Published on Up Close (https://upclose.unimelb.edu.au)

Episode 70: Drug Use, HIV and Harm Reduction in North East India

Drug Use, HIV and Harm Reduction in North East India

VOICEOVER
Welcome to Melbourne University Up Close, a fortnightly podcast of research, personalities and cultural offerings of the University of Melbourne, Australia. Up Close is available on the web at upclose.unimelb.edu.au.

JENNIFER COOK
Hello and welcome to Up Close, coming to you from the University of Melbourne, Australia. I’m Jennifer Cook. The history of how governments have attempted, with varying degrees of success, to control and manage the devastating and long-term effects of HIV Aids is as fascinating as it is fraught. And one place where the clash between public health policy and culture is particularly complex is in the northeast of India. More than 2.5million people in India are living with HIV Aids. And the Nossal Institute for Global Health is working hand-in-hand with local communities in the north-east Indian states of Manipur and Nagaland to implement innovative programs to not only reduce the risk of contracting HIV Aids, but to help those living with the disease or its myriad of flow on effects. But just how has this, a traditionally conservative, religious, ethnically diverse community coped with the onset of HIV? With me in the studio is Dr.Peter Deutschmann, associate director at the Nossal Institute for Global Health. And, Dr.Michelle Kermode, senior research fellow with the Institute. I’m also joined by Prarthna Dayal, the senior program officer with the Nossal Institute for Global Health. Welcome to you all. Now, Peter, if I could begin by asking you to explain to us, what it is about Manipur and Nagaland that sets it apart from the rest of India, not only geographically but culturally?

PETER DEUTSCHMANN
Indeed. Whilst they’re two states in India, they are geographically to the far northeast, bordering Myanmar. And share more with Myanmar, China and Nepal, from a cultural and ethnicity point of view than perhaps the rest of India. They are both small population states, two million per state. Quite distinct from the very populous states of India. But, also distinct is the fact that they are states
predominantly of Christian populations. Again, very distinct from the predominantly Hindu states of India.

JENNIFER COOK
And they don’t actually see themselves as Indian, as such, do they? They take great pride in their own identity.

PETER DEUTSCHMANN
Indeed. Their primary allegiance is a tribal one. And secondary to the region. Their languages have more in common with Chinese and Burmese languages than India. And their cultural heritage is, is that whilst animist people groups having migrated from western China many centuries ago, they, a century ago adopted Christianity as a faith, which sets them apart and that is very much linked in part to the clash between a public health approach to HIV infection in the context of drug use we are about to talk about.

JENNIFER COOK
So, let’s look at that. You have this diverse culture, something between 25 and 50 different dialects, strongly Christian and conservative Christian, too. So, what kinds of challenges does that kind of diversity pose to the implementation of HIV Aids programs? And just how has that move been made towards what we now have as a gradual acceptance of harm reduction as a policy?

PETER DEUTSCHMANN
Well, if we go back two decades, so, into the late 1980s, early 1990s, when HIV infection first emerged, it was preceded by a decade of increasing drug use. Heroine, readily available, having been trafficked through Burma up through the northeast of India and to the rest of the world, was available at a time when young people were well educated but increasingly idle and experimented in their youth with drugs that were readily available and strongly addictive. And in that community setting, HIV was readily spread because by the time of its emergence, the drug was essentially being used in intravenous injectable form.

JENNIFER COOK
And Prarthna Dayal, I’ll just ask you, I think it is really important that we understand the wave that came before the HIV and this increased use of drugs, it just seems that there are many layers that the family and the community have to deal with, so by the time the person has tried the drug, got with their peer group, contracted HIV, often the family is a bit worn out. Have you found that to be the case?

PRARTHNA DAYAL
Well, there is a very high level of stigma and discrimination against people living with HIV in the two states we are talking about because of that layered effect. There is stigma against the drug users, which gets compounded once they have HIV. So, in 2005, we conducted a rapid assessment of the levels of stigma and found a high level of stigma, in the home, in the religious setting, in health care settings that were gendered and compounded by an association of drug use and sex work.
JENNIFER COOK
And, I am assuming to with this strong Christian community as well. Am I right in thinking there would have been a ?just don?t do it? kind of attitude?

