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Human Rights Abuses and Suicidal Ideation among Male Injecting Drug Users in Delhi, India

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Abstract

Background—Human rights abuses, denial of care, police surveillance, and violence directed at IDUs have been found to impact HIV prevention efforts due to decreased attendance in harm reduction programs. The association of mental health status with rights abuses has not been examined extensively among drug users. In India, drug control laws are often in conflict with harm reduction policies, thus increasing the likelihood of rights abuses against IDUs. The purpose of this study was to describe human rights abuses occurring among IDUs in Delhi and examine their association with suicidal ideation.

Methods—343 IDUs were recruited in two research sites in Delhi through respondent driven sampling and were interviewed with a cross sectional survey questionnaire that included items on human rights and socio demographics.

Results—IDUs in the study experienced many human rights abuses. Notably among these were denial of admission into hospital (38.5%), denial of needles and syringes (20%), police arrests for carrying needles and using drugs (85%), verbal abuse (95%) and physical abuse (88%). Several human rights abuses were associated with suicidal ideation. These include being denied needles and syringes (OR: 7.28, 95% CI: 3.03- 17.49); being arrested by police for carrying needles and using drugs (OR: 2.53, 95% CI: 1.06- 6.03), and being physically abused (OR: 1.66, 95% CI: 1.05- 2.23). The likelihood of suicidal ideation is also strongly related to the cumulative number of abuses.

Conclusions—These findings demonstrate that there is a high prevalence of human rights abuses among IDUs in Delhi. Given the alarming rate of suicidal ideation and its close relationship with human rights abuses it is essential that IDU interventions are executed within a rights-based framework.

Keywords

Human rights; IDU; India; Suicide; HIV/AIDS

Conflict of interest: None

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Introduction

The discussion on the intersection of human rights and public health is especially relevant in the context of a sensitive disease like HIV/AIDS which disproportionately affects populations who are marginalized, poor, and historically discriminated against. Injecting drug users (IDU), by the very nature of their criminalized and illegal behaviours, are more likely to come under the purview of law enforcement. There have been numerous reports of frequent rights abuses among IDU, as well as societal stigma that leads to the curtailment of many of their rights. IDUs are also frequently denied the basic right to care : only 10% of IDUs worldwide are reached by public health interventions (Beyer et al, 2010). For example, a study showed that while IDUs constituted 83% of HIV infected in Eastern Europe, only 24% were on HAART (Donoghe et al, 2007). Access to health services is often found to be impeded by stigma and discrimination (Ahern et al, 2007; Ronzani et al, 2009; Wolitski et al, 2009). A recent systematic review revealed the effects of denial of harm reduction services, law enforcement practices, and discriminatory access to ART on vulnerability to HIV and service access (Jurgens et al, 2010). For instance, police presence and harassment in the vicinity of needle exchange programs have been found to lead to decreased attendance at voluntary treatment programmes and needle exchange sites, increased needle sharing, unsafe injecting and improper disposal of needles (Rhodes et al, 2005; Rhodes et al, 2003; Aitken et al, 2002; Blankenship & Koester, 2002); Best et al, 2001; Maher and Dixon, 1999; Weatherburn and Lind, 1997; Bluthenthal et al, 1999). These factors have been found to increase the likelihood of IDUs in acquiring HIV infection (Broadhead et al, 1999). In fact, there is increased evidence of the rapid seroconversion to HIV and hepatitis among incarcerated IDUs indicating the lack of access to harm reduction within prison settings (Beyrer et al, 2003; Jurgens et al, 2009; Choopanya et al, 2002). Other human rights of IDUs are also documented to be consistently abrogated. They are held by the police without formal charges or coerced into confession while in withdrawal (Human Rights watch, 2004; Human rights watch, 2008; Human rights watch, 2010). The right to a decent standard of living is almost always denied to drug users (Wodak, 1998). In India, IDUs are often illiterate, live in urban slums, and are poor (Mohan & Dhawan, 2002; Shetty et al, 1997.) which enhances the frequency of violations of social and economic rights.

