Women and Drug Abuse

The Problem in India

United Nations
International Drug
Control Programme
Regional Office for South Asia

Ministry of Social Justice
and Empowerment
Government of India

Cover painting courtesy Miss Upinder

This is an independent expression of an artist

"It is a depiction of glorified love while it is pure and pious, an aura of different hues that banish the blues of poison, compassion unfolds, links love to life. The supreme spirit (an incarnation of family) brings inexplicable bliss that keeps the evils at bay".

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Women and Drug Abuse: The Problem in India

National Survey on Extent, Pattern and Trends of Drug Abuse in India

Ministry of Social Justice and Empowerment, Government of India
&
United Nations International Drug Control Programme, Regional Office for South Asia

CONTENTS

FOREWORD

In order to generate more knowledge in the area of drug abuse, the Ministry of Social Justice and Empowerment and the United Nations International Drug Control Programme, Regional Office for South Asia commissioned a few thematic studies as part of their project, National Survey on Extent, Pattern and Trends of Drug Abuse in India. What has emerged from these studies are monographs, which attempt to analyse and disseminate data based on this research. One component of this project is a monograph entitled 'Women and Drug Abuse: The Problem in India'.

The monograph attempts to provide the reader an insight into issues pertaining to drug abuse by women on the one hand, and the burden felt by women as a result of drug abuse by someone in the family. It therefore deals with women affected and afflicted by drug abuse.

This study is certainly a stepping-stone towards generating meaningful data in future. I hope that these studies will raise more questions than they can answer, because the purpose of every study is not merely to provide answers to known questions but to begin a quest for more informative knowledge and understanding. I hope the monographs succeed in doing first that.

Jayati Chandra, IAS
Joint Secretary (SD)
Ministry of Social Justice and Empowerment

PROLOGUE

The drug menace touches millions of lives in both developed and developing countries. Its most negative impact is concentrated amongst the vulnerable and marginalized in societies. A major part of this vulnerable section comprises women afflicted and affected by drug abuse. On the one hand, these are women who are drug abusers and on the other, they are those who are burdened by drug abuse through intake by family members.

Cognizant of this fact and in line with its mandate, the United Nations International Drug Control Programme, Regional Office for South Asia (UNDCP, ROSA) and the Ministry of Social Justice & Empowerment have launched major initiatives in the area of drug demand reduction. One of these includes monographs on various thematic studies.

This monograph entitled 'Women and Drug Abuse: the Problem in India' highlights the various issues concerning drug abuse among women and burden on women due to drug abuse by family members. The aim is to make this data available to a wide section of people and provide understanding of the issues in drug use relating to women.

This monograph is an important step forward in the joint efforts of UNDCP, ROSA and the Ministry of Social Justice & Empowerment to generate knowledge on vital drug related issues in the region. It is hoped that this research will also provide reference points for assessing long-term change in years to come. We hope to undertake a number of specialized studies in the future, with greater depth of analysis, to serve as useful tools for decision makers in the region.

Renate Ehmer
Regional Representative
UNDCP, ROSA

PREFACE

Much of the information on abuse of drugs in India is anecdotal and the available reports are from small-scale surveys carried out in isolated areas of the country. Rational responses and national programme planning require accurate data collected through painstaking research from many parts of the nation. In 1999, the Ministry of Social Justice and Empowerment, Government of India and the United Nations International Drug Control Programme, Regional Office for South Asia decided to undertake a large-scale national survey to obtain information on extent, pattern and magnitude of drug abuse in the country. For this purpose multiple indicators and several methods to assess the situation were chosen.

The major components of this study are National Household Survey of Drug and Alcohol Abuse (NHS), Drug Abuse Monitoring System(DAMS) and Rapid Assessment Survey (RAS). Additionally, special studies on populations like women, rural subjects, people living in border towns and prison population have also been carried out.

The data on drug abuse among women in India is scanty, though it is widely believed that this phenomenon is not non-existent. The current monograph extracts information from the special focussed thematic study titled 'Drug Abuse among Women in India' and the data pertaining to women drug abusers from the component RAS to provide a glimpse of pattern and dynamics of drug abuse by women. Women, even if they are non-users themselves, perceive the adverse impact of drug abuse in the family. The second focussed thematic study titled 'Burden on Women due to Drug Abuse by Family Members' examines just this and describes the various 'burdens' of having a drug user in the family.Thus, the monograph presents a composite picture of drug abuse as it affects women. However, a degree of caution is required in interpreting the data. As the sample interviewed in all the three studies is non-random and small, the information should not be generalised for women and drug abuse in India. Despite these shortcomings, the information in the monograph enriches the National Survey.

The report is the collective effort of several persons who designed, executed and analysed the data obtained by a multitude of field research staff. The effort has been enormous and it is no mean achievement. It is hoped that the monograph would provide sufficient scientific leads to plan a larger study on Drug Abuse among Indian Women.

It is expected that the detailed information in this monograph will aid policy makers frame responses and strategies for interventions.

Rajat Ray
Scientific Editor

ACKNOWLEDGEMENTS

The UNDCP, Regional Office for South Asia (ROSA) and the Ministry of Social Justice and Empowerment, Government of India, gratefully acknowledge the contributions of the research team, and the site investigators who participated in these studies.

Dr. Pratima Murthy is the principal author of the monograph. The 'Rapid Assessment Survey' was coordinated by Dr. M.Suresh Kumar and was carried at 14 sites by the following site investigators: Ms. Mukta Sharma (Amritsar, SHARAN), Mr. Mahesh Nathan (Jamshedpur, Calcutta Samaritans), Mr. Sundar Daniel (Shillong and Jowai, North East India Drugs and AIDS Care), Mr. C.G.Chandra (Dimapur, Vivekananda Society), Fr. Joe Arimpoor (Hyderabad, SAHAI Trust), Dr. Pratima Murthy (Bangalore, National Institute of Mental Health and Neuro Sciences), Dr. V.S.Mani (Thiruvananthapuram, SAHAI Trust), Dr. D.R.Singh (Goa, Tata Institute of Social Sciences), Mr. Gabriel Britto (Ahmedabad, National Addiction Research Centre), Mr. Jimmy Dorabjee (Delhi, SHARAN), Mr. Hijam Dineswar Singh (Imphal, The Kripa Society), Dr. Samiran Panda (Kolkata, RIICE, Society for Applied Studies), Dr. M.Suresh Kumar (Chennai, SAHAI Trust), Mr. Eldred Tellis (Mumbai, Sankalp Rehabilitation Trust). We gratefully acknowledge the support given by UNESCO in sponsoring the study at the following 5 sites: Delhi, Imphal, Chennai, Mumbai and Kolkata.

The focussed thematic study 'Drug Abuse among Women in India' was co-ordinated by Ms. Shobha Lal Kapoor (Mukti Sadan Foundation, Mumbai) and was carried out at three sites by the following investigators: Mr. Vijayan Pavamani (The Calcutta Samaritans, Aizawl), Ms. Shobha Lal Kapoor (Mukti Sadan Foundation, Mumbai) and Dr. Sunil Mittal (Caring Foundation, New Delhi). We gratefully acknowledge their contribution.

The focussed thematic study 'Burden on Women due to Drug Abuse by Family Members' was co-ordinated by Dr. Mala Kapur Shankerdass (Development Welfare and Research Foundation, New Delhi) and was carried out at eight sites by the following investigators: Dr. Shanti Ranganathan (TT Ranganathan Clinical Research Foundation, Chennai), Dr. Vivek Benegal, (National Institute of Mental Health and Neuro Sciences, Bangalore), Dr. Sunil Mittal (Caring Foundation, New Delhi, Sites: Solan & Shimla, and Chandigarh), Dr. Mala Kapur Shankerdass (Development Welfare and Research Foundation, New Delhi), Mr. U. Nabakishore Singh (Centre for Social Development, Imphal) and Dr. Anil Awachat (Muktangan Mitra, Pune).

Individual site reports are available and this monograph is a compilation of the report of the various components and account prepared by the individual site investigators.

We acknowledge Mukti Sadan foundation for providing photographs for this document.

National Survey on Extent, Pattern and Trends of Drug Abuse in India (AD/IND/99/D-83)

Project Team:
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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CSW	Commercial Sex Worker
DAMS	Drug Abuse Monitoring System
HIV	Human Immunodeficiency Virus
KI	Key Informant
IDU	Injecting Drug Use
NGO	Non Governmental Organization
RAS	Rapid Assessment Survey
STD	Sexually Transmitted Disease

EXECUTIVE SUMMARY

This monograph provides a keyhole into the world of women affected by drug use from three major perspectives- from the micro perspective of having a drug user in her family and that of being a drug user herself and from the larger perspective of being female in the Indian socio-cultural context.

In India, even though the problem of drug abuse and women is being increasingly recognised, this phenomenon and related problems have not historically been visible in official statistics or studies. This monograph then, is a preliminary step towards understanding the complex issue of women and substance abuse. It provides a keyhole into the world of women affected by drug use from three major perspectives – from the micro perspective of having a drug user in her family and that of being a drug user herself and from the larger perspective of being female in the Indian socio-cultural context.

Data for this monograph is taken from the existing literature on the subject of drug abuse and women in India, analyses of gender relations in the country and from three commissioned studies. These are a part of the project 'National Survey on Extent, Pattern and Trends of Drug Abuse in India' supported by the Ministry of Social Justice and Empowerment (Ministry), Government of India, and the United Nations International Drug Control Programme, Regional Office for South Asia (UNDCP, ROSA).

Findings of Studies

The first study, entitled 'Burden on Women due to Drug Abuse by Family Members' found that the major burden on women living with drug using family members was the economic costs of addiction. However, women are also subject to gendered, social pressures including the burden of blame for drug use in the family and thus, despite handling many drug related burdens – financial, emotional and physical, many respondents remained isolated without social support. Almost half the women in the sample had experienced physical and verbal abuse at the hands of the drug user but most women were afraid of approaching the police for fear of getting the drug user into trouble with the law. Despite significant psychological distress then, many women never received any treatment even as they advised their drug using family members to get help and accompanied them to a treatment centre.

The second set of studies looked at drug use among women. Data was primarily drawn from the study 'Substance Abuse among Women' and the 'Rapid Assessment Survey (RAS)', along with other sources. The RAS found that a majority of female respondents are single, educated, employed and report the early onset of drug use as well as high levels of drug use in their families. The women in the study also reported unsafe practices such as early initiation into sex and the sharing of needles and syringes among IDUs.

The 'Substance Abuse among Women' study corroborates the RAS's demographic findings. Its respondents, from Mumbai, Delhi and Aizawal, were also mainly young and employed. It also confirmed that heroin and pharmaceuticals are among the predominant drugs used by women. While there are important regional and population variations especially in terms of family support for managing addiction, it is clear that while female drug users from peripheral populations (commercial sex workers) are in contact with treatment services, a significant number of

others are neither aware of services, nor have sought any treatment. Positively however, many women drug users did report strong religious beliefs and a spiritual inclination that has been successfully incorporated into treatment.

Emerging Trends

In terms of substance abuse among women, it appears epidemiologically that the 1990s witnessed an increase in the use of opiates, especially heroin, among women in different cities. In general, it can be argued that role transition, lifestyle changes, specific vulnerabilities and social disadvantage all increase the risk of drug use among women. The growing financial independence of women has brought with it changing lifestyles as well as additional tensions where women become the sole economic provider for the family. Peer pressure, a need for excitement, and stress also appear to operate as initiators into drug use.

These factors interact in a complex manner and together increase the risk of drug abuse through a multiplier effect. The drug using woman is perceived as deviant and is thus stigmatised and socially isolated. This in turn increases and compounds social disadvantage. Involvement in criminal activity and commercial sexual activity as a means of enhancing income to support drug use is an expected outcome and, as such, perpetuate the vicious cycle of social marginalisation and drug use.

Research shows that women, both those using drugs and those not, are increasingly being involved in the drug distribution network. Dire economic conditions and the lure of money often lead women to become involved with drug couriering and peddling. The usual profile of a drug courier is a woman of childbearing age, single or married with children, unemployed, a trader or menial worker and financially impoverished. Another reason for drug peddling, especially among drug users, is that it is a supplementary or exclusive source of income for procuring drugs where women are drug users themselves.

Future Directions

The last decade has seen some significant initiatives (though few in number) addressing the burden of care for women with drug abusing family members, as well as some initial initiatives for women drug users and those involved in drug trade. Some of the path-breaking initiatives to reduce the burden of drug abuse in the family have actually been achieved through self-help groups. Programmes for alternative livelihood have also been set up.

However, many groups of stakeholders recommend the need for a focused policy and concerted national and regional action to address gender aspects of the drug abuse problem, from both perceived 'burden' and 'drug use' perspectives.

There is also a need for a shift from a purely individual, single-cause linear model to a multi-cause interactive model in understanding addiction. Drug abuse and its effects on women needs to be understood in the context of gender as a process and an institution. Thus, all treatment modalities that serve women, and those that cater to women burdened by drug abuse in the family, must be sensitive to needs such as counselling, family therapy, ancillary services such as transportation, child-care, housing, legal assistance and job or vocational training. They must be sensitive to diverse cultural needs. Alternative facilities such as separate women's treatment programmes, acceptance of children in treatment programmes, attention to pregnant drug users, and economic rehabilitation issues need to be addressed as well.

There is a need for a shift from a purely individual, single-cause linear model to a multi-cause interactive model in understanding addiction. Drug abuse and its effects on women need to be understood in the context of gender as a process and an institution.

1

Introduction

Women, who traditionally appeared to have some kind of immunity to drug abuse, at least in terms of 'social inoculation', are now recognised as also being susceptible to drug use and its related problems.

Over the last two decades, the use of illegal drugs has spread to practically every part of the globe. No nation remains immune to the devastating problems caused by drug abuse. Perhaps the biggest problem is that it makes its deepest impression on those most vulnerable. Women, who traditionally appeared to have some kind of immunity to drug abuse, at least in terms of 'social inoculation', are now recognised as also being susceptible to drug use and its related problems.

Women can be seen as being involved with drugs from three perspectives (World Health Organization, 1997):

- Women non-drug users with drug abusing families or partners.
- Women who themselves consume drugs.
- Women who are involved in the production and/or distribution of drugs.