PETER DEUTSCHMANN
Indeed. With the evolution of drug use and then HIV on top of it, the initial response was dual: very compassionate, but quite authoritarian. And, the only real response was one of abstinence. Every attempt was made to ensure that young people didn?t use drugs, but it often led to incarceration. When I first visited in the early 90s, I found 600 inmates in the main jail in Imphal, the capital of Manipur and 560 were there as a result of drug addiction. Not necessarily under court order, but placed there by their parents for a period of compulsory abstinence. But of course, on return to the community setting young people took up drugs readily again. And so, the community was increasingly frustrated with that approach, which in one sense was a good antecedent to the introduction of a public health response which was to look at, ways to prevent, to acknowledge that young people continue to use drugs, but identify ways in which one could prevent the spread of HIV among them whilst they were still using drugs.

JENNIFER COOK
We should also mention too, Michelle, the insurgent groups and their attitudes towards this.

MICHELLE KERMODE
This adds an additional layer of complexity to trying to work in this area. There is, going back quite a long way, an armed civil insurgent movement in both Manipur and Nagaland. Essentially they are agitating for separatism from the Indian central government and the Indian mainland. So, consequently there is a big presence of the Indian military up there. And that contributes to problems related to HIV, where you have large numbers of men who are coming into an area without their families necessarily. But it also means there is ongoing conflict. And that ongoing conflict has the effect of underdevelopment of the area. So, there is not a lot of investment in the area and that means, also that the insurgent groups call bans, or strikes, occasionally, which means you can?t deliver services and movement is restricted. So, people are trying to conduct their day-to-day lives in this context of uncertainty, in a way and ongoing conflict. And, these insurgent groups actually are like a parallel government. They have government ministers, they collect money from houses.

JENNIFER COOK
We can?t consider this region without taken them into account and understanding the many ways in which they infiltrate and are a part of that community.

MICHELLE KERMODE
And, historically have had support from people on the ground.

JENNIFER COOK
That?s right. ?Infiltrate? is the wrong word, isn?t it? They are a part of that
community.

MICHELLE KERMODE
And are themselves deeply conservative and will themselves actually take action against drug users and sex workers. Sometimes quite punitive and causes the sex workers and drug users to go underground much more because of the fear of the action from the underground movement.

JENNIFER COOK
And getting back to this society with, you have a group of men that is relatively well educated compared to the rest of India, isn’t it? And, high unemployment, and, is it the case too that the talent bleeds out of the state? So, that you have a group of bored educated men who live at home with nothing to do.

MICHELLE KERMODE
Indeed. So, these young men who are drug users, unlike drug users in a lot of western countries are living at home with their families. They don’t have much responsibility they have a lot of time on their hands, they don’t have work to do, they don’t have to contribute to the home in any significant way. So, they are kind of hanging out together with their friends based on neighbourhood and tribal networks. So, there is a lot of time to pass. And to occupy.

JENNIFER COOK
And reading the studies, you have done some work into how these young men actually start injecting drugs. What did you find?

MICHELLE KERMODE
We actually interviewed them and surveyed them and their own subjective reasons for initiating injecting drug use. Mainly for pleasure seeking. For fun, that is their stated reason. But also, for some of them who have become dependent from smoking heroine or from taking the pharmaceutical agent that they also use, spasmo-proxyxon, orally, it is an economic decision, because they can’t get the same effect from the drug and they can’t afford to keep buying it at the dose they need to get the highs. So, they then start injecting to get a bigger bang for their buck. That’s another reason.

JENNIFER COOK
They were introduced by their friends weren’t they? They were encouraged by their friends?

MICHELLE KERMODE
Peer pressure is the third reason. And that peer pressure came in two forms. One was, ?all my friends were kind of doing it, and I felt left out?, or the friends were actually urging them, ?this is great fun, you should do it.?

JENNIFER COOK
And I can imagine too, friends would also say, ?well, you can’t waste it. You can’t
smoke it to waste it, this is the way we are doing it. This is the smart way to do it. You are on board or you are out?'

