drug treatment in a different way. Harm reduction programs aimed their interventions only at certain high-risk groups, with unique treatment and prevention packages for each of their client constituencies. Under harm reduction, health was no longer a rigid ideal but an adjustable concept that could evolve with the needs of people. One could argue that such an approach to health was emblematic of shifting trajectories of public health programs across the globe. At the
same time, such changes in thinking were far from widespread and harm reduction faced severe
critiques on many fronts. It was difficult for people to agree on the goals, the limits and the focus
of treatment under harm reduction. What did recovery from addiction look like? Who would be
considered an ideal candidate for harm reduction? How could health be secured for the
disenfranchised and who would be responsible for its provision? In many ways this project
shows the tension between the socio-economic contexts of drug use treatment and the heavily
risk based technical/pharmaceutical approach that tended to frame the harm reduction movement.
Harm reduction had managed to open up new debates in the light of HIV. It now challenged
lawmakers, public health scientists and civic society to restructure their thinking about addiction
and recovery to forge a new path for seeking health.

Prior to the advent of harm reduction, drug users had limited options in the mainstream
health infrastructure of the country. They were and, in some senses, continue to be one of the
most underrepresented, unprotected and controversial patient figures within the Indian health
landscape. Drug treatment within the abstinence paradigm was confined largely to individual
initiatives and rarely drew on community or societal resources. Due to the influence of harm
reduction, drug abuse treatment was freed from such narrow confines. Not only did this open up
the field of drug treatment it also allowed for a close examination of its inter-linkages to
political, social and economic conditions.

In addition, harm reduction gave drug users a global platform through which they could
find and express a political voice. As my dissertation suggests, only a few enterprising peer
workers and recovering drug users were able to harness the potential of such a biological
collective. Most drug users that I encountered during fieldwork were the most unlikely of
“biocitizens”. Governed by the need to survive, their participation in the harm reduction
paradigm was both dispersed and mercurial. Pharmaceuticals were sought, used and abandoned as were needles and other treatment options in an effort to extend life, alleviate pain and overcome suffering. It would be difficult to attribute a political consciousness of health to such behavior. However, the very utilization of services and engagement with bureaucracy imparted their health practices with political flavor. Survival then became about politics, health and economics; all of which were heavily entangled in the personal narratives of addiction and recovery.

The question of survival was not only limited to drug users. It also extended to the stakeholders who were trying to establish themselves in national health politics. The emerging contentious and overlapping roles of the government, NGOs and bilateral agencies created an environment difficult to understand or even neatly categorize. Instead of the typical top-down type of relationships, my project showed that these stakeholders were engaged in loose and dynamic configurations that tended to both challenge their scripts while at the same time reinstate them. The government was present, albeit in a limited form and often misunderstood by the direct participants of the programs. These harm reduction participants on the street found it easier to revert to older constructions of the ‘welfare model’ of the state rather than understand these complex equations with non-state stakeholders.

Adapting to these changing conditions quickly required a “survival politics”, which was based on compromise, collaboration and often some chaos. During my fieldwork I saw many new actors preparing to enter and old ones getting ready to leave- a phenomenon quite common in the development sector in India. Most stakeholders understood this temporariness and were more likely to invest in “high yielding” short projects rather than make investments to bring forth long lasting structural changes in poverty, disease and marginalization. Instead of defining their
position regarding the harm reduction paradigm, stakeholders often preferred to remain cautious
and somewhat open ended in their views about harm reduction. They called this a non-
ideological and non-political stance towards drug treatment. Such a position was useful
considering the underlying uncertainty of the development/health context of the country. This
dynamism in the sector partially revealed the difficulty for its many players to ascertain their
positions long-term, while underscoring the dependency of these social actors on each other.
Ultimately my project argues, that harm reduction in India can be viewed as a battleground of
survival- it is the site of contestation, debate, innovation, collaboration and transition.