Impact on Women of Drug Use in the Family

Drug abuse poses various problems impacting not just the individual user, but also his or her family and community. The adverse impact of drug use on families is tremendous. It is the family to, or on which, the dependent user turns during crises of many kinds. Relationships suffer, financial sources are depleted, and health costs increase. There are greater employment problems and increased emotional stress. The consequences of drug abuse are often more severe for families in precarious or poverty-stricken circumstances. There is also a serious risk of transmission of HIV, STD and other blood borne viruses to partners of infected drug users. Drug use is often associated with domestic violence, which in turn aggravates the physical and emotional distress of the family. Common family responses include depression, stress and resentment. The non drug using partner may also take to drugs or alcohol for solace (UNODCCP, 2000, Shankardass, 1998).

Within the family, it is often the woman, in the role of wife or mother, who is most affected by an individual's drug use and has to bear a significant part of the burden on the family. This impact is even more pronounced in a developing country like India, where women already face social disadvantages. This aspect of the burden of drug use on women in India has received scant attention.

Drug Abuse among Women

Like many other societies, India is undergoing transition. Changing roles, increased stress and alterations in lifestyle bring with them newer problems, including drug abuse. Although the problem of drug abuse among women is being increasingly recognised, this phenomenon and related problems do not usually show up in official drug statistics. This is partly due to the limited number of women drug users and the largely subordinate position of women users in the drug subculture. However, women are likely to suffer greater consequences than men due to drug abuse.

Drug using women are likely to be more stigmatised than their male counterparts because their activities are regarded by society as 'double deviance' – as deviance from both

accepted social codes of behaviour and from traditional expectations of the roles of wife, mother and family nurturer (Fagan, 1994).

Women's Involvement in Drug Production and Distribution

While the 'big business' of illicit trafficking is a male-dominated activity in its upper echelons, women are frequently involved in cultivation, processing and drug dealing. A study of New York City cocaine markets in the late 1980s confirmed female involvement at the retail level as part of a diversified income strategy, which included legitimate activities and consensual crimes such as prostitution (Fagan, 1994). Poverty and intimidation are known to drive women into becoming drug couriers.

Women and Drug Abuse: the Problem in India

The relevance of a gender focus has been emphasised both in the *World Drug Report* (United Nations International Drug Control Programme, 1997) and the *South Asia Drug Demand Reduction Report* (UNDCP, ROSA, 1998). Drug use raises very distinct issues for women, from both the socio-cultural and physiological perspectives. In particular, the rising number of wives/partners of HIV positive drug abusers who have contracted the virus has drawn the attention of the international and national communities to gender issues in relation to interventions in the area of drug abuse.

Gender issues have largely been inadequately addressed in drug abuse research. In the South Asian sub-region, drug abuse among women has been even more poorly researched than in other parts of the world (UNDCP, ROSA, 1998). This is because the traditional estimates of drug abuse among women have been low, and it has simply been presumed that research findings applicable to men can be extrapolated to women drug users as well. This is clearly not the case.

This monograph attempts to provide a keyhole view into the world of women affected by drugs from two major perspectives – from the perspective of having a drug user in her family and from the perspective of being a drug user herself. It draws from three recent research initiatives undertaken by the Ministry of Social Justice and Empowerment (Ministry), Government of India, and the United Nations International Drug Control Programme, Regional Office for South Asia (UNDCP, ROSA).

As part of the project titled 'National Survey on Extent, Pattern and Trends of Drug Abuse in India', the UNDCP and the Ministry commissioned two focussed thematic studies that examined the issue of women and drug use in India from the two dimensions mentioned above:

- Burden on Women due to Drug Abuse by Family Members (referred to as the Burden Study), co-ordinated by Mala Kapur Shankardass (2002).
- Substance Abuse among Women (referred to as the Women's Study), co-ordinated by Shoba Lal Kapoor (2002).

Data on drug abuse on women is also available from the RAS, which was carried out in fourteen sites under two broad groups – one co-ordinated by Suresh Kumar (2002), and the other by Luke Samson and Jimmy Dorabjee (2001). This study throws an important light on women and substance use, especially in affording a comparison to male drug use.

This monograph presents a comprehensive view of the various dimensions of drug abuse among Indian women in the context of findings from these three studies. It draws attention to several important issues pertaining both to drug use among women and its antecedents and consequences from a gender perspective. However, it is neither an exhaustive compendium nor a comprehensive critique on research in this area, nor does it address in detail the larger and complicated issue of gender inequality and its implications for the drug abusing woman. This monograph is only a preliminary step towards understanding the complex and dynamic issues regarding women and drugs, and relevant issues in treatment, support and prevention of drug related problems among women. It is important to bear in mind that all three studies mentioned above were focussed surveys on the specific problems of women and drug abuse, for which respondents were selected through a process of purposive sampling. The study findings, therefore, are not generalisable for the country as a whole. The studies give us an important first glimpse into the problems women face vis-à-vis drug abuse.

This monograph presents a comprehensive view of the various dimensions of drug abuse among Indian women in the context of findings from three studies.

2

The Status of Women in India

A report commissioned by the United Nations raises several issues concerning the current status of women in India.

The problem of drug use and addiction among women cannot be separated from other aspects of their social existence and conditioning. The social and economic status of women directly impinges on their freedom in real terms. Their status is therefore of great relevance in cases of substance abuse by women themselves, and even more so where women suffer the consequences of such abuse by members of their family.

Women in India: How Free? How Equal?

India ranks 115 in the Human Development Index of 2001 (UNDP, 2001). The country has made considerable progress since independence; economic reform and liberalization measures over the 1990s have led to strong economic growth, increased exports and reduced inflation. Overall life expectancy is 62.9 years, and projections for 2000-2005 suggest that life expectancy of males and females will be 63.6 years and 64.9 years respectively (United Nations Population Division, 2000). According to the 2001 Census, overall literacy has increased to 65.38 percent (Census of India, 2001).

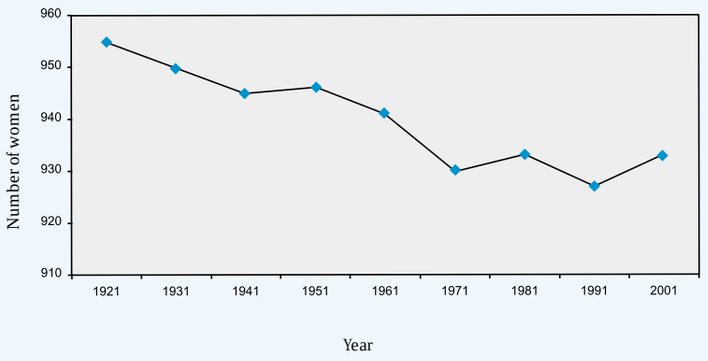
What does this mean for the country's women?

A report commissioned by the United Nations Resident Co-ordinator in India (Menon-Sen and Shivakumar, 2001) titled 'Women in India: How Free? How Equal?' raises several disturbing issues concerning the current status of women in India. The study's main findings are outlined below. Data from the Census of India 2001 and the Human Development Report 2001 also corroborate some of the study's observations.

These include:

- Although the absolute number of females has grown 21.79 percent in the last decade, the male-female ratio is still lower than it was 100 years ago. In societies where men and women are treated equally, women tend to outlive and outnumber men. Typically, one would expect to find 103-

Figure 1. Census of India: 1921-2001



105 women for every 100 men. The 2001 Census (Figure 1) reveals an adverse ratio of 93 women for every 100 men. With the exception of Kerala, every state has fewer women than men. India, in the words of Amartya Sen, has to account for some 25 million 'missing women'.

- The Indian girl child is disadvantaged right from birth. The sex ratio for girl children between the age of 0 and 6 years is 927, strengthening the fear that some girl children are never born or have no opportunity to survive.
- Only 54 percent of women are literate as compared to 76 percent of men.
- More than 36 percent of the population lives below the poverty line. Many of them are women.
- There are far fewer women in the paid workforce than there are men.
- In some states such as West Bengal, Orissa, Bihar, Assam and Arunachal Pradesh, between 63 and 85 percent of married women suffer from anaemia (IIPS, 2000 and ORC Macro 2000).
- The average Indian woman bears her first child before she is 22 years and has little control over her own fertility and reproductive health.
- In 1998 – 1999, only 48 percent of married women in the reproductive age group used any form of contraception (World Population Monitoring, 2000). This figure is much lower (30%) in poorer states like Uttar Pradesh and Bihar.
- For many women, abortion is the only method of contraception available.
- More than 570 women die per 100,000 births (World Population Monitoring, 2000), 70 percent due to totally avoidable reasons.
- Women are under-represented in governance and decision-making positions.
- Most women do not have any autonomy in decision making in their personal lives.
- In Madhya Pradesh and Rajasthan, less than 50 percent of women have access to money in the household (IIPS and ORC Macro, 2000).
- Women face violence inside and outside their family, as well as at the workplace.

Police records for the country as a whole show that a woman is molested every 26 minutes. A rape occurs every 34 minutes. Every 42 minutes, an incident of sexual harassment takes place. A woman is kidnapped every 43 minutes. And every 93 minutes, a woman is killed.

The impact of drug use on women, both directly and indirectly, needs to be understood within the context of these realities.

The impact of drug use on women, both directly and indirectly, needs to be understood within the context of these realities.

3

Impact on Women due to Drug Abuse in the Family

The repercussions of drug use on the family are tremendous. Within the family, it is women, the mother and/or the wife, who suffer the greatest and most direct impact of drug use by a family member.

Drug abuse wreaks serious damage to individual lives and thus the very fabric of society. It also inflicts a heavy social and economic cost on nations. No country, especially in South Asia, can afford to bear the social cost of this 'menace' (UNDCP, ROSA, 1998). Specific health, social and economic consequences vary, depending upon the segment of the affected population. For instance, disadvantaged populations like those living in urban slums and migrants from rural areas are likely to face more severe consequences.

Costs of Drug Abuse to Families

Visible Costs

- Drainage of personal and household resources
- Loss in income due to reduced productivity, disability or incarceration
- Costs of treatment

Intangible Costs

- Emotional distress
- Domestic violence
- Health problems
- Family disruption
- Child neglect

Economic Costs of Drug Abuse

There are tremendous economic costs associated with drugs. Benegal et al. (2000) have estimated costs associated with alcohol abuse, and similar assessments on the use of drugs have been done. For example, on average, drug abusers spend about Rs 500 (US $11) per week on drugs. A study in Delhi estimated that a user spends between Rs 35 and Rs 95 a day on the substance of choice (Prashanth, 1993). Dependence also has an impact on an addict's employment, and leads to losses due to missed work. These costs naturally erode the net earnings of the household and thus adversely impact living conditions and, often, subsistence.

Social and Psychological Impact on the Family

While the family situation is sometimes held responsible for perpetuating drug use (Machado, 1994), the repercussions on the family are tremendous. Within the family, it is women, the mother and/or the wife, who suffer the greatest and most direct impact of drug use by a family member.

Families may initially tolerate the use of socially and culturally accepted intoxicants by its members, but frown on addiction (Nahar, 1994, Sharma et. al., 1995). With progression of the abuse, a common response is to shield the drug user from the consequences, at the cost of great distress to family members. This response may be due to cultural and social constraints, the family's own understanding of drug addiction, the addict's behaviour, relationship problems, as well as the economic burden faced by the family.

Domestic Violence

A report of UNDCP (1994) on women and drug abuse focused attention on the alarming

'That Helpless Feeling'

Parents or relatives of drug addicts compound the problem by hiding the fact that one of their kin has fallen prey. There is a sense of acute embarrassment, shame and even guilt that a member of their family has gone 'astray'. Usually, no mention is made to friends or others till the situation has gone completely out of hand. Society is also responsible for such a defensive reaction. As a parent of a drug addict told me: "Rather than being judgemental, what we wanted from our circle of friends was sympathy and the message that they were there to help. We rarely got it and we felt totally isolated."

(Chengappa, 1998, in SASSRR, page 87)

indirect consequences of drug abuse, including domestic violence, on women. This correlation is now well recognised. The association between domestic violence and drug use is well known. A study from South America found that 97 percent of domestic violence involved an intoxicated male (Hsu, 1992). Eighty-seven percent of addicts being treated in a de-addiction centre run by police in Delhi reported having been violent with family members (Shankardass, 1998).

Marital Discord

Marital discord and family breakdown are some other serious consequences of drug and alcohol abuse. Enhanced economic burden, domestic violence, shifts in roles and responsibilities, and socially unacceptable behaviour such as extra-marital relationships, all lead to disharmony within the family. Death of the user or separation, especially within impoverished families, can force dependants and family members into various kinds of exploitative situations. In extreme cases, this includes children taking to the streets, and women getting involved in the sex trade.

Drug Addict held for Stabbing Wife

Narender Singh, 38, stabbed his wife Kamlesh to death because she refused to give him money for smack. They had been married for 20 years and had 2 sons, Manish, 18, and Sumit, 14. Kamlesh worked as a domestic helper and Narender lived off her earnings. On Dec 31, he asked her for money for smack and when she refused, he caught her by the hair and stabbed her three times on her neck with a *rapi* (leather cutting instrument). They live in Swatantra Nagar in Narela Industrial Area of northwest Delhi. Narender was arrested on the charge of murder.
- Excerpted from *The Hindu*, 2 January, 2001

Health Problems

The additional stress of coping with drug abuse within the family may produce physical and psychological distress and trigger drug or alcohol use in the woman. Some women may engage in prostitution to support their partner's drug habit, and are thus at risk of contracting sexually transmitted diseases, including HIV. Women in developing countries may be further disadvantaged by lacking access to information and education about drug and sex related diseases. The inability to negotiate safe sex is also an important affiliated risk. For women the risk of HIV infection during unprotected sex is 2 to 4 times to that of men. Globally women now account for 43 percent of total estimated population living with AIDS. In India there is evidence to suggest that the rates of infection in women are increasing since the mid-1990s (UNAIDS, 2000). Agarwal and his colleagues in their study (1999) from Manipur reported that the HIV prevalence among injecting drug using commercial sex workers (CSW) was 9.4 times higher than that of non IDU CSWs.