MICHELLE KERMODE
Yeah, I think that there is a lot of smoking that happens together, collectively, as well. There is a lot of poly-drug use, pills happening, alcohol happening, there is a bit of smoking of heroine, brown sugar, et cetera. And then gradually, as an addiction develops then they are pushed more towards injecting.

JENNIFER COOK
You’re listening to Up Close, coming to you from the University of Melbourne, Australia. I’m Jennifer Cook and I’m talking with Dr. Peter Deutschmann, Dr. Michelle Kermodr and Prarthna Dayal, from the Nossal Institute for Global Health, Melbourne University. So, let’s now look at what is being achieved. Tell us about Project Orchard and what its aims are.

PETER DEUTSCHMANN
Well, Project Orchard began in 2004. And we have just completed the first five-year phase and have just embarked, from April, on a second five-year phase of the project. It is a project of a large scale, across both states in partnership with the state government to address these issues that we’ve been talking about, by the introduction of public health measures that include needle and syringe exchange and more recently a methadone-like program. So, the replacement of an injectable drug with an oral substitution, in this case BUPA morphine, because methadone is still illegal in India. So, it is an equally effective drug, but more expensive, but it was introduced some two years back and it has been highly effective in assisting young people to no longer inject and to deal with their addiction through an oral form. We began in 2004, but really, the antecedent for this was the previous decade, so, from about 1994 onwards, there were public health responses. Indirectly we were involved in the very early piloting of both needle syringe exchange back in the mid-1990s and in the early 2000s, early introduction of oral substitution therapy. And in time, won over the local community. The Christian community, the parents, the government, with those approaches even though there was some hostility to their introduction. But, I mentioned earlier, the community, to a large extent, had tried everything that was both legally and illegally possible to have the young people abstain once addicted. But, increasingly, understood that addiction was so strong, that, even though the desire to have young people come off drugs eventually, something needed to be done in the interim to protect them from the spread of blood-born viruses through the sharing of unsterile needles and syringes to use the drug.

JENNIFER COOK
Peter, could you talk to us a bit about the struggle that the program has gone through in introducing the needle exchange and also condoms? Talk to us about that process.

PETER DEUTSCHMANN
Firstly just to outline the position of needle exchange and condom promotion in that context. We talked earlier about the community can and did initially perceive this as
an encouragement to drug use, an encouragement to engage in sexual activity outside of the constraints of marriage and the cultural setting. So, one of the barriers, initially in the introduction of what we would call a comprehensive harm reduction program was the community itself and the church in particular. But that program, whilst it introduced needle exchange, in other words, made clean, sterile needles and syringes as readily available as possible to drug users, and condoms, also provided a primary health care to treat infections associated with injection sites and sometimes these were local abscesses to the limbs, or also provided medication to treat sexually transmitted infections. Because it is not just HIV that was being transmitted, but through sexual activity other infections and through drug use, not just HIV, but hepatitis C and other forms of hepatitis of course. So, in that context, the community were won over in time by the more comprehensive approach and a comprehensive approach that acknowledged that, to some extent that this was an emergency response. This was to protect young people who were already injecting drugs. And an acknowledgement of the community they were continuing to inject. The community was essentially won over by the fact that this actually at least protected them whilst this activity was continuing from greater consequences of HIV infection, hepatitis, sexually transmitted diseases and the like. At the same time though the community was not just the barrier as Michelle mentioned earlier, the insurgent activity was also strongly opposed to this form of activity. Again because they saw it as promoting drug use, promoting promiscuity.

JENNIFER COOK
And also a lack of discipline, I suppose, within that culture?

PETER DEUTSCHMANN
Indeed. But at the same time they were recruiting young people for their activities, many of whom were in and of themselves young drug addicts. So, in time, they required and acknowledged the need of some of these services themselves. In order to maintain the health of their recruits and their community. And, increasing over time with advocacy and interaction with our teams, we?ve seen a greater degree of understanding. So, we?ve seen that within the wider-community, the families of drug users, the church and the insurgents. At the same time, another barrier to the promotion of this program and its benefits were the individuals who needed it most. Drug use, in and of itself is illegal, so drug users were largely hidden from services and the means that we adopted to reach them was the recruitment and the training of what we call ?peer educators?. People who are either current drug users or earlier were drug users who were part of the same social networks. Had the connections were able to reach out, communicate with, explain the benefits of the program and introduce places of convenience, private places outside the home, away from the police, the opportunity to access needles, syringes, condoms and first aid.