The National AIDS Control Organisation of India estimates that 7% of IDU nationwide in India and 22% in Delhi are infected with HIV (NACO, 2008). The prevalence of hepatitis C among IDUs is reported to be 60% (Sharan & Hopkins, 2007), contributing to increased rates of mortality and morbidity among this population. A recent study in Chennai noted a high mortality rate of 4.3 per 100 person years among IDUs (Solomon et al, 2009). Prevention and treatment programmes for IDUs are severely limited, and needle exchange and buprenorphine substitution programmes are mostly implemented as “pilot” projects run by NGOs with limiting funding streams. While possession of injection paraphernalia is not illegal, carrying syringes often exposes IDUs to police harassment. Despite a fairly recent act by the Narcotics Control Bureau of India (NDPS Act) of raising the allowable amount of drugs that can be carried, drug users still find themselves being arrested for minor offenses (Charles, 2005). Moreover, access to ARV treatment is poor for HIV-infected IDUs. A recent review of the coverage of HIV treatment estimates that only 1 out of 100 HIV-infected IDUs in South Asia in need of AIDS treatment are on ARVs (Mathers et al, 2010). Thus, IDUs in India experience severe limits to their right to health, right to life, right against arbitrary arrest, all of which are guaranteed under international conventions as well as the Indian constitution.

The present study aims to describe human rights abuses committed against injection drugs users in New Delhi, India. A second aim of the study is to examine whether there is an

association between human rights abuses and suicidal ideation. Human rights abuses, especially those related to forms of violence, have been found to be associated with poor mental health, particularly post traumatic stress disorders (Kaminer et al, 2008; Norris et al, 2003; Creamer et al, 2001). Suicidal thoughts and behaviors have been found to be highly related to partner violence among women (Ellsberg et al, 2008) and among refugees who have been exposed to torture (Ferrada- Noli et al, 1998). Although most studies report that it was difficult to definitively establish causes of suicide, the strength of the associations suggested that mental health could be an outcome of abuse rather than a precursor of abuse (Ellsberg et al, 2008). Data on psychopathology of IDUs is scant in India, and very few interventions actually address mental health issues among IDUs. A key aim of this study was to examine whether indicators of psychopathology are linked with human rights abuses, with a view toward preventing such abuses as a means of suicide prevention.

Methods

We used a cross sectional study design among of 343 IDUs who were sampled in two sites in Delhi using Respondent Driven Sampling (RDS), a technique similar to snowball sampling that is used for hidden populations, but without its biases such as masking or under representativeness and volunteering or over representativeness (Heckathorn, 1997). This method was adopted for its recruitment efficiency in terms of number of new recruits we could access per week, and timeliness in data collection (Malekinejad et al, 2008). Eight seeds (the initial IDU recruiters) were selected, four from each site, based on varying demographic characteristics. They were provided with three coupons each to recruit their peers if they were deemed eligible for the study. The peers in turn recruited their own peers, and the process thus continued until the sample size was reached.

Selection of sites and Sampling

Two sites, one in the north and the other in the west of the city, were selected as research sites. The site in Northeast Delhi, is called Yamuna Bazaar, where an abundance of chemist shops that sell injectable pharmaceuticals, and neighborhood temples that distribute free food attract many IDUs who use drugs and sleep in the nearby parks and footpaths. Most of the drug users in this area had migrated from nearby towns and villages as well as from Nepal and Bangladesh for work. The second site, Mongolpuri, is a resettlement colony situated in the western part of the city. Male IDUs, above 18 years of age, and who had injected in the last week were eligible for participation. We did not include female IDUs as they are very few in Delhi.

Ethical approval

Ethical approval was obtained from institutional review boards of both The Johns Hopkins University, Bloomberg School of Public Health, and The Society for Service to Urban Poverty (SHARAN), India.

Interview and Study Measures

We developed a survey instrument that asked about situations where IDUs face discrimination and potential rights violations. The structured questionnaire was interviewer-administered. The interviewers were recruited from local NGOs, and were trained in interviewing skills and other research techniques in a four day training programme, conducted at the beginning of the study. The study participants were paid 50 rupees and were served tea and snacks at the end of the interviews. Data collection took four months to complete, from August to December of 2007.

The questions in the survey were developed based on previous surveys with the same population, in consultation with experienced staff from drug user organizations consisting of both ex- and current drug users, and on testimonies of drug users (NEIHRN, 2006). They were also based on existing literature on human rights measures (PHR 2003; Kreiger, 1999). Furthermore, we examined international human rights conventions that India has ratified, such as the International Convention on Civil and Political Rights and the International Convention on Social, Economic and Cultural Rights, particularly the right to health. We took particular note of rights abuses that could be linked to Indian national laws. We sought to define “lack of food and shelter due to drug use” as a rights abuse as it clearly violates the right to an adequate standard of living as granted in article 11 of the UDHR (UN, 1948). Indeed, food insecurity has become one of the greatest barriers to effective HIV prevention and treatment efforts as it increases vulnerability to infection, via biological and social means, while also posing challenges to treatment adherence, and impacting on clinical outcomes (Anema et al, 2009). We took into consideration the definition of torture as provided in the International Convention Against Torture, and included verbal and physical violence perpetrated by public officials as well as by non state actors in measuring this concept. We included arrests and lock ups for carrying syringes and using drugs as violation of the right against arbitrary arrest as there is no Indian law that penalizes for carrying syringes or drugs (in small amounts) meant for consumption. Some of the items on dignity violation corresponded to the taxonomy provided by Jonathan Mann (Mann, 1998): identification with group; invasion of personal space; humiliation. Another item (being avoided by people) was added following focus group findings on experiences of dignity violation.