Enhanced economic burden, domestic violence, shifts in roles and responsibilities, and socially unacceptable behaviour all lead to disharmony within the family.

4

Burden on Women due to Drug Abuse by Family Members: 'The Burden Study'

The specific burden on non-drug using women on account of drug use by a family member has not been adequately addressed. A focussed thematic study titled 'Burden on Women due to Drug Abuse by Family Members' sought to address this lacuna.

While the burden on families has begun to come into focus since the 1990s, the specific burden on non drug using women on account of drug use by a family member has not been adequately addressed. A focussed thematic study titled 'Burden on Women due to Drug Abuse by Family Members' sought to address this lacuna in the Indian context. The perceptions of key informants, as well as of affected women themselves, on the social, familial, economic, health and psychological consequences in such circumstances were documented. The study was exploratory and qualitative in nature, and covered 8 cities across the country.

Study details

City	Number of respondents
Bangalore	27
Chennai	24
Delhi	23
Chandigrah	21
Solan & Shimla	20
Imphal	20
Pune	20
Thiruvananthapuram	24
Total	179

Key Informant Interviews

One hundred and forty-three key informants (KIs) – 83 women and 60 men – were selected. KIs included staff and heads of NGOs, social workers, doctors (including psychiatrists), government officials, police, media specialists, academics and lawyers. Across all sites, drug use was considered to be a predominantly male phenomenon. Most KIs perceived an increase in drug abuse among males, which they attributed to increased availability and accessibility, reduced legal controls, transition from culturally sanctioned to recreational use, peer pressure, poor living conditions, lack of alternate recreation, unemployment and poverty. All the KIs felt that although there were few women users, their problems were not well appreciated.

With regard to the impact of male drug abuse on women, there was an almost unequivocal opinion that the greatest burden was economic, followed by stigmatisation, emotional and relationship difficulties, and neglect of children. Domestic violence, crime, increased trafficking were recognised as possible outcomes of individual drug use. KIs felt it was likely that children in drug abusing families would be neglected and more prone to child labour or delinquency. While the KIs in Pune were primarily concerned about the loss of security for the family, additional concerns in Imphal and Chennai included the increased risk of women having to compromise their dignity and resort to prostitution, increased risks of HIV and drug peddling. All KIs felt that women were the most important treatment motivators of drug abusers, but they tended to ignore their own needs and problems.

Most KIs, even in the larger cities, felt that treatment facilities were inadequate, overcrowded or too expensive.

Self-Perception of Burden Among Women in Drug Using Families

Interviews were carried out with 179 women between the ages of 18 years and 60 years, living with a current regular drug user (daily or near daily use of drugs other than only alcohol and tobacco). None of the women themselves were current regular drug or alcohol users. Only one respondent was interviewed for every drug abuser. The women were interviewed primarily in treatment centres or at home. In Imphal, all the respondents were interviewed in their homes.

The primary data, stemming from in-depth interviews with women respondents, was complemented by secondary data collated through various reports, documents, government and international publications, published research findings, personal communications, police, hospital and treatment centre records.

Drug Using Family Member: A Brief Profile

The drug abusers in the families of these women were all male, with more than two-thirds being between the productive ages of 16 years and 35 years. A large number (55%) had a history of drug abuse since their teens, and 67 percent had been using drugs for more than five years. Although the majority were polydrug abusers, the primary drugs of abuse were heroin (40.8%), cannabis (38.5%) and alcohol (36.3%). There were signific ant regional variations, with a higher number of respondents from Bangalore, Thiruvananthapuram and Solan and Shimla reporting current cannabis use in 17/27,16/24 and 12/20 cases respectively. A large number from Imphal reported use of propoxyphene (8/20). Hardly any of the family members were reported to have used opium. Minor tranquilliser abuse was concurrently reported in 13 of the respondents' drug using family members from Bangalore. While a small number reportedly used cough syrups, only one family member was reportedly using inhalants and four amphetamines (all from Imphal).

Key Informants' Perceptions

Drug Use

- Drug abuse on the increase among males
- Women users are few, but not adequately recognised

Burden on Women

- Economic
- Stigma
- Emotional difficulties
- Interpersonal difficulties
- Neglect of children
- Loss of security
- Compromised dignity
- Violence and crime
- Health risks (including HIV)

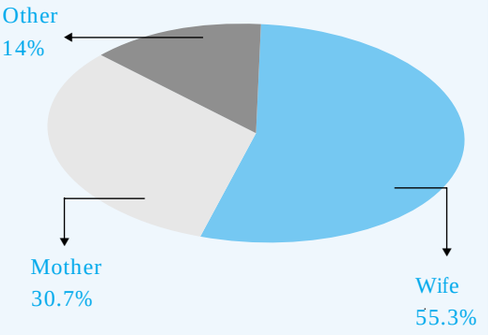
Profile of Respondents

Most of the women (60.3%) were between 20 and 40 years of age. The vast majority were Hindu (67%), while 14.5 percent were Christian and 13.9 percent Muslim. Imphal was an exception, with a greater proportion (45%) of Christian respondents. While about a fifth were illiterate, 60 percent had only studied up to matriculation and 16.9 percent had completed their graduation. A majority of the women were married (84.4%), and very few had been divorced or separated (2.8 %) Most of the respondents (68.5%) lived in nuclear families.

Relationship of Respondent to Drug Abuser

The majority of the women in the study were wives or mothers of the user. A small number were living with drug using brothers or brothers in law (Figure 2).

Figure 2. Relationship of Respondent to Drug User



Interviews were carried out with 179 women between the ages of 18 and 60, living with a current regular drug user

A sizable proportion of the drug users were unemployed. Unemployment or diversion of money for drugs created a huge economic burden, especially in families with low incomes.

Economic and Working Status of Respondents

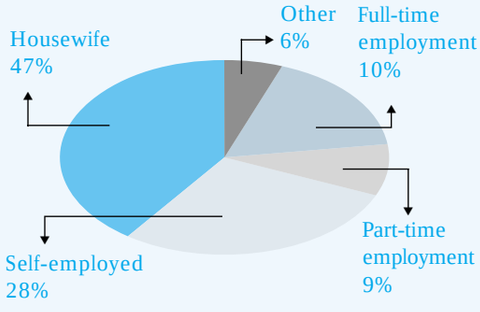
A small number of respondents had a family income of less than Rs 1000 and in Bangalore, Chennai, Pune and Imphal, 43 percent had monthly incomes ranging between Rs 1000 and Rs 5000 (Table 1).

Table 1. Self-Declared Monthly Family Income

Income level	*Percentage of Respondents*
Less than Rs 1000	9.1
Rs 1000 – 5000	43.2
Rs 5000 – 10,000	31.2
Rs 10,000 – 15,000	10.8
> Rs 15,000	5.7

Many of the respondents were housewives. Twenty-eight percent were self-employed, with respondents in Solan and Shimla primarily involved in agricultural occupations and the majority in Imphal being service providers (Figure 3).

Figure 3. Working Status of Respondents



Seventy-four out of 179 abusers were currently under treatment and 86 had received some form of treatment in the past.

Economic Concerns

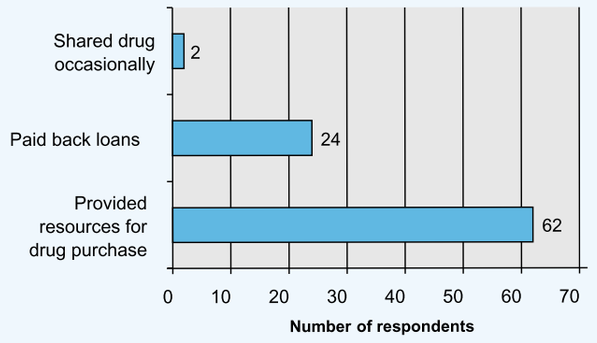
A sizable proportion of the drug users were unemployed (39.1%). In the Delhi site, 73.9 percent of drug using family members were reportedly unemployed, and the corresponding figure for Pune was 40 percent. While a majority of those employed spent a sizable proportion of their income — between 42% (Thiruvananthapuram) and 85% (Bangalore) — on procuring drugs, 58 percent of users in Thiruvananthapuram depended on their families to support their drug habit. Unemployment or diversion of money for drugs created a huge economic burden, especially in families with low incomes.

Profile of the drug users

- Mostly in the productive age-group
- More than 55% initiated drug use between 10–20 years of age
- 67% had been using drugs regularly for more than 5 years
- 44% took financial support from family for their drug habit
- Current drug used was primarily heroin
- Other common drugs concomitantly used were cannabis and alcohol

Many of the respondents (62) were forced to part with money or goods to the drug user (Figure 4). Respondents usually gave money because of coercion, or because they could not tolerate the drug user's condition during withdrawal. Ironically, some of the women did not know on what the money would be spent. Twenty-four had paid back loans taken by the user. Only two women reported that they themselves occasionally used drugs with the user.

Figure 4. Contribution of Women to Drug Use



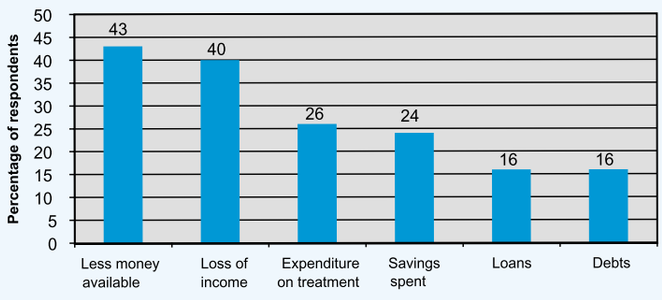
Although many of the women were working to run the household, a considerable number were forced to part with a large part of their earnings to support the drug user's habit. Some women kept some money aside, without letting the spouse know about it. However, if the husband/son came to know of this, it would

lead to arguments as well as domestic violence, leading to further distress. The resulting desperation of women caught in such situations is reflected in the statement of an HIV-positive woman from Imphal: *I feel like committing suicide when I come home and find that the little money I have saved and hidden for my daughters has been stolen by my husband. He doesn't care even a bit for them. What will happen when both of us die soon?*

Financial Loss

Respondents, depending on their resources, felt the financial burden of drug use differently. Perceived burden is summarized in Figure 5.

Figure 5. Perceived Financial Burden Due to Family Member's Drug Use



Expenditure on treatment was a significant expense, with respondents reporting having paid anywhere between Rs 1500, at a government facility in Thiruvananthapuram, to more than Rs 16,000 at a private treatment centre in Chennai.

Social Burden

One of the major burdens the women faced was the burden of blame – blame for the drug use in the family member, blame for hiding the issue from others, and blame for not getting timely treatment. Thus, the woman often became the victim of not just the drug abuser, but also society.

With regard to social impact within the family, a considerable number of respondents felt that drug abuse had caused a disruption in their family routine, leisure time activities and celebrations (Table 2).

Table 2. Impact of Drug Abuse on Family Relationships and Activities

Item	*Percentage of Respondents*
Impaired communication	62.6
Family leisure disturbed	51.0
Disturbance in family celebrations	49.0
Feeling of stigmatisation	44.0
Disrupted family routine	43.6
Less time spent together	42.5
Avoidance of interaction and communication with family members	41.9
Reduced sharing of feelings with family members	40.8

Sexual Relationships and High-Risk Sexual Behaviour

Sixty-four respondents reported dissatisfaction in sexual relationships with their drug abusing partner. Some women reported that their husbands had lost interest in sex. Only a minority reported sexual violence (3.9%).

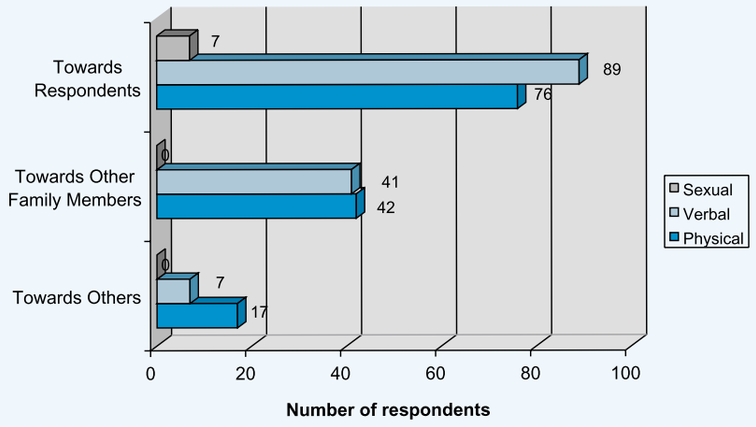
Domestic Violence

Violence within marital relationships, even independent of drug abuse, is known. It is unfortunately often accepted as a normal part of marriage, in yet another glaring example of gender inequity and human right violations (Menon-Sen and Kumar, 2001). Drug abuse magnifies this phenomenon. The victim in drug using families also sometimes rationalizes violence as an expression of guilt of the drug user, because he is unable to perform his role in the family. Most domestic violence reported in the study was directed at the women respondents, and took place in the context of demands for money to sustain the habit. To prevent further violence, the woman usually conceded and

One of the major burdens the women faced was the burden of blame - blame for the drug use in the family member, blame for hiding the issue from others, and blame for not getting timely treatment.

Most domestic violence reported in the study resulted from demands for money. Almost half the women had experienced physical and verbal abuse from the drug user.

Figure 6. Domestic Violence Due to Drug Use



provided the money. Far from ending the conflict, thus began a vicious cycle of violence as an effective mode of extracting money.

Almost half the women had experienced physical and verbal abuse from the drug user. Physical abuse ranged from 'slaps', being 'pushed around, punched and kicked', to being 'hit against the wall'. This sometimes resulted in bruises, broken noses, and other serious injuries. Sexual assault included dominating sexual behaviour by drug using partners, sexual deprivation and being bullied into having sex. Verbal abuse included intimidation and constant humiliation, often in front of other family members and outsiders.

Most respondents suffered the abuse silently, responding with humiliation, frustration, helplessness and suicidal thoughts. Some had learnt to avoid any confrontational situation that would perpetuate the violence. Only a few respondents from Chandigarh reported that they had retaliated when such cruelty was inflicted on them. All of them were mothers who often beat up their sons when the latter demanded money for drugs or were seen consuming drugs.

