2. INTRODUCTION

South Asia — comprising Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka — is wedged between the world's two largest areas of illicit poppy cultivation, commonly referred to as the Golden Crescent and the Golden Triangle.[2] Most of these countries in South Asia have a long history of psychotropic substance use with opium and cannabis being the most popular traditional drugs available and used. Epidemics of heroin use and injecting in this sub-region, which took off in the early 1980s, have expanded in the recent past with the addition of pharmaceutical injecting. The pharmaceuticals of choice for IDUs, mostly in urban settings, are opioids alone such as buprenorphine or a cocktail of buprenorphine with antihistamine injections or sedative injection preparations such as benzodiazepines. The region has recently witnessed the arrival and use of amphetamines and 'amphetamine type stimulants' (ATS).

It is not only the drug chosen for injecting that differs between countries and different states/provinces within the same country in South Asia, but also the HIV prevalence among IDUs. The multi-person use of contaminated syringes and needles, the sharing of injection paraphernalia, the link-injectors between different networks of IDUs, the injecting practices in shooting galleries and prisons and the unsafe sexual practices under the influence of drugs are some of the factors that have been associated with high HIV prevalence among IDUs in Nepal and parts of India. In contrast, Bangladesh and Pakistan have consistently recorded a low HIV prevalence among IDUs over the last few years. However, a high self-reported rate of injection equipment sharing and the alarmingly high prevalence of blood borne viruses such as Hepatitis C clearly depict the vulnerability of IDUs to contracting HIV in some of these settings. For example, 89 per cent of 178 IDUs tested positive for the Hepatitis C virus (HCV) in a study conducted in 1999 in Lahore, Pakistan (UNODC and UNAIDS, 1999). Sri Lanka, Maldives and Bhutan are yet to see any serious in-roads by HIV among IDUs.

The links between injection drug use and commercial sex, and the influence of such links on the sexual transmission of HIV (both among IDUs as well as outwards from IDUs to their non-injecting sexual partners) are also becoming increasingly evident in the sub-region. According to one study, 57 per cent of the female sex workers who also injected drugs in Manipur, a north-eastern

[2] The 'Golden Crescent' comprises the opium producing areas of South-West Asia, including Afghanistan and parts of Pakistan's North-West Frontier Province and Baluchistan. The 'Golden Triangle' is situated in South-East Asia and comprises parts of Myanmar, Thailand, the Lao People's Democratic Republic and Vietnam.

state of India having a common border with Myanmar, were HIV positive. This compares with 20 per cent HIV prevalence among non-injecting drug-using female sex workers in the same state (Panda S et al, 2001). About one-third of the female IDUs involved in sex work in this study had male IDUs as their regular sex partners. It is also important to recognise that Manipur witnessed an explosive HIV epidemic among IDUs in late 1980s and recorded 45 per cent HIV prevalence among their non-injecting wives of HIV positive IDUs ten years later. This case control study revealed that such couples had three times the odds of being concordant for HIV positive test results when either member had history of having a sexually-transmitted disease (Panda S et al, 2000).

In the midst of all this heterogeneity characterising the IDU scene and HIV prevalence among IDUs in South Asian countries, one thing common is the poor access of IDUs to addiction treatment as well as HIV/AIDS prevention and care services. The UNODC-ROSA project 'Prevention of transmission of HIV among Drug Users in SAARC Countries' therefore undertook the responsibility of developing a series of six modules, which together form an 'Intervention Tool-kit', that will help in capacity building for field-level intervention teams. The modules are:

1. Introduction to 'HIV-intervention tool-kit' and 'basics of conducting rapid situation and response assessment' (Rapid Situation and Response Assessment — RSRA)
2. Peer led community outreach intervention for drug users (Peer Led Intervention — PLI)
3. Safer practices (SP)
4. Buprenorphine substitution (Oral Sublingual Buprenorphine — OSB)
5. Methadone substitution (Methadone Maintenance — MM)
6. Low cost community based care for drug users (Low Cost Community based Care and Support — LCCS)

Although the modules form a complete set, which together address different intervention options for preventing the spread of HIV from and among drug users and the 'why' and 'how' of those interventions, each is designed to stand alone. Nonetheless, it is recommended that the practitioner first reads Module 1 and Module 2 together, before going on to the rest. One needs to also assess whether any one intervention or combination of interventions, will be appropriate for a particular area or country, in the light of the pattern of drug use as well as HIV prevalence among drug users.