JENNIFER COOK
So, very grassroots.

PETER DEUTSCHMANN
Extremely. And sort of, if you like, non-institutionalised. These were not dependent
on drop-in centres, not dependent on access to hospitals. These were very grassroots. These were people sent out into rural communities and the backends of townships. Out of sight.

JENNIFER COOK
And so do you see that kind of one-on-one beginning as instrumental in moving community attitude and awareness forward?

PETER DEUTSCHMANN
I think the one-on-one aspect was of greatest assistance in actually making contact with and maintaining contact with young people who use drugs.

JENNIFER COOK
So, finding the people you needed to help.

PETER DEUTSCHMANN
Indeed.

JENNIFER COOK
First you had to find them before your help.

PETER DEUTSCHMANN
Exactly. And I think what was most credible about dealing with the wider community, if you like, the parents and the church community were the fact that our teams, our health professionals were drawn from that very community. They were of the community. And they became strong advocates among their peers. In other words, other parents, other members of the churches existent there were able to influence their opinion over time.

JENNIFER COOK
Just talk to me a little bit more about these oral substitutes and their effectiveness. Do they break that drug cycle for these young people?

PETER DEUTSCHMANN
Well, firstly they acknowledge the addiction. So, initially they’re introduced by prescription and remain a drug of prescription by, say, a medical officer or an appropriate health authority. And that is very much dose dependent, so it is important to get the dose right initially to remove the cravings. So, it is blocking the cravings, which would otherwise lead to a seeking out an illegal source of the drug, heroine, and its injection. Overtime it is possible to reduce the amount of the oral drug, even to the point of coming off the oral drug. That is the desire of everyone. Both the addict, his or her family, and the practitioner, but that is not always possible. So, sometimes it is important to just have a small maintenance level, sufficient for the person to no longer have cravings in order that their life is then stabilised. Then there is the potential to re-enter education, go back to school or look for employment. Or, care for one’s family and children.
JENNIFER COOK
Peter, tell us about the impact of the drug substitution program.

PETER DEUTSCHMANN
One of the remarkable things about the introduction of the drug substitution program was the attractiveness of the affected community, drug users themselves, and particularly women who used drugs. In the past, one of our struggles had been to reach so-called hidden populations, and especially women who inject drugs. There is an even greater stigma attached to women. And, what we found with the introduction of the oral substitution program was that young men and women in increasing numbers came forward to access that part of the program, whereas they were reluctant to access the more traditional part, such as needle exchange. Not only was it acceptable to them and drew them into the program and for greater benefit for everyone, it increased greatly the acceptability among the general population. We discovered the general population were more open to that as a means of addressing drug use and the prevention of the spread of HIV than for example the distribution of clean needles and syringes, the promotion and distribution of condoms as a means of preventing the spread of HIV.

JENNIFER COOK
And did the acceptance of that program make it easier for Project Orchard to come in and then introduce some other programs, sort of on the coat tails of that?

PETER DEUTSCHMANN
Indeed it did. It allowed two things. We initially introduced it on almost a pilot scale. The demand was such that we were able to, in time, to introduce it on a very large scale across greater populations. That was one of the by-products. The other by-product is, you are right, that it received such prominence that the other components, those components that induced greater distress in the general community about whether they were promoting drug use are increasingly acceptable because the dominant part of program is the provision of an oral substitute to injectable drugs.

JENNIFER COOK
You can see, too, just how, almost overwhelmingly complex, the situation is, isn?t it? You know, once you get the drug addict, healing and off the drug, then of course, Michelle, as you were mentioning you need them to come back into a community that does have employment opportunities that can run smoothly. So, this is doing what you can, where you can, isn?t it?