Very few women approached the police for help either during the user's intoxication or for support to take the drug user for treatment (only 8.5% reported doing the latter). In Imphal, two women had approached the local insurgent outfit for help with their drug abusing relative. Most women were afraid of approaching the police for fear of getting the drug user into trouble with the law. (The Narcotics and Psychotropic Substances Act 1985 prescribes stringent punishments for drug possession, of even small quantities for personal consumption.)

Effect on Role Function

Many of the respondents felt they had not been able to perform optimally in their role as housewife (53%) as well as at work (42%) because of their family member's drug use. Half the respondents felt their children had been neglected on account of drug abuse. A small number (11%) recognised serious emotional problems in children.

Common Health and Emotional Problems

- Weight loss
- Insomnia
- Aches and pains
- Anxiety
- Depression
- Guilt
- Irritability
- Suicidal thoughts

Emotional and Health Problems among respondents

Drug abuse and its social consequences commonly led to feelings of guilt, shame, embarrassment, anxiety (55%), depression (43%) and frequent suicidal thoughts (35%) in the victims. Shame and embarrassment caused many a woman to build a 'wall of silence' around her, thus increasing her isolation and helplessness in the situation. Many of the respondents preferred to remain socially isolated because of the fear that the stigma of drug use in the family would jeopardize their chances of finding marriage matches for their children.

Since the bulk of respondents were in

nuclear families, the women were often alone in their misery. Some of them also reported the lack of support from their families of origin. When a wife went to her parent's place, unable to bear any longer the husband's violent behaviour under intoxication, her brothers and parents would send her back to her married home, saying that the husband 'was a nice man' and that this was 'a small issue'. Thus, women were often endlessly stuck in such situations with no escape.

Many of the respondents described a feeling of loss — loss of prestige (personal and familial), feelings of love, care, and understanding, security, friends and finances.
'It felt like an extended period of loss with no visible end'.

A common response was: 'I feel extremely frustrated and tense and anxious and irritable all the time. I have no interest in other things of life'

Much of the emotional distress was also driven by concerns about the drug user and the rest of the family. As one respondent stated: *I know my son is involved in pick-pocketing as he has no other source of income. More than his habit, I am tense about this. I have to live in constant fear that my son may be picked up by the police for pick-pocketing*. Fear of such outcomes often acts as a pressure point on the woman, who then provides money to procure drugs. For some other respondents, enabling behaviours (that maintain the drug habit) emerged from worry about social ostracization and stigma. Some women would encourage the drug user to use the drug at home, to prevent any social disruption.

In addition to emotional distress, many of the women faced various health problems including weight loss (40%), aches and pains (23%) and insomnia (47%). A majority of them had not sought any help for these problems or for associated health problems like hypertension or diabetes. Most of them felt their health problems would vanish if the abuser gave up his habit.

Despite significant psychological distress, a lot of the women never received any treatment, several believing that treatment for psychological distress was a vanity that only the rich could afford. Some of them did take help; some others relieved stress with self-chosen psychotropic medication, putting themselves at great risk of addiction.

Response to Drug Use

Expressing disapproval of drug use (60%), urging the family member to quit (57%), threatening to leave (49%), expressing concern (47%) and, in some cases, trying to restrict the person's freedom (31%) were ways in which respondents tried to discourage drug use. The threat to quit, and/or leave home was never really put into action. Such threats were commonly made by the spouse of a user, with the user invariably responding with an assurance that he would 'mend his ways', which almost never happened. In addition to the concern felt for the partner, various social constraints as well as the low levels of education and economic dependence, seemed to prevent affected women from taking such a step. In the odd case where a separation had occurred, there was always the user's mother to provide support and 'pick up the pieces'.

About half the respondents (51%) had advised the drug using family member to take help, and 49 percent had accompanied him

Many had attempted to provide treatment for the drug abuser, but were overwhelmed by the high costs involved.

Women are the major supporters for the family and the drug user, and thus need to be supported and empowered in their caring roles.

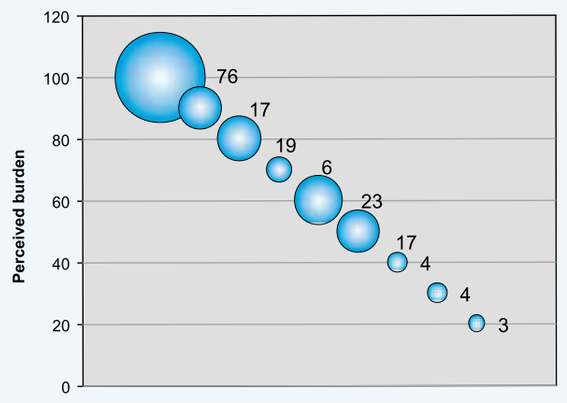
to a treatment centre. Twenty-six respondents had not motivated the user towards help, either because they were not aware of help or they felt there was no point.

Many had attempted to provide treatment for the drug abuser, but were overwhelmed by the high costs involved. In the words of a respondent: *I finally approached an NGO for my husband's treatment, but I lost heart the moment I heard the fee for a month's treatment. It was what we earn in 3-4 months*. The lack of appropriate treatment services, and the risk of relapse, often make the women feel hopeless and helpless. The poignancy of the situation is best reflected by the remark of a Sub-Inspector of Police from Imphal: *Many wives and mothers are pressing us to keep their wards in jail, where they are without drugs*.

Perceived Burden Due to Drug Abuse

The women were asked to rate their perceived burden on a centile scale of 0 to 100, with 100 representing the maximum burden and 0 the least. The majority of respondents (76) perceived maximum burden (Figure 7). Poor financial conditions appear to contribute to a perception of greater burden.

Figure 7. Perception of Family Burden due to Drug Abuse



Social Support

The lack of social support was another important observation. With more people living in nuclear families and relatives shying away, especially when there were monetary expectations, lack of support from the family of origin together with the blame for the addiction, all add up to an overwhelming burden on these women. And yet, they were still taking on the major responsibility of looking after the family and the drug user.

Conclusion

The family burden, especially on the woman, of caring for drug users is indeed substantial. Apart from the economic burden, women make many adjustments, at the cost of their own welfare, growth and development. They are victims of the drug user, as the user is of drugs. The lack of social support and appropriate help serves to aggravate the economic, social and emotional burden placed on these women. Along with these issues of bearing the pressure and the distress the consequences of drug use bring, women are the major support(ers) for the family and the drug user, and thus need to be supported and empowered in their caring roles.

Some of the respondents in this study were probably better off compared to others in the community with fewer resources. This can be gauged on the basis of both their monthly income and the fact that they were able to bring their family members to treatment, itself a luxury given the cost of treatment and the time away from work. If this group experienced such significant burden, one can well imagine the plight of families with more scanty resources.

The study thus highlights the need for:

- In-depth understanding of key issues such as exploitation, vulnerability, stigmatisation and lack of social support for affected women.
- Greater attention to women's own issues of health and economic security.
- Education about potential risks of exposure to HIV and other sexually transmitted diseases.
- Support for women.
- Greater sensitivity to the needs of the family, especially women, within treatment programmes.

(The specific needs for women dealing with a drug using family member are discussed in Chapter 11).

5

Drug Abuse among Women: Emerging Global Trends

In many developed countries, drug abuse is no longer an exclusively or predominantly male activity, as reflected in Table 3. In general, male and female drug use patterns seem to be more even in industrialized countries. There is, however, hardly any information on abuse among women from developing countries, where official data suggests that drug abuse referrals are almost exclusively a male phenomenon (see, for instance, the figure for treatment from Pakistan).

In a recent research article published, Perkonigg et al, (1998) reported that in a community sample in Europe, men were slightly more likely to ever use drugs and used them more frequently than women. In the same study, the authors reported that based on personal interviews, 30 percent of adolescents and young adults were using 1 or more illicit drug at least once in their lives. The criterion for abuse was met by 4.1 percent of all men and 1.8 percent of all women. In a study from Australia, Swift et al, (1996) reported that a sizable proportion of women drug users had experienced physical and psychological problems. Poly-drug use was the norm among these women. There was also increasing evidence from the UK, Switzerland and Australia towards increasing drug use among women (World Health Organisation, 1990).

Women and Drug Use in the United States

- 9 million women have used illegal drugs in the last year
- 3.7 million taken prescription drugs non-medically during the past year
- 70% of the AIDS cases among women are drug related
- Emergency room visits by women increased by 35% between 1990 and 1996
- Only 41% of women who need drug treatment actually receive it
- Admission for tranquiliser abuse is greater for women than men (1:0.7)

SAMHSA, 1998, NIDA, 1998

Table 3. Selected Country Data on Male/Female Ratios relating to Drug Use

	Australia	Colombia	Pakistan	Sweden	UK	USA
Lifetime prevalence	1.3:1	1.2:1	-	1.6:1	1.5:1	1.2:1
Annual prevalence	1.5:1	0.7:1	-	-	2.0:1	1.5:1
Persons in treatment	2.4:1	-	99:1	3.3:1	3.0:1	2.5:1
Injecting drug users	2.1:1	-	-	-	3.3:1	2.2:1

(Adapted from the World Drug Report 1997, UNDCP)

The 1997 National Household Survey on Drug Abuse in the United States found that 34 percent of white women, 19 percent Latinas and 25 percent African-American women reported lifetime illegal drug use.

In many developed countries, drug abuse is no longer an exclusively or predominantly male activity.

However, it does appear that the rise in drug use among women is genuine, a conclusion supported by the global changes that favour such an increase.

Emergency room visits by women in the U.S. because of drug-related problems apparently increased by 35 percent between 1990 and 1996 (SAMHSA, 1998). More recent figures from the National Institute of Drug Abuse (NIDA, 1998) suggest that almost half of all American women aged 15 years to 44 years have used drugs at least once in their lifetime. In Colombia, more than two thirds of prescription drug misuse is by women. It is widely believed that female involvement in drug related problems is seriously under-reported in many countries, especially in the Third World, and that because female drug abuse tends to be more stigmatised, women are less likely to come forward for help.

A question that is often asked is whether there is indeed a true increase in drug use among women, or whether there is an apparent rise that can be attributed to more gender-specific research. However, it does appear that the rise is genuine, a conclusion supported by the global changes that (unfortunately) favour such an increase of drug use among women. One such change is the transition of women from the traditional roles of mother and homemaker to that of an economic provider for the family. Another is emancipation and greater economic independence. Though the latter can be considered a positive gain it can also impose greater levels of stress, and drug use is a possible response in the absence of other coping mechanisms.

6

Drug Use among Women in India: An Overview

Traditional Use

Traditional use of various kinds of drugs by women is not unknown in many parts of India. During *Shivaratri* and *Holi*, everyone, male and female, drinks a beverage made from cannabis leaves and dry fruits. Opium has traditionally been used as a tranquilliser for children (Charles et. al., 1994). Chewing betel nuts with the leaf of the betel tree and lime paste was a habit adopted from childhood onwards; its preparation occupied a central position in ritual and social life (World Drug Report, 1997). Cultural use of alcohol has been also known in some tribal populations. Chewing tobacco in the form of a wad kept in the mouth is still common practice among many, including women, especially from the lower socio-economic strata.

However, regular use of substances by women outside religious, cultural or medicinal contexts has not been recognised until recently. Although the Expert Committee appointed by the Ministry of Health and Family Welfare (1977) estimated that of the opium addicts in the country (approximately 99,000 in 1970; 94,200 in 1973), 25-30 percent were female, women users have never figured in subsequent epidemiological studies, which identified drug abuse as nearly exclusively male.

Epidemiological Surveys: Shortcomings in Identifying the Problem

Epidemiological surveys have been unable to provide adequate insights into the pattern and relationships between drug use and psychosocial consequences for women in India. National multi-centred studies in the late 1970s, 1986 and 1989 reported negligible drug use rates among women (Mohan, 1981, Mohan and Sundaram, 1987 and Ministry of Welfare, 1992).

The 1981 study reported alcohol use in 3.2 percent and use of amphetamines in 0.1 percent of women in the sample. The authors observed that girls had moved from 'never use' status to 'ever use', although the use of barbiturates, cannabis, heroin, pethidine and morphine was as low as 0.1 - 0.3 percent. In the 1986 study, the pick-up rates were similarly very low. However, among the small group of female drug users identified, the primary drug being misused was tranquillisers, followed by tobacco. A 1992 study commissioned by the Ministry of Welfare in thirty-three cities was unable to identify women users as the 'sex' variable had been omitted in the study questionnaire.

The Unsuitability of Traditional Epidemiological Surveys

- Low pick-up because of low prevalence
- Low reporting rates
- No gender focus
- Epidemiological field staff not trained to be sensitive to gender issues
- Interviews usually structured, do not provide qualitative information

Four large epidemiological studies were undertaken in the early 1990s, covering North, West, South and Northeastern India, with sample sizes varying from 4,000 to 30,000 (Channabasavanna et. al., 1990, Singh et. al.,

Regular use of substances by women outside religious, cultural or medicinal contexts has not been recognised until recently.

Further work in the area of women and drug use suggests that women in urban areas have 'graduated' to the abuse of opiates, cannabis and synthetic drugs.

1992, Mohan et. al., 1993 and Mohan and Desai, 1993). Findings indicated that drug abuse was a predominantly male phenomenon, and that 92-94 percent of women had never used drugs in their lifetime. The study carried out in the Northeast (Imphal), however, identified 19 women among 130 heroin users (Singh et al, 1992).

Treatment Centre Data

Data from treatment centres also fails to provide adequate information on substance abuse among women. For instance, information from 194 counselling and de-addiction centres run by NGOs and funded by the Ministry of Welfare covering 93,234 referrals between April 1993 and March 1994 does not provide separate information on women drug users. A project carried out in Delhi, Jodhpur and Lucknow between 1989 and 1991 provided information on 10,321 new subjects reporting for treatment at 33 different agencies – 24 government and 9 NGO (Mohan et. al. 1993). One to three percent of treatment seekers in this group were female. Further profiling was therefore confined to male drug users. The DAMS component of the 'National Survey on Extent, Pattern and Trends of Drug Abuse in India' collected data in 2001 from treatment seekers in various treatment centres across India. The report of this study shows that among 16,942 new treatment seekers, about 3 percent were women (UNDCP, 2002a).