**Contributions.**

My project makes several contributions both in terms of social theory and practice. First,
the Indian state adopted many diverse positions as reflected in its activities and approach during
the course of my study. For instance, the state was at times ‘activist’ like (Biehl, 2007) in its
efforts at certain other times it acted in a more neoliberal managerial (Foucault, 1991) format
and, at yet other moments it reverted back to its welfare roots. I argue that similar to Sharma’s
(2008) claims of “selective implementation of neoliberal technologies”, the case of harm
reduction in India can be viewed as a site of “exception” (Ong, 2006). While the state’s welfare
arm continued to influence and shape the larger discourses of health in the country and define its
day to day functioning, harm reduction interventions reflected a different ideology. Not only
was the state contracting these harm reduction services out to the NGOs and community
organizations, it was also, involving a large number of players in the actual construction and
development of policy. Unlike other health programs, it was trying to adopt a more calculable,
evidence –based approach, this was geared towards reducing risk, increasing the use of
pharmaceuticals and pushing for the empowerment of “rights bearing diseased-citizens”.
Such an explanation of “exception” however, may not completely describe the shifts in the state’s positions that I observed during my research. My project showed that the state was in a type of “transition” revealing new postures and possibilities at different times. These multiple shifts produced a variety of frameworks via which the state operated and made its presence felt in people’s lives. These diverse approaches in governance were most likely the result of emerging global influence in statecraft, internal pressures from constituencies and lobby groups, rapid economic and political transformations and bureaucratic hurdles. The state was in part adapting to evolving conditions while at the same time trying to retain its old character and influence. My research highlights new areas of study of the state and its practices within spheres of development.

Second, health in India was already a heavily privatized sector even before the emergence of these neo-liberal shifts. Large gaps in health infrastructure, with scarce resources within a broken public health system had left drug users especially marginalized. Hence the question of “rolling” back of services does not necessarily hold true for this particular case. In fact, harm reduction had introduced an entire new spectrum of services, which, until now were not available for drug users. Sharma points towards the power of democratic populist politics that seems to place equal but contradictory pressure on the government as the neoliberal forces. The welfare functions were not fully erased even while newer forms of health initiatives were being launched. My research demonstrates the complexities in understanding how health policies function within evolving conditions of neoliberal rule.

Third in terms of privatization of state functions, in many ways the NGOs had become a service wing of the state. NGOs were now closely monitored through state laws, funding, administrative strictures and regulation. My fieldwork participants reported that NGOs were
often times considered a type of government agency or a symbol of the government. NGOs were also becoming sites of expertise and knowledge. In fact, the government had reluctantly come to understand and even rely on their expertise to run these harm reduction projects and train other stakeholders. Also, the NGOs had associations and links with bilateral organizations and international donors, which, in many ways superseded their collaborations with the government. This provided the NGOs with greater social currency and value than would have been otherwise accorded to them. NGOs occupied a much more flexible position in this multi-stakeholder environment, often transforming their identities and building linkages anew. My research brings attention to the roles of NGOs and their influence within global development.

Fourth, the participation of international and bilateral organizations in the harm reduction arena has both challenged the Indian state’s role, at the same time opened surprising avenues for convergence. These global players have changed the playing field of development by drawing on their vast resources, international experience and significant exposure. The Indian state has been able to evolve it own perspective towards health at the same time retain its significance in this multi-stakeholder environment. This research highlights the nature of development and health under contexts involving both local and global players- especially highlighting the possibilities and limitations of such collaborations.