PETER DEUTSCHMANN
Indeed, what we are talking about ? it?s almost like an emergency intervention. To quell the spread of HIV, to limit its spread and to limit its spread, not just among drug users, but into the general population and so through drug users to sexual partners through infected sexual partners to unborn and born children. So, that is the dilemma. However, it is only part of the answer. Because the context in which this has happened ? high education, under-employment ? and unless those things are addressed by the government at the same time, then you have a continuous
spiralling effect where young people remain potentially idle and socially because the currency of drug use is so strong, we find that even on oral substitution treatment, some people go back to injection. Not because they're craving it but because it is part of the social transaction.

JENNIFER COOK
You're listening to Up Close, coming to you from the University of Melbourne, Australia. I'm Jennifer Cook and I'm talking with Dr. Peter Deutschmann, Dr. Michelle Kermode and Prarthna Dayal from the Nossal Institute for Global Health, Melbourne University. Prarthna, this is a good time now to talk to you about your work with the OSD Program, which stands for Overcoming Stigma and Discrimination in this region, so, could you tell us about the particular challenges that you face, and they're many, trying to inform a community with up to 50 different dialects on how to prevent HIV Aids?

PRARTHNA DAYAL
Yes, in fact, the project is really a communications project with all the different dialects in the communities. That is one of the main challenges we face. Because, often the decisions on which language, you can't translate those concepts in each of those dialects to the quality that you want them. And the whole process of a selection of a small group of languages then becomes a political process almost, which languages you do select?

JENNIFER COOK
I can imagine there would be some very heated discussions.

PRARTHNA DAYAL
And how to reach the maximum population through those languages that you are developing the communication materials in. And one of the reasons this project came about was that we did find a high level of stigma, but also the communication materials that existed in India weren't applicable to this region because of its uniqueness and cultural differences.

JENNIFER COOK
In what way didn't they measure up?

PRARTHNA DAYAL
The materials that exist are made for an audience that looks different culturally and ethnically. They speak a different language. And when you are trying to change behaviour you the audience to identify with the characters. And so the sense was that doesn't apply to us. That doesn't happen here. So, it is really, the project is about using local producers and local stories to touch the audiences in a way.

JENNIFER COOK
And how successful do you think you have been?

PRARTHNA DAYAL
Well, we are still in the middle of it. But, I think what has made a difference is that the audience has been able to identify with the messages that have been portrayed. The messages are coming from their own communities. It is people that they know. And these are very small communities as well. So, everybody knows the main players out there.

JENNIFER COOK
Are they quite isolated? I?m trying to get a sense of ? are we talking about isolated communities or bigger towns?

PRARTHNA DAYAL
Well, it?s smaller towns. Very spread out. This is a very hilly region. A lot of villages are completely cut off. In fact, one of the other challenges is that the reach of TV, radio is not as widespread as you would imagine in other parts of India. So, to reach a larger community it is that much harder. And a lot of the villages are cut off during six months of monsoons and rains and it is just hard to get the messages out there.

JENNIFER COOK
But I can see what you are achieving here is something very important in that you are empowering the local community to control the message and speak to their own people. Has that been a part of your aim?

PRARTHNA DAYAL
Yeah, there is inter-personal communication component to the project, where we are really targeting the community leaders: religious leaders, youth leaders, women leaders, to be able to take the messages to their communities.

JENNIFER COOK
And how well has that been working?

PRARTHNA DAYAL
The leaders are very receptive to it. Partly they don?t have the tools to be able to address it. So, sometimes they want to be able to make a difference and to address it. So, it is educating the community about, that this does exist in this society and these are the findings that we?ve had. And then what are the effects of that on their own communities?

JENNIFER COOK
And things can be changed.

PRARTHNA DAYAL
Things can be changed.

JENNIFER COOK
That is very, very interesting. Also, it is very important with this project, isn?t it? That these programs are in the hands of the local communities so that people will actually come and use them. They?re not going to be so keen if it an authoritarian, say if it
were the police or the government or? Peter?