An analysis of treatment records from hospitals, rehabilitation centres, and counselling centres in Bangalore between 1972 and 1993 yielded 60 female users out of the 772 cases covered (Machado, 1994). Twenty-nine of these were poly-substance abusers and 15 used tranquillisers.

Looking Beyond Numbers

New research techniques and a greater attention to gender issues have led to a reassessment of this 'traditional' statistical picture. The result is a more informed and at the same time more alarming scenario, which acknowledges that a significant share of female drug problems does not show up in official statistics, that women become increasingly involved in all forms of drug-related problems and are thus likely to suffer far worse consequences than men. The new understanding probably reflects both a genuine increase as well as the heightened awareness that improved research methods have brought.

Focus on Women Drug Users

In 1991, the Narcotics Board and the Ministry of Welfare, Government of India, commissioned two pilot studies of female substance abusers, affected family members and women volunteers from Calcutta and Bombay (Mumbai) (Mondol, 1992; Kapoor, 1992). The samples were small (30 and 21 respectively), and the women were recruited through either treatment centres or self-help groups. They were largely middle and upper class, and were involved in jobs traditionally associated with women. In both cities, women were dependent on alcohol, prescription pills, or heroin and cannabis. (Common problems reported by these women users are listed in the box.) Several health problems, financial hardships, and occupational and psychological problems were seen. Navaratnam (1992) analysed these findings further: In both groups, there were a substantial number of single women (53% and 62% respectively). While respondents from Bombay reported greater use of alcohol (67%) and prescription drugs (62%), those in the Calcutta group testified to dependence on brown sugar (50%) as well as alcohol (50%).

Common problems faced by women drug users

- Health problems - body aches, giddiness, asthma
- Financial hardships
- Job related difficulties - due to poor educational qualifications and inadequate professional skills
- Parenting difficulties – separation from children, relationship difficulties with children
- Family problems - broken families, family conflicts, tension, violence, communication difficulties
- Emotional problems - depression, worry, loss of memory

Mondol, 1992; Kapoor, 1992

Further work in the area of women and drug use suggests that women in urban areas have 'graduated' from alcohol and psychotropic substance abuse to the abuse of opiates, cannabis and synthetic drugs, as evident in the studies mentioned above and an analysis of treatment records (Kapoor, 1996).

7

Study on Substance Abuse among Women: 'The Women's Study'

This study, also a part of the 'National Survey on Extent, Pattern and Trends of Drug Abuse in India', attempted to examine substance abuse patterns in women, special characteristics of women drug abusers, and gender issues in treatment. The study had two components, as with the study on burden on women – key informant interviews and detailed interviews with women drug users.

Key Informant Interviews

A total of 30 key informants (KIs), 15 each from Mumbai and Delhi, were interviewed. KIs were drawn from several strata of society and included doctors, lawyers, police officers, service providers and members of self-help groups.

Their perceptions helped to gauge the extent of drug abuse among women in the two cities, and also contributed to an understanding of general issues important in addressing such abuse among women. The salient impressions of the KIs are summarized in Table 4. The KIs in Mumbai were of the opinion that as many as 5-10 percent of women used drugs, most commonly tobacco and alcohol. In general, there were believed to be few injectors of heroin. While the problem of drug abuse is present in all strata of society, KIs felt that women from marginalized groups such as sex trade workers, domestic workers and wives or sexual partners of male users appeared to access established drug treatment centres more than women from affluent or upper middle class families. Apart from alcohol, tobacco and heroin, substances used were sedatives, buprenorphine, cannabis, cough syrup, opium, with the more affluent using ecstasy, cocaine, and purer forms of heroin. Young girls living on the streets tended

Table. 4 Common Consequences and Issues relating to Drug Abuse among Women

Area	*Consequence*
Physical	● Malnutrition
	● Sexually transmitted diseases (STDs) including HIV
	● Tuberculosis
	● Respiratory infections
	● Skin infections and infestations
	● Anaemia
	● Headaches
Psychological	● Insomnia
	● Depression
	● Anxiety
Social	● Reduced family support
	● Family rejection
	● Deviant lifestyle

This study attempted to examine substance abuse patterns in women, characteristics of women drug users, and gender issues in treatment. The study had two components-key informant interviews and detailed interviews with women drug users.

Women drug users were mostly in their twenties and thirties. A majority of the women drug users were employed

to use inhalants or solvents, a cheaper substitute for heroin. The Delhi KIs were of the view that psychotropic, analgesic, anti-depressant and other prescription drug abuse was more apparent. Those service providers working in general hospitals in Delhi and catering to poorer populations reported abuse of heroin, opium, cannabis, country liquor and cough syrup by women. In terms of treatment, KI's reported that professionals and service providers lacked the gender sensitivity required to address women's needs and that existing treatment services were inadequate.

Primary Data

The respondents for this study included 75 women drug abusers enrolled through a snowball sampling technique from Mumbai, Delhi and Aizawl. Snowball sampling is an iterative process where data collection begins soon after the key informants within a sub-population are identified, and 'leads' from each wave of referral are followed-up until the pre-target sample is reached. The Mumbai sample consisted of women drug users involved in sex work, the Delhi sample comprised mostly working women, and the Aizawl sample was constituted by women drug abusers in treatment.

Potential respondents were identified from substance use treatment agencies, public hospitals, self-help programmes, religious and spiritual organizations, psychiatrists in private practice. They were also recruited directly from the street (especially in Mumbai).

The interviews focussed on socio-demographic details and drug use history, as well as health, social, psychological and spiritual dimensions of the individual respondent's life. A major emphasis in the study was on the assessment of social support systems available to the woman user.

Face to face interviews were conducted either in the homes of respondents, treatment centres, or other places suggested by them. Each interview lasted at least an hour. Although there was a pre-designed questionnaire, interviewers spoke with respondents in a more open-ended manner and made more verbatim records in order to capture the qualitative aspects of drug use. Field notes were maintained in addition to personal diaries of experiences, which included difficulties faced in data collection. Such observations added greatly to a more sensitive understanding of the problem. Interviews were conducted in Hindi and Marathi at the Mumbai site, in Hindi at the Delhi site and in Mizo at Aizawl.

Demographic Profile

Age Distribution and Religion

As can be seen in Table 5, the women were mostly in their twenties and thirties. In Delhi, there were 2 women between 56 and 60 years of age. Thirty-three of the respondents were Hindu, 28 Christian and 13 Muslim. All except one of the respondents from Aizawl were Christian, and the Mumbai site had mostly Muslim respondents (40%).

Table 5. Age of Respondents (Number of Subjects)

	Aizawl (N)	*Delhi (N)*	*Mumbai (N)*	*Total*	
				N	*%*
15 – 20 years	8	2	2	12	16.0
21 – 30 years	14	12	11	37	49.3
31 – 40 years	2	7	10	19	25.3
> 40 years	1	4	2	7	9.3

Education

Half the respondents from Mumbai and Delhi were illiterate. Of the total sample, very few (5.5%) had received any technical or professional training, and Aizawl had the highest number of school drop-outs (Table 6).

Duration of Stay in Location

Sixty respondents had been in the same city for more than ten years. Mumbai had a multilingual group, with most having immigrated from other parts of the country, as well as two from Nepal and Bangladesh.

Employment Status and Income

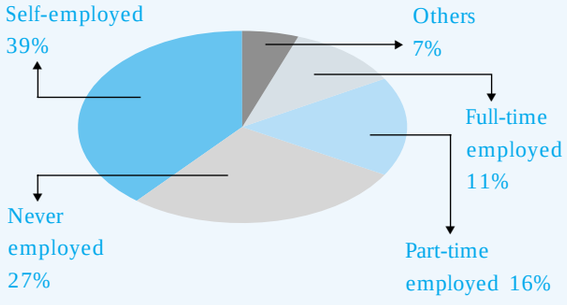
A majority of the women drug users were employed (Figure 8). There were more women

Table 6. Education (Number of Subjects)

	Aizawl (N)	*Delhi (N)*	*Mumbai (N)*	*Total*	
				N	*%*
Illiterate	-	12	13	25	33.3
Primary	2	4	5	11	14.7
Middle	16	1	4	21	28.0
Matriculation or junior college	7	-	3	10	13.3
Graduate or above	-	8	-	8	10.6

in full-time and part-time employment in Delhi, including three in the professions, six who worked as balloon vendors and five as labourers. On the other hand, most women in the Mumbai group were employed (21/25) mainly in commercial sexual activity. Respondents from Mumbai either made their earnings from commercial sex alone (68%), or by combining commercial sex with other activities such as peddling, stealing, rag picking or begging (32%). The 'never employed' group was almost exclusively from Aizawl (19/25).

Figure 8. Employment Status (Percentage)



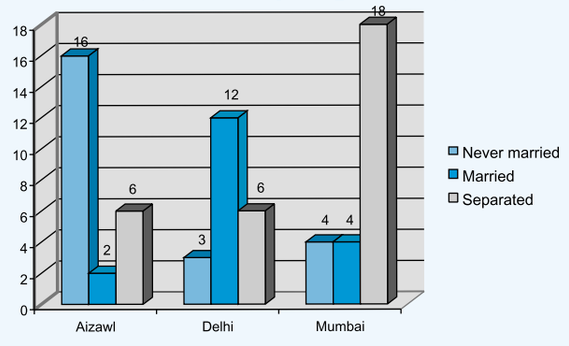
The women from Aizawl had very little personal income. While eight respondents from Delhi reported earning below Rs 1500 per month, the majority earned between Rs 1500 to Rs 5500. Mumbai's sex workers calculated their income on the basis of daily earnings, which varied from Rs 300 per day (36%) to Rs 2000 per day (8%). Lower earning was associated with primary activities such as rag picking or begging, especially among those with physical problems. Respondents who spoke English and were able to attract upper middle class clients, and those who were willing to offer fellatio or sex without condoms, had higher daily incomes.

Marital Status and Current Living Arrangements

Most women from the Aizawl sample had never been married (64%) and many lived with their families of origin. Almost half the women from Delhi were married, and lived in their marital homes. Mumbai had a large number of women who had run away from home at an early age and were entrapped in the flesh trade. Fourteen respondents from the Mumbai sample lived with their sexual partners or husbands on the streets, railway platforms or in rented shacks. A significant number of the total sample (30) had been separated (Figure 9). Only four women had remarried (5.3%), and two were living with their sexual partners. Fifteen respondents (20%) had married before the age of 16 years, including three respondents from Mumbai having been married off between the ages of 5 years to 10 years.

Forty-two respondents (56%) had no children, 15 (20%) had one child

Figure 9. Marital Status of Drug Users (Number of Respondents)



Note: *There were 1, 3 and 1 widows in Aizawl, Delhi and Mumbai respectively.*

Almost half the women from Delhi, lived in their marital homes. Mumbai had a large number of women who had run away from home at an early age and were entrapped in the flesh trade.

Fifty-one respondents (68%) had started drug use between 11 and 20 years of age. The predominant drugs of abuse were heroin, propoxyphene, alcohol and minor tranquilizers.

each, 8 (10.7%) had two children, 6 (8%) had three and 4 (5.3%) had more than three. Within the Mumbai group, only three respondents had their children living with them. The majority had left their children with their parents, siblings or ex-husbands. In other cases, the child had been given up for adoption. Teenage children were often living on their own, and some of the grown up children had married. Most children of the Delhi respondents were living with their parents, while the responsibility of childcare in the case of the few mothers from Aizawl fell upon the children's grandparents or aunts.

Drug Abuse by Family Members

Forty respondents (53%) reported family histories of drug abuse, primarily in fathers or partners, while only six respondents reported alcohol or drug use among female relatives. Thus, many had been exposed to drug and alcohol use in the family even before their own initiation into drug use.

Drug Abuse by Family Members

Alcohol	30.7%
Heroin	25.3%
Propoxyphene	6.7%

Drug Use Patterns

Age of and Reasons for Initiation

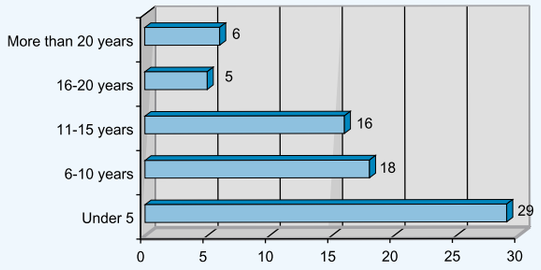
Fifty-one respondents (68%) had started drug use between 11 and 20 years of age. At one end, three of the respondents from Mumbai had been initiated before the age of 10 years, while at the other end three from the Delhi sample had started drug use after the age of 40.

Most drug using women (48%) reported that their friends introduced them to drugs, 16 percent said they initiated drug use to relieve stress, and some (roughly 11%) were introduced by their spouse or partner (Table 7). Reasons for continuation of drug abuse were: pleasure, avoidance of withdrawal symptoms and relief from stress. Many in Mumbai gave multiple reasons.

Duration of Use

While 38.7 percent of the total sample had been using drugs for less than five years, 36 percent had done so for more than ten years.

Figure 10: Duration of Drug Use (Number of subjects)



** Data not available for one subject*

Mumbai had a larger number of respondents with long term drug use, with 20 of the 25 respondents admitting to use for more than ten years (Figure 10).

Table 7. Primary Reasons for Initiation of Drug Use

	Aizawl (N)	*Delhi (N)*	*Mumbai (N)*	*Total*	
				N	*%*
Influence of friends	20	9	7	36	48
Stress and tension	-	2	10	12	16
Influence of spouse/partner	-	7	1	8	10.7
Curiosity/ experimentation	4	-	-	4	5.3
Influence of other family members	-	2	1	3	4
Others	1	5	6	12	16

Drugs Abused

The predominant drugs of abuse were heroin, propoxyphene, alcohol and minor tranquilizers. Some abused cough syrup and cannabis. Many were multi-drug users. Thirty out of these seventy-five women were injecting drug users, with the bulk of them in Aizawl and Mumbai. Heroin abusers were seen in all three cities, though more often in the Delhi and

Mumbai samples. In Aizawl, propoxyphene was the major drug of abuse.