Demographic information included questions on age, educational level, occupation, income, injecting status (buprenorphine or heroin), marital status, and residential status. Mental health status included questions on admission to psychiatric care, suicidal ideation and suicide plan in the last 6 months, developed in accordance with the definitions provided by O'Carroll. (O'Carroll et al, 1996). To assess recent suicidal ideation, the respondents were asked “During the last six months, have you ever had thoughts of taking your own life, even if you would not actually do it?” To assess suicidal plan respondents were asked “During the last six months did you ever make a specific plan about how you would take your own life?” We included these measures as they had been used previously among IDU populations (Havens et al, 2006; Lloyd et al, 2007).

The human rights violations questionnaire was translated into Hindi by an independent translator. It was then given for evaluation and to determine face and content validity to staff members of drug user organizations. Two focus group discussions (FGDs), (one composed of 22 IDUs and the other of 15 IDUs), were conducted with IDUs in order to explore their perspectives and perceptions of human rights, rights abuse, stigma, and discrimination. Next, the questionnaire was administered to 12 IDU respondents for pilot testing.

Data analysis

Stata 10 was used for analysis. A cumulative human rights abuse score was calculated ranging from 0 to 12, categorized into low, medium and high. We conducted logistic regression on suicidal ideation and the cumulative human rights abuse variables. A multivariate analysis was then performed with suicidal ideation as the outcome variable and demographics and human rights abuses as predictor variables. Backward selection of covariates was conducted to retain the most important variables and to have the most parsimonious model.

Results

Characteristics of the sample

The median age of participants is 33 years, ranging from 18 to 61 years. Participants are mostly single (61%), with no education (53%), and live on the streets (63%). Most inject a cocktail of buprenorphine, an analgesic found in chemist shops, with an antihistamine and diazepam. Less than a quarter inject “smack” or unrefined heroin. The majority are employed as scavengers or rag pickers (87.6%). More than half of the respondents also exhibited poor mental health status as indicated by the high rates of suicidal ideation (57%) and suicide plan (42%).

Prevalence of Human rights abuses

Table 1 presents the prevalence of major rights abuses and perceived discrimination. Between a quarter and one third of the respondents reported experiencing discrimination either in the general health care or in the harm reduction setting (table 2). The majority of the respondents named 6 major public hospitals as being the sources of discrimination. The frequency of other sources included NGOs (n=7), smaller municipal hospitals (n=3), private hospitals (n=2), and private doctors (n=5). Almost half of the respondents (47%) reported three or more instances of lifetime discrimination. A majority (85%) of the respondents reported being arrested for using drugs or carrying needles (table 1). Nine respondents (4.4%) reported being raped in jail. The majority of the sample (63%) had never been tested for HIV, the most common reason being that they had no information of voluntary counseling and testing facilities. With the exception of six individuals who discontinued ARV treatment or had a high CD4 count, the other HIV positive individuals (n=7) were not on ARV treatment either because they had no information about such treatment or they were not referred to the appropriate treatment facility. The majority of study participants also reported a history of physical abuse and public humiliation.

Association between human rights abuse and suicide ideation

Simple logistic regression of suicidal ideation and selected human rights abuses show an association between these two variables. Odds ratios calculated after adjusting for the effects of demographic characteristics and statistically significant human rights abuses demonstrated that being arrested by the police (OR: 2.53, CI: 1.06- 6.03), being fired from a job (OR: 3.90, CI: 2.06- 7.38), being forced to go without food and shelter (OR: 3.73, CI: 1.97- 7.28), being refused needles and syringes (OR: 7.28, CI: 3.03- 17.49) and being threatened with violence (OR: 1.44, CI: 1.08-1.92) and being physically abused (OR: 1.66, CI: 1.05- 2.23) were associated with suicidal thoughts. When we included the cumulative human rights abuse dummy variable, the odds of suicidal ideation increased incrementally along the levels of abuses (table 2). Compared to those experiencing a low frequency of abuses, those experiencing a moderate number of abuses had twice the odds of suicidal thoughts while those experiencing a higher number of abuses were 15 times more likely to have suicidal thoughts.