At the implementation level my project revealed many key areas of learning. First, these specialized harm reduction services provided drug users an entirely new set of treatment choices that seemingly accorded them greater participation in the treatment process. Clients were, thus, asked to assume responsibility for their health and engage in risk reducing rational measures to improve their condition. At the same time however, they were subsumed under the larger context of draconian laws, an outdated public health system and societal stigma. For clients, this
often meant that despite the presence of excellent harm reduction options, their daily lives continued to be plagued by poverty, inequity and discrimination. Structural links especially with public health systems is important for the success of the program. The drug users need assistance with drug dependence, basic health care as well as larger socio-economic protection. Until these links become strong drug users- with or without harm reduction, will continue to face challenges. My research identifies the gaps and limitations within the current harm reduction regime in India, while highlighting the areas of success.

Second, these programs worked towards reducing risk related to drug use and HIV. The drug users did not perceive risk the same way as the state or other actors. Drug users often viewed risk in terms of “overall living conditions” and not “disease focused” behaviors. For the state, international donors and bilateral agencies calculable measures of risk were essential to show the efficacy of their programs. Thus, the number of needles exchanged, amount of pharmaceuticals given out, number of people accessing programs, amount of condoms distributed and the scope of outreach were crucial indicators of risk reduction. Even though clients continued to voice social, psychological, physical and economic concerns, these remained outside the purview of risk reduction. NGOs often saw the contradictions between reported changes and experiential transformations. Even as they made attempts to address this gap, there were no critical evaluations of the very nature of risk as perceived by the drug users and its impact on survival.

Risk had also led to a segregation of population based on behaviors (drug users, truckers, sex workers etc..) generating an entirely new hierarchy and language around stigmatized behaviors. Harm reduction programs emerged with specific “solutions” catering to these “specialized populations”. While bringing attention to these hidden groups, such a strategy had
also simultaneously isolated them, overriding some of the broader concerns that surrounded all groups vulnerable to HIV. My research critically shows how risk as a notion comes to both shape and restrict harm reducing endeavors within the Indian context.

Third, drug users were compelled to think of their harm reduction treatment as adhoc and partial. Harm reduction programs remained ill equipped to consider and support long-term treatment, leaving drug users stuck in a system with uncertain future. This was partially due to the larger structures of funding and organization of harm reduction services. But also more fundamentally treatment was no longer viewed in a holistic manner, quite contrary to the ideals of continuum of care that are considered integral for harm reduction interventions. My project identifies the inherent contradictions of harm reduction’s promises and its day-to-day impact on drug users.

Fourth, instead of claiming that these harm reduction programs were pushing pharmaceutical treatment over and above other forms of treatment, I argue that health and treatment itself was being viewed through the presence of chemicals. Drug users understood the power pharmaceuticals held for both “legitimate” recovery and “illegitimate” addiction. No longer, I argue was life thought of devoid of substance, but instead life was in fact measured through the meter of substance. The pharmaceutical was no longer seen as alien or synthetic but instead is seen as integral to the continuation of life- personal and organic. As healthy life becomes inseparable or dependant on a pharmaceutical life, it slowly blurs the difference and shapes a unique subject for whom survival exists only within these parameters. My research shows how new ways of healthy living were being constructed via the pharmaceuticals not beyond it.
Fifth, the harm reduction model has generated diverse types of biological citizens who have come to define themselves, relate to social systems, address their needs and participate in social lives through the rationalities and logics of this paradigm. This is most visible in the lives of those peer workers who occupy both categories of client and service provider. These workers must “live and recover” while “promote and believe” in harm reduction. In this interchange of roles and responsibilities they redefine both the paradigm and themselves. The clients are also clearly the inculcating new ways of survival both through and outside of the paradigm. The delicate balance of freedom, social justice and compliance become the substance of this type of citizenship. Harm reduction, though was focused on injecting drug users- a “privileged” subsection of the drug population, it managed to also create opportunities for drug users in general. My project shows that while the landscape of treatment is uneven, drug users adapted, adopted and put forth new ways of relating and engaging in this system.