Money for Drugs

Drug peddling was a common activity for enhancing income available for drug use. Less common ways of earning the required money included beer bar dancing, rag picking, gambling and administering injections to other addicts for payment (Table 8).

Table 8. Sources of Income for Drugs

Activity	*Percentage*
Sex Work	45.3
Drug Peddling	30.7
Other personal earning or household income	29.3
Stealing, extortion, blackmail	17.3

Note: *Respondents submitted multiple responses on this question.*

Drug Abuse and Health Consequences

The women drug users in the sample commonly reported insomnia, depression, anxiety, and body aches. Eight respondents reported suicide attempts. Among the Mumbai group, five reported having had tuberculosis and four jaundice. Four knew they were HIV-positive and another seven had been treated for sexually transmitted disorders. Intravenous drug users from Aizawl reported regular hospitalisation for overdose and treatment of abscesses.

Table 9. Common Physical and Emotional Problems

Activity	*Percentage*
Reduced sleep	66.7
Depression	62.7
Anxiety	53.3
Body aches	28
Aggression	18.7
Headache	17.3

Note: *Respondents submitted multiple responses on this question.*

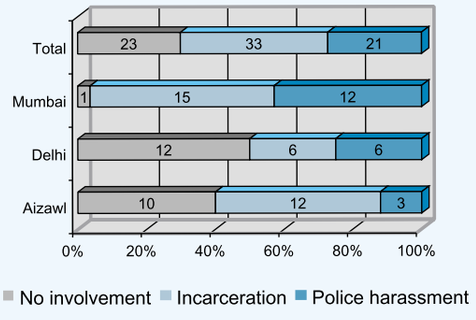
TP

Menstrual problems were reported by seven (9.3%) respondents. At least nine women had undergone surgery, each for a different reason, and a similar number reported abortions. Five women from Mumbai had each lost a child below one year of age.

Legal Problems

Only 23 respondents reported no legal involvement (Figure 11). These were mostly from Delhi and Aizwal. In contrast, only one Mumbai respondent was free from legal problems. In the case of four (5.3%) respondents, involvement with the police was not akin to arrest/incarceration – police personnel accompanied the drug abuser and her family to a treatment centre.

Figure 11. Legal Problems due to Drug Use



Note: *Respondents submitted multiple responses on this question.*

Personal and Social Consequences of Drug Abuse

Delhi's drug users reported frequent violence from their non-drug using spouses, because of their drug use. Their husbands were

The women drug users in the sample commonly reported insomnia, depression, anxiety, and body aches as health problems.

Many women drug users had strong religious beliefs and a spiritual inclination. Many women in the Mumbai sample appeared to have developed a stronger spiritual slant. The women from Aizawl were strongly religious.

reportedly dissatisfied with the sexual relationship. There was little support from the family and friends, and most separations occurred because of continuing drug use by the woman.

Many of the users who were mothers experienced severe guilt for neglecting their children and families. Negative impact on children included rebelliousness and disobedience, graduating to deviant peer affiliations in the school and neighbourhood. Some, however, felt that they were playing their role satisfactorily. Feelings of low self-esteem – a sense of being wronged, of being a 'failure' – were also noticed among respondents in Delhi:

- *I feel like a total failure. I am subjected to so much rejection.*
- *People in the family are harsh because I am a woman.*
- *If I was a boy, no one would have dared to mess with my life.*

In Aizawl, though knowledge of and access to treatment was relatively lower, the family structure, flexibility and religious inclination appeared to act as stabilizing factors, with less family discord. The women here were also more self-confident. Both the family support and the strong religious affiliation appeared to contribute to this. However, the notes of gender discrimination, guilt and the sense of struggle were familiar:

- *Sometimes I think I should have been a boy, because boys have more freedom. They do things and yet don't get a bad name. For us girls, we have to stay at home, do all the routine work, which is boring. I get fed up of the same things.*
- *Yes I see my good qualities. But I have more bad qualities than good.*

Some of the other responses reflected the respondent's need for continuing drug use: *During my use when I was tripping, I was very happy. But once it is over I become sad and even angry. I can find real joy in tripping. I wish I was on a trip all the time so that I don't have to be sad ever.*

Responses of Families

Family members living with the women drug users reported frequent physical and psychological distress. Problems in communication, emotional outbursts, and blaming were frequent. While fathers were fairly distant and uninvolved, the women users shared a better rapport with other women in the family.

Respondents from Aizawl enjoyed better family cohesion: *My family is a happy family. If there is anything to be done they do it happily. It is only me who causes all the problems. I never cooperate with them, so they cannot have a family gathering. I was ok when I was using drugs. I used to cooperate. When I am tripping, I don't like company. I want to be alone and away from home.*

The situation was quite different in Mumbai, where women users living on the streets rarely visited their family of origin. Relationships with in-laws were also strained. In general, because of their dual situation, the women preferred to stay on the streets than in their married homes. They made occasional visits to meet their children, and in many cases, provided financial support to their families. The families of many of those who had migrated to the city were unaware both of their profession and their drug use: *My relationship with my family is fine. I visit them on and off. I give them money and support. I left home at 13 and I have not disclosed to them that I have left my husband, my using status or my profession. They think that my husband and I are happily married and my husband does some bank business and supports us. I come from a poor family. I dreamt of getting married to somebody who will remove me from this situation. But things went bad for me.*

Some felt their family did not care as long as the money flowed in: *When I had money everyone used to visit me. Now they don't come near me, nor do they enquire about me. My mother never told me not to do prostitution, drug peddling or use drugs…* Families that were aware of their daughter's profession and drug using status usually rejected them: *My brother-in-law and sister have cut off from me and threatened to garland me with shoes and take out a procession in the village. They have told me never to come home*. Some of the women had also been separated from their husbands because of their

drug use and presently lived on the street with partners, who often assumed the role of 'street protector'.

Self-Esteem and Spiritual Orientation

A majority of the drug users reported poor self-image, low self-esteem, and a lack of contentment. Some were fatalistic: *I am fed up of being a fixer. I am likely to die soon. It is difficult to come out of this. If a person does not get happiness, security from childhood, he is bound to go in such a line. I think it is destiny. God is testing us.*

However, many had strong religious beliefs and a spiritual inclination. Many women in the Mumbai sample who had attended Narcotics Anonymous (NA) meetings appeared to have developed a stronger spiritual slant. Some were practicing *Vipassana* meditation and Yoga. The women from Aizawl were strongly religious. Some had become Born Again Christians, others attended gospel campaigns and church meetings. As one user put it: *Even if I am blown, I don't forget to say my prayers.*

The drug using sex workers reported being tired of selling themselves for sex. Numerous factors contributed to their dejection and lowered morale: poor financial security, lack of specific goals, dual stigma attached to their status, shame associated with the profession they were in, lack of social support, and concern about the future of their children. Yet, some were hopeful of: *getting married one day and starting a normal family life*. A few were more accepting of their situation: *I am proud to be a woman. So what if I am a prostitute. I have my own self-dignity and respect. Being a woman is a very great thing; despite being in prostitution, I am happy. I am doing something on my own. I am not dependent on others*….

Reasons for Wanting to Stop Drug Use

The most common reasons behind a desire to quit was wanting to lead a normal life (24%), wanting to improve their children's life (23%), because of health problems (25%) and being tired of the associated problems that came with drug abuse. For a few, the reasons for wanting to quit were more personal: to increase the chance of marriage of a child, because their partners had quit drug use, or because they had grown tired of sex work for drugs.

Support Systems

The women users in the Aizawl sample had greater primary support systems from their families than those in the other two sites. In Mumbai, because of the disintegration of a formal family structure, there was a greater need for organized systems of support. All the women respondents in Mumbai had accessed treatment services at least once, but only a small percentage regularly utilised and benefited from them.

Twelve of the 25 respondents in Mumbai still recognised their mothers as providing the greatest support, while the drug using partner was the most immediate support system for many in that sample. Other supports were fellow pavement dwellers from diverse backgrounds – *dhobis*, petty shopkeepers, hawkers, beggars and rag pickers. Many women enjoyed social companionship within the street community.

For the Delhi respondents who were mostly married and employed, support was more commonly forthcoming from non-abusing friends and colleagues at work. For a few women (three), the husband or partner provided emotional support and also accompanied them for treatment. Those who were experiencing serious marital conflicts, turned to a mother, sister or son for emotional support.

Organised Treatment Services: Consumer Perspectives

While all the drug abusing women from Mumbai had been in contact with treatment services, a significant number from Aizawl had not sought any treatment. In all three cities, specific issues that interfered with treatment included concern for children unattended at home, fear of exploitation, fear of withdrawal, and the lack of a supportive environment.

Nine respondents in Mumbai (12%) had been to treatment centres on three or more occasions. However, returning to the street environment after treatment invariably led to recidivism. In Delhi, there was a significant lack of awareness of treatment facilities. At least eleven of the 25 respondents had never sought

In all three cities, specific issues that interfered with treatment included concerns for children unattended at home, fear of exploitation, fear of withdrawal, and the lack of a supportive environment.

"Employment and shelter is a must for us. Besides these, there should be proper and cheap treatment available to us, and proper guidance to help us off our addiction".

any treatment for drug problems. They did not understand addiction as an illness, and thought they could quit on their own. Others were so overwhelmed by problems of subsistence and care of their children that their own treatment needs took a back seat.

Of the Aizawl sample, 20 women were currently in treatment but had never sought treatment previously. Interestingly, most treatment centres managed withdrawal without any medication, and paid greater attention to prayers and spirituality.

Needs of Women Drug Users

The treatment needs and support systems required for women drug users were comprehensively summarized by many of the respondents themselves:

- *Everyone says so many facilities are there in this and that organization. But in reality things are not like that. Then we feel we have no place. It is all in the name of professionalism. They want to fill up registers and show the sponsors. In reality things are bad. Services need to be improved for women users. They are in a worse situation compared to male users. Women need to be given more chances. Staying facility should be given to them and work should also be given.*
- *Employment and shelter is a must for us. Besides these, there should be proper and cheap treatment available to us, and proper guidance to help us off our addiction.*
- *The company makes a difference after treatment is over. Don't allow them to go back on the road. Employ them and let them lead a normal life. Don't leave us back on the street.*

A Recovering User

When I was using, I was sad, depressed. I hardly talked to anyone. I preferred being alone. Happiness prevailed everywhere except in me. I had lost interest in my life. Today in recovery, I am very happy. I feel as if I have got a new life now. I want to live like a lively person and be hard working. I want to keep others happy. My home people will not accept me, I know, but I will try my best to win their confidence. Initially, good people were novel to me. But being clean has taught me to appreciate others.

8

The Rapid Assessment Survey: Gender Comparisons of Drug Users

Rapid Assessment Survey (RAS) is a methodology to obtain information on 'hard to reach' populations, in this case drug users. In the RAS conducted in 2000-01, a large amount of qualitative and quantitative data was gathered from key informants and drug abusers. In-depth unstructured interviews, focussed group discussions, city mapping and structured interviews were carried out in fourteen Indian cities: Amritsar, Jamshedpur, Shillong, Dimapur, Hyderabad, Bangalore, Thiruvananthapuram, Goa, Ahmedabad, Kolkata, Delhi, Chennai, Mumbai, and Imphal (UNDCP 2002b). The sample was identified through the snowball technique, hence the proportion of women drug abusers does not necessarily reflect the exact prevalence of the phenomenon in these cities. The data from this study should therefore not be generalised to project an estimated number of drug abusers (men or women) in these cities or the nation as a whole. Furthermore, the data was not uniform and complete in all regards and the information may apply to the (non-random) population studied. Despite these shortcomings, several important indices have come to light and tentative inferences can be drawn.

By bringing together information on both men and women abusers (though not randomly selected samples, and hence not truly representative), the RAS provides useful and necessary points of comparison on gender lines. It can therefore tell us something of import about drug abuse among women. After a summary of the RAS findings on women users, points of comparison are noted.

Number of Women Drug Abusers

Altogether, 4648 drug abusers were interviewed and 371 of them were women. Certain inter-centre variations were noticed. The Kolkata, Chennai, Jamshedpur and Ahmedabad samples had very few women. Goa had the highest proportion (20%), followed by Thiruvananthapuram (16%) and Mumbai (15%). In the remaining sites, the percentage of women varied between 4 and 11 percent (see Table 10).

Demographic Profile of Women Users

The mean age of drug users in Amritsar was 23 years, 28 years in Goa, 31 years in Thiruvananthapuram and 32 years in Mumbai. Around 45 percent of women users in Imphal were within the age group of 25 - 29 years, and about 80 percent of those in the Delhi sample were between 16 - 35 years of age. There were a sizable number of single women users (75% in Goa and Hyderabad, 60% in Thiruvananthapuram, and around 40 percent in Mumbai and Imphal). The proportion that was illiterate varied widely from centre to centre – from 6 percent (Thiruvananthapuram) to 71 percent (Delhi). The level of education was higher in some cities -66 percent of women drug users in Thiruvananthapuram had studied up to secondary school, and 37 percent from Goa were graduates. More than 75 percent of users in the Mumbai, Dimapur and Thiruvananthapuram samples were employed. In three sites, a large number of these women were homeless - the proportion varied from 51 percent (Thiruvananthapuram), to 66 percent (Delhi) and 79 percent (Mumbai). Women users in the remaining sites were living with their families.

By bringing together information on both men and women abusers, the RAS provides useful and necessary points of comparison on gender lines.

Table 10. Number of Women Drug Abusers in RSA samples

Site	Total sample size	Females	Percentage of females
Amritsar	327	16	4.9
Jamshedpur	353	1	0.3
Shillong	320	36	11.3
Dimapur	261	28	10.7
Hyderabad	300	29	9.7
Bangalore	275	12	4.4
Thiruvananthapuram	308	50	16.2
Goa	373	76	20.4
Ahmedabad	314	3	1
Chennai	300	0	0
Mumbai	356	53	14.9
Imphal	308	30	9.7
Kolkata	388	2	1.0
Delhi	465	35	7.5
Total	**4648**	**371**	**7.9 (mean)**

Drug Abuse by Family and Friends

The proportion of drug users with abuse by family members varied between 48 percent (Imphal) and 83 percent (Bangalore) for the five sites for which this information was available. Information on drug using friends was available from four centres – it ranged from 75 to 96 percent.