PETER DEUTSCHMANN
Indeed. I think that the strength of this program is that implementation is through a local partner and the Emmanuel Hospital Association, is our Indian partner, based, in many states of India including these states in the north-east. The team based there is locally recruited from the northeast, from these two states and therefore speak the local languages, understand the setting. They are individuals who have worked in this environment, of course, for some time, preceding Project Orchard. In turn, Project Orchard has developed through our implementing partner, EHA, has developed the capacity of community-based organisation. So, if you like, local groups to be the means of bringing services to an otherwise hidden population. Remembering that drug use is an effectively illegal activity, so the reach has been extended by community groups. Often groups of individuals who, some of whom have been drug users themselves. So, their network and their reach is substantial, such that we have been able to, over time, reach 80% of the total population of drug users in those two states, which is what we believe is required if we are to reduce the infection rate of HIV, reduce its prevalence. And, there are already signs that we are achieving that.

JENNIFER COOK
But, Michelle, Project Orchard, just doesn?t deal with drug users, does it?

MICHELLE KERMODE
No, it is also trying to prevent, not just HIV transmission through unsafe injecting but also sexual transmission of HIV. So, it tries to work with the partners, the sexual partners of the injecting drug users. It also has programs that target women who are engaging in sex work. And also men who have sex with men. So, all of those groups are targeted with programs that try and reduce the risk of sexual transmission of HIV.

JENNIFER COOK
And, all of those groups that you mentioned face large prejudices, don?t they, from the community?

MICHELLE KERMODE
Indeed. For MSM, men who have sex with men, many people in the northeast don?t even know that they exist, in a way. So, they are quite a hidden population. For the sex workers, the prejudices against them is extremely strong in this conservative Christian environment. It makes it very difficult for a woman in any way to self-identify as a sex-worker because she risks quite a, some potentially serious consequences. Historically, some women have been tortured, they have had their head shaved, they have had their pictures published in the paper and that sort of thing. It happens less so now because of advocacy, but it is a very shaming thing to be identified as a sex-worker; so, women don?t come forward and self-identify in that way. That means they can?t form a collective to organise themselves to try and protect their own interests. It is hard to bring them together to do that because they want to remain hidden.
JENNIFER COOK
What about the partners of HIV positive men, the women who contract HIV and Aids and then become widows? There are two groups of women I?m talking about. The terrible stigma of both, if you could just explain.

MICHELLE KERMODE
Sure. So because most of the drug users in north-east India are men, only less then 10% would be women and because a lot of these young men, have over the last decade or two died from HIV or from overdoses this leaves quite a large group of young widows. Some of whom themselves may have been drug users with their husbands, but many who weren?t drug users, some who didn?t even know that they were marrying drug users and some of whom are HIV infected and some of their children are HIV infected. So, these women have to deal with being a young woman on her own, widowed, possibly HIV infected. And so, widows in Indian society are quite marginalised and if you are an HIV infected widow whose husband died from drug use, it can be pretty tough. And, they?re often in situations of poverty, they?re under enormous stress, because they?re young women and don?t have a husband, they can be seen as sexually available. And even if they?re not engaging in sex work and a small proportion of them do engage in sex work in order to get income, but even if they?re not and they go out, people accuse of them of going off to do sex work. So, they?re very stressed. They?re a very stressed group. They?re uncertain about their own future. They?re uncertain about the future of their children and the groups that we met with originally when we did a situation assessment amongst these women in 2004, their distress was palpable. You just had to talk with them for ten minutes and it was very clear that they were finding life very difficult.

JENNIFER COOK
Well, they?re dealing with so much on so many fronts, aren?t they? And so much of it is hidden.

MICHELLE KERMODE
Absolutely. And, they also were isolated from each other. They weren?t having much contact. They were feeling they were the only one who had this problem. And a lot of concern amongst the people who provide HIV prevention services that these women are accessing services, but in some ways accessing HIV prevention services is very low down on their list of needs. They are much more preoccupied with livelihood issues. Trying to get on with their in-laws. Because often they are still living with their husband?s family, but in a very unsatisfactory way. Worrying about, if they have HIV, how can they get treatment, how can their children get treatment, who will look after their children after they die? So, these were their preoccupations, rather than making sure they use condoms when they have sex if they are engaging in commercial sex.