Discussion

We found that IDUs in our sample in New Delhi have experienced significant human rights abuses. As well, suicidal ideation and suicide attempts are frequent and associated with many negative life events. These results lead us to believe that IDUs' lack basic rights to health due to lack of medical treatment, drug treatment, and health information. As a result the prevalence of major health problems like HIV and hepatitis C are strikingly high and growing.

One way to address this is through HIV/AIDS policy and the rights of infected or vulnerable people detailed by The National AIDS Control Organisation of India (NACO) and The National Human Rights Commission (NHRC, 2008) of India have in recent years put forth laudable policy initiatives calling IDUs to have access to treatment and prevention services. Yet our study findings show that there are significant gaps in realizing these goals. In Delhi NACO-funded ARV delivery is now available in nine major hospitals, and HIV voluntary counseling and testing is available in 62 centres, yet many IDUs in our study had no knowledge of VCT access and few have been tested for HIV. We also identified numerous IDUs who were denied needed ARV treatment. We also found that many IDUs are arrested for possession of only small amounts of drugs, which is contrary to the recent amendment of the NDPS Act. Likewise, carrying needles is not illegal in India, yet frequently IDUs are harassed when found with injecting equipment. Food security and housing are also urgently needed among the vast majority of IDUs we studied, and the lack of these basic human needs severely compromises health intervention efforts.

Our study also found that over 57% of IDUs in the study had recent events of suicidal ideation, and suicide ideation was associated with a history of human rights abuses. Suicidal ideation is a significant predictor of suicide (Mino et al, 1999), making these findings of grave concern. IDUs in this study who were unable to buy food or who were fired from jobs also reported a higher rate of suicidal ideation. Social and economic stresses such as unemployment, marginalization, and inability to buy food are reported to contribute to a majority of suicides in India (Prasad et al 2006; Vijaykumar et al, 2005; Gururaj et al, 2004), and this implies that basic attention to food security and housing could help to mitigate suicide among IDUs. Indeed, structural interventions such as access to employment and housing have been known to reduce vulnerability to HIV infection (Dworkin et al, 2009; Aidala et al, 2005) and by doing this, we could not only improve the lives of IDUs and remove barriers to risk reduction but also use them as means to suicide prevention. Moreover, as we saw from our results, suicidal ideation was not only related to these economic pressures but also extended to other rights abuses such as verbal and physical violence, arrests for carrying needles and using drugs, and discriminations faced in health settings. We also found a dose response relationship between suicidal ideation and exposure to human rights abuses, with higher odds of suicidal ideation reported for higher levels of rights abuses. A recent systematic review also found that exposure to torture and other negative experiences are associated with higher rates of reported depression and PTSD among displaced populations (Steel et al, 2009). Perhaps, these experiences undermine confidence and self esteem, rob an IDU of hope and optimism, and thus may be associated with suicidal ideation. We believe that protection of basic human rights create conditions whereby an IDU can live without fear and neglect, and therefore experience more positive mental health, thus preventing demoralization and suicide.

The data for the study were carefully collected by project staff, and there were multiple layers of data review and quality assurance implemented to ensure that the results were accurate. However, the methodological challenges of studying IDUs in India should not be underestimated. The homelessness, frequent migration, and stigmatization among IDUs in the study setting necessitated a cross sectional design, thus we are limited in our ability to account for directionality of effects and we cannot definitively conclude that human rights abuses have caused suicidal ideation. Excluding women from our sample, even though they were very few in number, is a major limitation in that we could not get insight into the gendered dimension of human rights abuses and discrimination among women IDUs. Women drug users are often denied custody of their children (Nelson- Zlupko, 1995), are accused of endangering the fetuses (UNODC, 2004) of their children and may face severe restrictions in accessing drug treatment as these are often designed for men (Sarin and Selhore, 2008). We, therefore, recognize the future need to especially examine rights

violations among women drug users. In addition, the study design required us to rely on self-reports in the study, and we could not longitudinally track experiences of discrimination and suicide ideation. The survey methodology limited an in depth understanding of the contexts in which discriminations or rights abuses occurred. Future qualitative research can help in understanding much of the context. Questions about arrests and detention are also based on self reports and not validated by official documents, which were not available to the study team. There is also a need for more research on validation of human rights measures among IDUs. Given the novel nature of this study we had to rely on existing and adapted measures of human rights abuses previously used for other populations. Another limitation is that we did not measure depression among the sample. At the onset of this study we did not anticipate these very high rates of suicide ideation, and limits to the length of the survey instrument precluded inclusion of valid depression scale measures. Depression and suicidal ideation are highly correlated (Kosten & Rounsaville, 1988; Darke et al, 2004) in the IDU population, and in future research it would be interesting to see whether IDUs also have high levels of depression.