Reasons and Drugs of Initiation

Depression, tension, peer pressure, curiosity and pleasure were often reported as reasons for initiation. Alcohol was the most common drug of initiation (60 - 90%) followed by cannabis (18 - 57%) in most of the centres. Some 45 percent in Mumbai and 27 percent in Imphal were initiated to drug use with heroin. In Amritsar, however, sedatives and tranquillisers were the first drugs of abuse among some.

Current Drugs of Abuse and IDU

Heroin, alcohol, cannabis and painkillers (in tablet form) were the dominant current drugs of abuse. Abuse of heroin was reported more often from Delhi (99%), Imphal (80%) and Dimapur (56%). Ninety-four percent of users from Thiruvananthapuram reported poly-drug use. In Goa, the most common drug of initiation as well as current primary drug of abuse was cannabis (58%).

Heroin, alcohol, cannabis and painkillers (in tablet form) were the dominant current drugs of abuse in the RAS.

Some of these abusers were using drugs through the injection route. The proportion of IDUs (current and ever) varied between 3 percent in Delhi and 73 percent in Imphal. Many of them - between 75 percent (Thiruvananthapuram) and 86 percent (Imphal) – reported sharing needles and syringes. In these two centres most women drug abusers reported that they cleaned their needle and syringe with any available water, and some reported that the needles and syringes were easily available from pharmacies. The reasons sited for injecting drugs were: less cost, more pleasure and group behaviour. Several health hazards like blocked veins and abscess formation were reported. A case history from Ahmedabad illustrates this (see box on page 28).

Injection Drug Use (IDU)	
Delhi	2.8%
Amritsar	6.3%
Mumbai	16.7%
Dimapur	17.9%
Thiruvananthapuram	18%
Hyderabad	34.5%
Shillong	36%
Imphal	73%

A married woman of about 30 years was found injecting drugs. The frequency of injecting was so high that she had developed wounds on her forearm. She was admitted to a private hospital where pus was extracted and wounds healed. Strangely, her family members were unaware of her addiction. Her mother-in-law was diabetic and was required to take insulin everyday. Only when the needles kept for the mother-in-law went missing did the family members come to learn of her addiction. It was found that the woman had been in love with a young man who had later married the addict's younger sister. She turned to this habit in order to get over the frustration of failure in love. Subsequently, she sought treatment at a private clinic.

Comparison of Drug Use Patterns of Men and Women

Some centres compared the available data for men and women. The following section discusses briefly the differences and similarities that emerged. Socio-demographic and drug use patterns in women differed from those of men within the same city, as well as across cities (Table 11). A remarkable finding was that a significantly larger number of female users were single in Hyderabad (75%), Thiruvananthapuram (60%) and Goa (75%). The respondents from Goa were better educated than their male counterparts (37% of women and 14% of men were graduates).

While at Amritsar and Thiruvananthapuram women had initiated drug use at an age later than men, in Goa the mean age of initiation in women was 15.9 years compared to men (17.4 years). In the latter centre, interestingly, females had initiated drug use earlier than males (65% females compared to 30% males had started drug use between 14 and 18 years of age).

Urban Drug Use – Some Current Trends among Women

- More single women
- More educated
- Many employed
- Early onset of drug use
- High levels of drug use in families
- Many drug using friends
- Early age of initiation into sex

A remarkable finding was that a significantly larger number of female users were single in Hyderabad, Thiruvananthapuram and Goa. The respondents from Goa were better educated than their male counterparts. In the Hyderabad sample, more women reported injecting use than men.

Table 11. Demographic Parameters and Drug Abuse History (Men *vs.* Women)

Variable	*Hyderabad*		*Thiruvananthapuram*		*Goa*	
	Females (N=29)	Males (N=271)	Females (N=50)	Males (N=258)	Females (N=76)	Males *(N=297)*
Mean age (years)	26	30	31	30	28	33
Mean age at initiation of drug use (years)	Not available	Not available	22	19	16	17
Married (%)	25	39	40	50	25	39
Positive family history of drug use (%)	50	9	73	82	24	28
Friends using drugs (%)	97	73	Not available	Not available	51	49
IDU (%)	35	16	18	38	Not available	Not available
First experience of sexual intercourse (age in years)	18	18	Not available	20	Not available	Not available

Despite the small numbers of women gathered in its net, the RAS in urban settings reveals several interesting features- younger age, more educated women drug users, unsafe injecting and unsafe sexual practices.

In the Hyderabad sample, more women reported injecting use (35%) than men (16%). Drug use among friends of the respondents was fairly high (52% in Thiruvananthapuram, 51% in Goa).

When the sexual behaviour of drug users was compared in Hyderabad, women drug users reported earlier age at first sexual experience (17.9 years) compared to males (18.4 years). They reported equal number of sexually transmitted infections, greater number of sexual partners (6.5 % compared with 4.7 %) and less frequent condom use. Disturbingly, all the IDU women in the Thiruvananthapuram sample had shared needles at some time or the other.

Despite the small number of women gathered in its net, the RAS in urban settings reveals several interesting features – younger age, more educated women drug users, unsafe injecting and unsafe sexual practices.

9

Drug Use and the Indian Woman: The Emerging Picture

The information reviewed for this monograph is insufficient on several counts. The sources of information available are scanty, the number of studies (and respondents) few in number and selected through purposive sampling. Thus, the data is not truly representative of women in India and no attempt should be made to estimate the number of drug abusing women in absolute numbers in any of the sites. However, examining the studies in conjunction shows several common themes and trends of drug use among women.

Drug Use still a 'hidden problem'

While the issues of sampling and numbers may on one hand be seen as inadequacies, on the other they underscore the fact that women drug users are indeed 'a hidden population' and drug use among women 'a hidden problem'. Exploring the tenuous relationships between drug use and women's socio-cultural contexts requires the judicious use of qualitative and quantitative methods of research. Regardless of the strategy adopted, it remains difficult to interview women users because of the additional stigma and perceived consequences, especially in marginalized groups, attached to the phenomenon of drug abuse among women. With the caveat of findings being non-generalisable but informative, certain consistent observations can still be made based on the earlier studies, as well as the study on drug abuse among women (referred to as the Women's study) and the RAS.

Changing Patterns of Drug Use

One of the main observations is the changing pattern of drug use among women. Although a 1977 Government of India Report suggested that 25 - 30 percent of registered opium addicts were women (Ministry of Health and Family Welfare, 1977), any reports of drug use among women around that period and even earlier were largely anecdotal. The first review of women drug abusers in treatment in the 1970s and 1980s reported poly-drug use and tranquilliser abuse (Machado, 1994). However, the 1990s witnessed an increase in the use of opiates, especially heroin, among women in different cities including Mumbai (Kapoor, 1992) and Calcutta (Mondol, 1992). Furthermore the data from the current project from several sites viz. Delhi (Women's study and RAS), Dimapur, Thiruvananthapuram (RAS) and Aizawl (Women's study) suggest such a trend. Goa, however, appeared to have a larger number of cannabis users (RAS).

Availability and accessibility of drugs appears to influence drug using patterns among women as reflected by the rise in heroin and propoxyphene. It is estimated that abuse of psychotropic as well as of other opiates (including codeine containing cough syrups), is prevalent, but this has not been adequately studied.

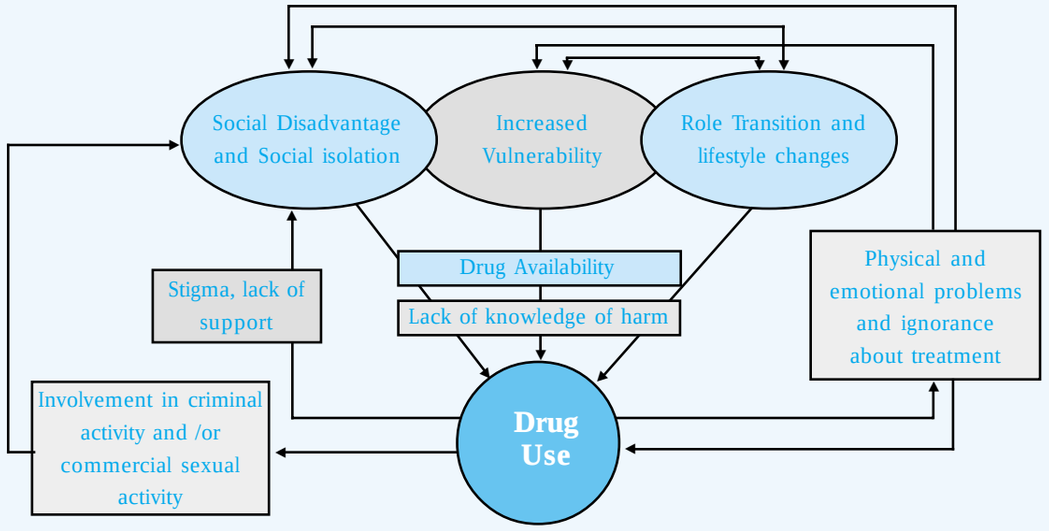
Factors Leading to Drug Use among Women

Social disadvantage, specific vulnerability, role transition and lifestyle changes, all appear to increase risks of drug use independently and also through complex interconnections, as illustrated in the accompanying figure (Figure 12).

Women drug users are indeed 'a hidden population' and drug use among women 'a hidden problem'. Exploring the tenuous relationships between drug use and women's socio-cultural contexts requires the judicious use of qualitative and quantitative methods of research.

The female drug user is perceived as deviant and is thus stigmatised and socially isolated. This in turn increases and compounds social disadvantage and leads to emotional problems, further enhancing vulnerability to continued drug use.

Figure 12. Interacting factors leading to drug use among women



Social Disadvantage

Social disadvantage, while not the sole reason, is known to increase risk of drug abuse, especially in the presence of specific vulnerability and altered roles and relationships. Social disadvantage includes situations such as:

- Poor educational status
- Lack of specialised training in a vocation
- Young age at initiation of work
- Early marriage
- Lack of social support

Specific Vulnerability

Factors increasing vulnerability to drug use among women consistently visible throughout the Women's study include:

- Drug use in family of origin
- Drug use in spouse
- Involvement in a sexual relationship with a drug using partner
- Emotional distress including low self-esteem, depression, and stress
- Early financial independence coupled with poor decision-making skills
- Peer group influence

Role Transition and Lifestyle Changes

Emancipation, along with its advantages, also brings with it changing lifestyles as well as additional stress due to role transition. This is amply reflected in the RAS where the profile of the urban woman drug user is that of an educated, often single and economically independent woman, who is often an economic provider for the family. Peer pressure, a need for excitement, and stress appear to operate as initiators into drug use. High levels of drug use in the household, early sexual experience, financial independence all appear to increase the vulnerability of this group.

As mentioned earlier, the three factors interact in a complex manner and together increase the risk of drug abuse as if through a multiplier effect. The drug user is perceived as deviant and is thus stigmatised and socially isolated. This in turn increases and compounds social disadvantage and leads to emotional problems, further enhancing vulnerability to continued drug use. Involvement in criminal activity and commercial sexual activity as a means of enhancing income to support drug use is an expected outcome. These factors, in combination with health problems and ignorance about treatment, all lead to feelings of hopelessness and helplessness in the user, and perpetuate the vicious cycle of social marginalisation and drug use.

Impact of Drug Use by Women

Studies of women who seek treatment for alcohol and drug problems reveal a dramatic connection between domestic violence, childhood abuse and substance abuse

(SAMSHA, 1997). Women substance users have high levels of depression, anxiety, feelings of powerlessness, and also low levels of self-esteem and self-confidence (Dansky et.al., 1995). There is a whole range of health, social and economic problems that such women face.

TP

Research from Asia with respect to women and drug abuse is scanty and, where available, limited in focus. No systematic efforts were made to conduct studies on women drug users in the region till the early 1990s, though a study of the problems of heroin-addicted women in treatment and an in-depth follow-up study of women drug dependents from Malaysia (Wong et. al., 1988) were published earlier. In the 1990s studies from Singapore (Mansor and De Zilva, 1992), Sri Lanka (Ellawala, 1992) and Malaysia (Navaratnam, 1992) have emerged.

It is highly likely that the representation of women in treatment, in practically all countries across the world, is much lower relative to the scale of the problem (see Table 3). This may be on account of stigmatisation, lack of awareness, lack of support, and different prioritisation for women (concerns about their children and family override concerns for treatment). Further, the isolation and alienation produced by drug use, especially by behaviours such as involvement in sex work, cause further marginalisation of this group.

Women's Involvement in the Drug Trade

An aspect of the relationship of women and drugs we have not yet discussed is the involvement of women in the drug trade. Women are frequently involved in cultivation, processing and drug dealing. For example, in Africa, women produce 80 percent of the agricultural products in rural areas; women are the predominant harvesters of opium in Asia and coca leaves in South America (World Drug Report, 1997). In India, research studies (Ray et al., 2001) as well as anecdotal reports suggest that women have been involved in the production and marketing of opiates.

Women (both those who use drugs and those who do not) are increasingly involved in the drug distribution network. Changes in social and economic conditions, changing patterns of drug use and increasing female involvement in the informal, illegal economy have all been contributory factors. Dire economic conditions and the lure of money often lead women to become involved with drug couriering, and peddling. The usual profile of a drug courier is a woman of childbearing age, single or married with children, unemployed, a trader or menial worker and financially impoverished (Odejide, 1992). Some of the women involved in peddling are ignorant of the magnitude of problems caused by drugs. For many others, the financial temptations are more likely to outweigh moral considerations, especially when the disparity between criminal income and legitimate earning potential becomes extremely wide. Anecdotal reports suggest that the drug mafia in Mumbai uses women (referred to as '*bhabi*' or '*aapa*' – sister-in-law or sister), whose husbands are in jail, as drug couriers.