Recovery has ultimately always been about possibilities- predicting the chances of improvement and change, generating hope for a potential future and imagining new ways of being. As India and other nations look into the future of drug policy, harm reduction and HIV they must re-craft the notion of treatment and recovery, allowing for such possibilities of a “healthy life”. Harm reduction is about shifting the narrative, building new bridges as well as embodying new stories and identities. But most of all my participants showed me, that harm reduction was about making claims for the ordinary life.

Looking forward.

My project emphasizes the need to undertake more studies within social work, which examine the state, via its processes, appearance and affect. Social work has traditionally viewed the state in certain circumscribed ways i.e. provider of services, law maker and securer of justice,
but with a growing diverse network of stakeholders now involved in state activities, there needs to be a robust re-examination of the state. There are vast implications for the study of social policy and practice, which are changing under this new environment. It is no longer sufficient to conduct studies that do not account for both global and local players that work with the state. I intend to conduct future research in this direction to develop a more thorough understanding of the state and its new modalities.

My research focuses on the way social problems are defined and the manner in which solutions are sought within social work. Multiple social actors with blurry boundaries often come in with competing interests (in opposition to the state) and ways of understanding the problem. In such circumstances, social workers are forced to compromise, adjust and create consensus amongst these contested explanations in the field. Social work research, I argue must engage and investigate the underlying differences in problem constitution and the implications for policy/practice. This is not merely an issue of implementation but rather what is at stake is the way in which, vulnerable groups get categorized, understood and in some senses “produced”. As social work researchers’ we must examine not only the basis of our own assumptions about social issues but also the way problems get shaped in the arena of public policy and social intervention. My future research will address such issues of knowledge construction and their implication for social solutions.

This dissertation also attempted to understand the manner in which neoliberal conditions are transforming the field of social rights and responsibilities and the inadvertent consequences of such shifts. My research drew attention to the way previously overlooked populations were brought into the governance fold through complex mechanisms of the drug-HIV policy. Health and development, I showed, are increasingly becoming sites to investigate the new ways in
which rights are distributed as well as the possibilities and the limitations of welfare. I intend to continue conducting research to examine the diverse implications of neoliberal governance in transforming communities and marginalized individuals.

My work will also contribute to the growing field of health research in India, especially adding ethnographic richness to the understanding of harm reduction and addiction. With the new policy for HIV being instituted there are changes being made to the existing harm reduction interventions; my research can help shed light on some of the gaps and issues around implementation. The growing development sector in India is a fascinating field of diverse pressures, new alliances and contestations. Bulk of the attention is drawn towards HIV related work, with not much focus on the evolving drug treatment sector. Given the large investments in drug treatment and the growing cadre of workers receiving training in harm reducing techniques; my future research hopes to contribute to a better understanding of this newly evolving sector.

As I came close to completing fieldwork many questions remained unanswered – How will harm reduction transform “drug affected” communities? What are the long-term health implications of harm reduction? What are the political consequences of such a movement? What was the way harm reduction was adapting its tenets within the Indian context? How are peer workers battling these uncertain terrains of health politics and economics? There were also ethical and practical questions about harm reduction that continued to plague me - Was harm reduction able to offer options to extend life or curtail it? What was the impact of such harm reducing measures on the families of such harm reducers? What was our responsibility as social scientists in the promotion and acceptance of this model? Would such a model indeed usher in better rights and living conditions for drug users who are at the margins of our society? I intend to continue to write and examine these issues in my future work I hope to draw from the lives of
those living through, within, outside and in-between this regime of harm reduction and distill
new ways to think and work on issues of addiction and health.
REFERENCES


Biswa, S. (1994, April), Hooked to a new high. *India Today*.


Crawford, R. (1994). The boundaries of the self and the unhealthy other: Reflection on health, culture and AIDS. *Social Science and Medicine, 38, 1347-1365.*


Rao, P. J. V. R. (2010). Avahan: The transition to a publicly funded programme as a next stage. Sexually Transmitted Infections, 86(2) Retrieved from http://sti.bmj.com/content/86/Suppl_1/i7.full.html#related-urls