JENNIFER COOK
Michelle and Prarthna both Project Orchard and OSD are now in an exciting and I?d say crucial crossroads in terms of funding and direction, do you want to explain that a bit to us Michelle and tell us what the future holds?
MICHELLE KERMODE
Sure, I’ll just explain that Project Orchard was originally funded for five years through the Bill and Melinda Gates Foundation and then, that five years has recently rolled over and we are now into phase two of the project, the funding has been extended for another five years and in many ways the lessons we have learnt from the first phase or the things that we didn’t achieve, or that we wanted to achieve have now become the focus of phase two. The longer-term goal is to transition the responsibility for HIV prevention in these particular districts back to government. And so, we will be working towards that over the next five years as well.

JENNIFER COOK
Now Peter, I could just get you to look forward, imagine you are gazing into your magic crystal ball, what do you see as the future for Project Orchard and also for this community?

PETER DEUTSCHMANN
Project Orchard, as we said earlier, has been in existence for five years and we have an opportunity over the next five years to see the services that we have developed with the government, but strengthened alongside the government approach, see that transferred to the government health system. But at the same time in that transition, ensuring that those who reach the community most effectively, the community based organisations are still an integral part of that. And part of the success of the program to date has been the intimate support of the community-based organisations through training, supervision, and really, walking alongside allied health workers. These are not doctors and nurses, but they are well-meaning people who have been trained over the years to deliver these health services. Our aim in the next five years, is to see all this transferred and incorporated into the local government program, so that Project Orchard is not of itself, will phase out, in these five years, but it should echo through government programs and well-resourced local community based programs.

JENNIFER COOK
And hopefully it will become a part of everyday life in this region, which has become an accepted part of the policies and what is available.

PETER DEUTSCHMANN
What we hope to see is, a bit like communities in Australia, where, as much as we don’t like to see drug use, we recognise the need for these sorts of provisions among young people of every generation who use drugs to protect them whilst they are using drugs. So, we hope to see this as an integral part of the community’s acceptance. At the same time though, what we have identified through the program in the last five years and what we want to see maintained is the gradual and continued reduction of HIV infection. That means that even though young people might choose to use drugs in the future, because of the programs and their existence, the likelihood of them becoming infected freshly with HIV or hepatitis for that matter will continue to reduce over time. So that, in time, new drug users when they access programs that assist them to be no longer drug users, our aim is that they will not be HIV infected.
JENNIFER COOK
And what a great aim that is. We wish you the best of luck. We’ve been speaking with Dr. Peter Deutschmann, the associate director of the Nossal Institute for Global Health, the University of Melbourne and Dr. Michelle Kermode, a senior research fellow also from the Institute for Global Health, joining them is their colleague, Prarthna Dayal, the senior program officer, also at the Institute. Thank you for all of your time and your insights into HIV policies in this fascinatingly diverse northeast region of India.

PETER DEUTSCHMANN
Thank you.

MICHELLE KERMODE
Thank you.

PRARTHNA DAYAL
Thank you.

JENNIFER COOK
You’ve been listening to Up Close from the University of Melbourne, Australia. Relevant links, a full transcript and more information on this episode can be found on our website at upclose.unimelb.edu.au. You can leave a comment about any episode of Up Close by clicking at the link at the bottom of the page. Melbourne University Up Close is brought to you by the Marketing and Communications Division, in association with Asia Institute at the University of Melbourne, Australia. Up Close was created by Kelvin Param and Eric van Bemmel. And this episode has been produced by Kelvin Param and Miles Brown. Our audio engineer is Miles Brown and our theme music was performed by Sergio Ecole. Transcribed by Andy Fuller. I’m Jennifer Cook, until next time, thank you for joining Up Close. Goodbye.

VOICEOVER
You’ve been listening to Melbourne University Up Close, a fortnightly podcast of research, personalities and cultural offerings of the University of Melbourne, Australia. Up Close is available on the web at upclose.unimelb.edu.au. Copyright 2009, University of Melbourne.

© The University of Melbourne, 2009. All Rights Reserved.