Another reason for drug peddling, especially among drug users, is as a supplementary or exclusive source of income for procuring drugs. Thus, four of the women drug users from Aizawl (16%) in the Women's study stated that their occupation was peddling. It earned them anywhere between Rs 2500 to Rs 4500 a month. Altogether, 23 of the 75 (31%) drug using respondents in the Women's study reported involvement in drug peddling to support their addiction.

Women (both those who use drugs and those who do not) are increasingly involved in the drug distribution network. Changes in social and economic conditions, changing patterns of drug use and increasing female involvement in the informal, illegal economy have all been contributory factors.

10

Drug Use in Context

Clearly, drug abuse impacts women dually- male drug abuse creates an enormous burden on affected women, and drug abuse per se constitutes even more grave problems for women.

It is important to reiterate the need to view drug use in women within current socio-economic and cultural contexts. The situation of the Indian woman mirrors the challenges and difficulties faced by women all over the world (see box). Lack of knowledge and low status, coupled with low empowerment, continue to be the Achilles' heel for women's development.

Such social disadvantage and sub-ordination of women on one hand, and rapid socio-cultural and economic changes on the other have significantly altered traditional structures and institutions within society. Changes like these are invariably associated with social upheaval, and drug abuse is a known outcome of such change. Clearly, drug abuse impacts women dually – male drug abuse creates an enormous burden on affected women, and drug abuse per se constitutes even more grave problems for women. Deprivation results in

World's Women 2000:Trends and Statistics (Excerpts)

- Women are generally marrying later but more than a quarter of women aged 15 to 19 are married in 22 countries - all in developing regions. Informal sexual partnerships are common in developed regions and in some countries of the developing regions.
- Births to unmarried women have increased dramatically in developed regions
- Maternal mortality risks are still high in the developing world
- Women now account for almost half of all cases of HIV/AIDS, and in countries with high HIV prevalence, young women are at higher risk of contracting HIV than young men.
- Life expectancy continues to increase for women and men in most developing regions but has decreased dramatically in Southern Africa as a result of AIDS.

Work

- Women now comprise an increasing share of the world's labour force - at least one-third in all regions except in northern Africa and western Asia. Self-employment, part-time and home-based work have expanded opportunities for women's participation in the labour force but are characterized by lack of security, lack of benefits and low income.
- More women than before are in the labour force throughout their reproductive years, though obstacles to combining family responsibilities with employment persist.

Human Rights and Political Decision-Making

- Physical and sexual abuse affect millions of girls and women worldwide - yet are known to be seriously under-reported.

Education and Communication

- The gender gap in primary and secondary schooling is closing, but women still lag behind men in some countries in Africa and Southern Asia.
- Two-thirds of the world's 876 million illiterates are women, and the number of illiterates is not expected to decrease significantly in the next twenty years.

different outcomes in different situations. According to WHO (1990), deprivation must be viewed as a relative term, and must be applied when a person's socio-economic status is worse than her/his parent's – downward social mobility. In some countries, however, use of particular drugs was seen to represent a form of subjective upward social mobility for those of low socio-economic status.

From another perspective, urban settings appear to be associated with patterns of drug abuse in women mirroring that of men, with probably higher risk behaviours stemming from unsafe injecting and sexual practices.

Whatever the difference in social status and in patterns of drug use, the financial, social, physical and psychological consequences of drug abuse are tremendous. In the context of the adversities that most Indian women face in terms of illiteracy, low autonomy, and inadequate accessibility to health care, the effect of drug abuse is amplified. In their pivotal role within the family, women are similarly affected when there is drug use by family members.

In the context of the adversities that most Indian women face in terms of illiteracy, low autonomy, and inadequate accessibility to health care, the effect of drug abuse is amplified.

11

11. Changes, Needs and Future Directions

Some of the path-breaking initiatives to reduce the burden of drug abuse in the family have actually been achieved through self-help groups.

In India, in the last decade of the twentieth century, there have been significant initiatives (though few in number) addressing the burden of care for women with drug abusing family members, as well as some initial initiatives for women drug users and those involved in drug trade.

Some of the path-breaking initiatives to reduce the burden of drug abuse in the family have actually been achieved through self-help groups. Outstanding examples are the Meira Peibis (see box) and the Nagaland Mother's Association (Tarapot 1997).

Meira Paibis

The Meira Paibis are groups of old women who keep all-night vigils in the villages of the north-eastern state of Manipur to ward off crime and alcoholism. They later extended their activities to include drug addiction as well. These tribal women began by patrolling the valley, armed with torches and iron gongs. They tied empty liquor bottles to necks of men found drinking in public. They imposed fines of Rs 150 on men drinking in public and Rs 5000 on sellers of alcohol. In areas patrolled by these women, drug use patterns changed substantially, with decline in riotous behaviour, and greater safety for women at night.

Self-help and support groups have proved very effective in Imphal and Pune (for instance, the Sahachari Group, which provides therapy and support to wives of drug addicts). A novel initiative by police to provide support for women in distress is the Vanitha Sahayavani in Bangalore (see box).

Help-Line for women: The Vanitha Sahayavani

The Bangalore City Police has been a trendsetter in starting a separate help-line for women. Many of the callers are women who face domestic violence or harassment from intoxicated family members. The Sahayavani has helped hundreds of such women, through support and counselling, often helping to take the addicted individual for treatment. Such help-lines have also been introduced for children and the elderly.

Recommendations have been made by different groups regarding the special concerns of women substance users (UNDCP/ UNDPCSD/DAW and WHO/PSA, 1993). A recent joint workshop held by UNDCP, Regional Office for South Asia and the Ministry of Social Justice and Empowerment, titled 'Drugs are a Women's Issue', brought together NGOs involved in providing treatment and prevention work, NGOs working in women's development, concerned governmental agencies (like the National Institute of Public Co-operation and Child Development which trains functionaries for the Integrated Child Development Services), the National Commission for Women and the media with a view to sensitise diverse groups to the problem of women and drug use as well as initiate networks of prevention and care. This

monograph is also an initiative in this direction.

The UNDCP has initiated a programme of sustainable alternative livelihood in Northeastern India where illicit cultivation of opium poppy and related drug abuse are rapidly displaying signs of a social crisis in the four districts of Changlang, Tirap, Lohit and Yinkiong in Eastern Arunachal Pradesh.

However, most recent and current effort is sporadic and ad hoc. There is a need for a focussed policy and concerted national and regional action to address gender aspects of the drug abuse problem, from both perceived burden and drug use perspectives. There is a need for a shift from a purely individual, single-cause linear model to a multi-cause interactive model (as discussed in Chapter 9) in understanding addiction. It is not enough to look only at the internal and intra-psychic causes of women's problems including drug use, without a consideration of external and contextual factors and how they interact with the individual user. The social, political, cultural and economic factors that contribute to and maintain drug abuse must be addressed, as much as the psychological and physical consequences of prolonged drug use. Drug abuse among women thus needs to be understood in the context of gender as a process and an institution (Ettore, 2000).

The prominent influence of contextual factors over individual ones has specific implications for treatment and rehabilitation of women drug users, and for women affected by drug use. A recognition of this will in turn help develop programmes to improve the adaptive capacities of affected women, and enhance the supportive qualities of their environment. All treatment modalities that serve women, and those that cater to women burdened by drug abuse in the family, must be sensitive to needs such as counselling, family therapy, ancillary services such as transportation, child-care, housing, legal assistance and job or vocational training. They must be sensitive to diverse cultural needs. Alternative facilities such as separate women's treatment programmes, acceptance of children in treatment programmes, attention to pregnant drug users, and economic rehabilitation issues need to be addressed.

No single paradigm or strategy can effectively address the ever-changing drug scenario, especially given the regional variations and the pluralistic and cultural diversity of Indian society. Different elements of intervention and prevention may be drawn upon to develop an eclectic model, suitable and appropriate to local and regional situations.

Such elements should include:

- Bringing into national focus the issue of women and drug use.
- Media campaigns and information programmes that inform women of health and related risks of drug abuse.
- Strategies that discourage drug abuse and promote rehabilitation and recovery.
- Steps to increase women's access throughout the life cycle to appropriate, affordable and quality health care and related services.
- Improving access to appropriate treatment and rehabilitative services for affected women.
- Strengthening preventive programmes for promoting women's health.
- Support for programmes addressing HIV risk prevention for partners of drug users and for women drug users with high-risk sexual behaviour.
- Participation of women in demand reduction programmes.
- Dealing with situational factors that increase the burden on women due to drug abuse.
- Building up of support groups.
- Strengthening mechanisms to rebuild family relationships strained due to drug abuse.

Specific Strategies

Treatment providers need to view women substance users beyond their drug using and sex-work status. Programmes with a community focus are more accessible and less stigmatising. A range of services, apart from health care services and gender sensitive residential treatment and rehabilitation centres for women drug users, that need to be developed include:

All treatment modalities that serve women, and those that cater to women burdened by drug abuse in the family, must be sensitive to needs such as counselling, family therapy, ancillary services such as transportation, child-care, housing, legal assistance and job or vocational training.

It is necessary to emphasise that drugs mean different things to different people. Drug use can be a response to marginalisation, isolation and stress, it can also emerge from financial independence, positive growth and emancipation. Thus, drug use in women must be understood and addressed from all these perspectives.

- Information and education about drug use consequences
- HIV/STD Counselling and Testing facilities
- Gender sensitive training for counsellors
- Peer driven outreach services through training of ex-users, or other affected women
- Night shelters/hostels for the homeless
- Auxiliary services for children of affected women
- Vocational skills training and economic programmes like micro-credit co-operative schemes
- Services for pregnant women in the community with adequately trained and sensitive staff to recognise additional drug problems
- Legal Aid Cell and Advocacy groups
- Suicide prevention and crisis intervention help-lines
- Self-help groups and co-operatives
- Utilisation of government schemes for loan for small businesses
- Harm reduction programmes
- Life skill based approach, with focus on current gender issues in society
- Sensitisation and training for professionals, police and service providers to gender issues related to drug use
- Encouragement and support for alternative livelihoods for women involved in illicit drug cultivation and supply
- Networking of women-sensitive NGOs and government organizations working for women's development and women's problems.

Finally, it is necessary to emphasise that drugs mean different things to different people. While drug use can be a response to marginalisation, isolation and stress, it can also emerge from financial independence, positive growth and emancipation. Drug use is a dynamic phenomenon greatly influenced by prevailing mores, attitudes and behaviours in society. Its consequences also differ according to people's vulnerabilities, strengths and supports. Thus, drug use in women must be understood and addressed from all these perspectives.

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APPENDIX

STUDY LOCATIONS, ORGANISATIONS AND SITE INVESTIGATORS

Study: Burden on Women due to Drug Abuse by Family Members
(Co-ordinator: Mala Kapur Shankardass)

Site	Name of the organisation	Site Investigator
1.Chennai	T.T. Ranganathan Clinical Research Foundation	Shanthi Ranganathan
2.Bangalore	NIMHANS	Vivek Benegal
3. Chandigarh	Caring Foundation	Sunil Mittal
4. Solan and Shimla	Caring Foundation	Sunil Mittal
5. Delhi	Development Welfare and Research Foundation	Mala Kapur Shankardass
6. Thiruvananthapuram	Foundation for Integrated Research and Mental Health	Vishwananhan S. Mani
7. Imphal	Centre for Social Development	U. Nobokishore Singh
8. Pune	Muktagan Mitra	Anil Awachat

Study: Substance Abuse among Women
(Co-ordinator: Shobha Lal Kapoor)

Site	Name of the organisation	Site Investigator
1. Mumbai	Mukti Sadan Foundation	Shobha Lal Kapoor
2. Aizawl	Calcutta Samaritans	Vijayan Pavamani
3. Delhi	Caring Foundation	Sunil Mittal

Study: Rapid Assessment Survey
Sites Sponsored by UNDCP
(Co-ordinator: M. Suresh Kumar)

Site	Name of the organisation	Site Investigator
1. Amritsar	SHARAN India	Mukta Sharma
2. Jamshedpur	Calcutta Samaritans	Mahesh Nathan
3. Shillong and Jowai	NEIDAC	Sunder Daniel
4. Dimapur	Vivekananda Education Society	C. G. Chandra
5. Hyderabad	SAHAI Trust	Joe Arimpoor
6. Bangalore	NIMHANS	Pratima Murthy
7. Thiruvananthapuram	SAHAI Trust	V. S. Mani
8. Goa	TISS	D. R. Singh
9. Ahmedabad	NARC	Gabriel Britto

Sites Sponsored by UNESCO
(Co-ordinators: Luke Samson & Jimmy Dorabjee)

Site	Name of the organisation	Site Investigator
10 Delhi	SHARAN India	Jimmy Dorabjee
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12. Calcutta	RIICE, Society for Applied Studies	Samiran Panda
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14. Mumbai	Sankalp Rehabilitation Trust	Eldred Tellis

Women and Drug Abuse: The Problem in India

This monograph provides a window into the world of women affected by drug use in India. It concentrates on the experience of women living with drug use in the family and the experience of the female drug user herself. Data for the report was obtained from the existing literature on the subject, an analyses of gender relations in the country and from three specific studies.

Among the monograph's significant findings are

- The major burdens on women living with drug users are its economic costs, social blame and isolation.
- Many women with drug using family members are subject to physical and verbal abuse.
- Despite significant psychological distress, a majority of women living with drug users never received any professional support.
- The majority of female drug users in the sample are single, educated, employed and report early onset of drug use.
- Women drug users are engaged in unsafe practices such as early initiation into sex and the sharing of needles and syringes among IDUs.
- A significant number of women drug abusers, from non-marginalized groups, are neither aware of services, nor have sought any treatment.
- Many women drug users did report strong religious beliefs and a spiritual inclination that has been successfully incorporated by treatment groups.
- The 1990s witnessed an increase in the use of opiates, especially heroin, among women in different cities.

The monograph also discusses the role of women in the drug distribution system and treatment options for female drug users. Most importantly, it highlights the importance of considering gender as a cultural process and institution in grappling with the problem of drug use and women in India. To this end it makes recommendations on drug policy, treatment modalities and treatment services that incorporate this perspective.

This monograph is part of the project titled 'National Survey on Extent, Pattern, and Trends of Drug Abuse in India'.

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