In conclusion, we found that the majority of IDUs in the study regularly experience civil rights abuses, and these abuses are significantly associated with suicide ideation. A large proportion also experience systematic social and economic human rights abuses. There is a dire and immediate need for the implementation of policies to reduce human rights abuses directed at IDUs as well as mental health interventions to address the potential for suicide. There also is a need for evidence-based treatment programs to address core issues of addiction, poverty, homelessness, and the lack of basic human needs among IDUs in India. India is a signatory to numerous international conventions promoting and protecting fundamental rights, and these rights are protected by the Indian constitution. Such policy safeguards, along with advocacy and social mobilization, have succeeded in bringing the rights of many marginalized citizens such as Dalits and women into the mainstream political discourse of India. However, sadly this study shows that IDUs have not been afforded similar advancements extended to other marginalized groups. Perhaps, due to the fact that IDUs' status and identity are derived from behaviors they are deemed unworthy of social acceptance and thus have their rights consistently abrogated. Their addiction, poverty, stigmatization, criminalization, and low social standing also limit their ability to advocate for themselves. We believe that a history of viewing addiction as a behavioral and personal moral problem has fostered the kinds of human rights abuses we have documented. A rights-based strategy for IDU interventions and drug policy is good both for those struggling with addiction, and for society as a whole.

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Table 1
Prevalence of key rights violations among Injecting drug users in Delhi (N=343)

MEASURES	IDU REPORTING YES (N/%)
Discrimination in health care setting	
Refused admission	132 (38.5)
Refused medical care	93 (27.1)
Refused pain medication	70 (20.4)
Refused needles	76 (22.2)
Refused buprenorphine substitution)	11 (3.2)
HIV/AIDS counseling, testing and treatment coverage and experience	
Tested for HIV only once	66 (19.2)
Pre test counseling not provided	5 (4.0)
Informed consent not given	
Test results not kept confidential	7 (5.6)
Eligible but not on antiretroviral treatment for HIV+ IDU	15 (11.9)
Lack of health information	
No information of VCTC	114 (33.3)
No information of drug treatment centres	121 (35.3)
No information of HIV/AIDS	159 (46.4)
No information of hepatitis C	291 (84.7)
Inadequate living conditions	
Forced to go without food and shelter due to drug use	147 (43.5)
Thrown out of job because of drug use	243 (71.9)
Arbitrary arrest	
Arrested for using drugs and/or carrying needles and syringes	291 (84.8)
Arrested more than 3 times	130 (37.9)
Locked up for using drugs	254 (74.5)
Imprisoned for drug related activities	205 (60.1)
Torture and other degrading treatment	
Threatened with violence	287 (83.7)
Insulted with derogatory words	327 (95.3)
Publicly humiliated (head tonsure, chained to tree, paraded naked)	189 (55.1)
Physically abused (beaten by hand/rod/stick; kicked, punched; stabbed; shot)	301 (87.8)
Social exclusion	
Not allowed to meet own children	67 (19.5)
Not allowed to meet family	89 (26.0)
Not invited to family celebration	106 (31.2)
Discouraged from community festival	110 (32.1)
Dignity violation	
Perception of being seen only as a drug user	312 (91.0)

MEASURES	IDU REPORTING YES (N/%)
Perception of being avoided or feared	306 (89.2)
Perception of invasion of personal space	313 (91.3)
Perception of being seen as less than human	309 (90.1)

Table 2
Odds ratio of suicidal ideation and cumulative human rights abuse among injecting drug users in Delhi (N=333)

Cumulative human rights abuse	IDUs with suicidal ideation (N/ %)	IDUs without suicidal ideation (N/ %)	Odd ratio	95% CI
High (8-12)	104 (82.5)	22 (17.5)	15.76***	6.57- 37.81
Medium (5-7)	75 (44.6)	93 (55.4)	2.69*	1.20- 6.01
Low (1-4) Reference group	9 (23.1)	30 (76.9)	1.00	

p<0.001,

**
p<0.01;

*
p<0.05

Sample size changes due to missing values