

## 3. THE NATIONAL SURVEY- OBJECTIVE AND METHODOLOGY

The objective of the present survey is to develop national baseline estimates and determine the extent of drug abuse. It suggests steps to be initiated or strengthened in the field of demand reduction in India. The key indicators are: prevalence and pattern of drug abuse among the general population, demand for treatment for drug abuse and the pattern and problem of drug abuse among identified drug users. The project includes three major components and five focussed thematic studies:

1. National Household Survey on Drug and Alcohol Abuse (NHS)
2. Drug Abuse Monitoring System (DAMS)
3. Rapid Assessment Survey (RAS)  
14 sites
4. Focussed Thematic Studies:
  - 4.1 Drug Abuse among Women
  - 4.2 Burden on Women due to Drug Abuse by Family Members
  - 4.3 Drug Abuse among Rural Population
  - 4.4 Availability and Consumption of Drugs in Border Areas
  - 4.5 Drug Abuse among Prison Population

The period of data collection was March 2000 - November 2001. Each component has separate specified objectives and a distinct methodology. These are briefly discussed below.

### 3.1 National Household Survey (NHS)

This component proposed to study: (a) prevalence of abuse of various licit and illicit substances for the country as a whole and (b) socio demographic correlates of drug abuse.

The non-institutionalised male population between the ages 12 and 60 years in all the erstwhile 24 states\* (excluding Jammu and Kashmir) of the country covering both the rural and urban population was included in the study. Persons staying in the hostels, prisons and other institutions were not included. Within each of the sampling domains (states, rural and urban areas), a systematic, multi-stage stratified random sample was chosen. The sampling unit in the first stage corresponded to the PSUs (Primary Sampling Units) of the 1991 Census of India.

The census consisted of villages in the rural sector and wards in urban areas. At the first stage, the PSUs were selected in

#### Box 3.1

##### Objectives (National Scenario)

- Prevalence of lifetime and current use of various drugs
- Estimate the extent of drug dependence
- Socio-demographic correlates

\* At the time of planning of the survey, the states of Bihar, Madhya Pradesh, Uttar Pradesh were not divided leading to formation of 3 new states viz. Jharkhand, Chattisgarh and Uttaranchal respectively.

Box 3.2

**Methodology**

- Non-institutionalised males between 12-60 years
- Rural and urban sample
- Selection of primary sampling units
- Sample selection by probability proportional to population size

Box 3.3

**Core Data Items**

- Section A - Basic household information
- Section B - Socio demography of respondents
- Section C - Screening for various drugs of abuse
- Section D - Diagnosis of abuse and dependence

Box 3.4

**Objectives**

- Develop a monitoring system for the country
- Collection of data from people seeking treatment
- Develop a format for collecting information on a regular basis

each state through PPS (Probability Proportion to Population Size) sampling.

Information was obtained through face-to-face interviews. The field staff underwent training for the purpose and had a detailed instruction manual with them. By and large, the interviews were completed in a single session. After an exhaustive review of the available international instruments used for the epidemiological study and screening for drug abuse (including the Alcohol Use Disorder Identification Test - AUDIT, Babor et al 1989, Composite International Diagnostic Interview Substance Abuse Module-CIDI-SAM, Robins et al 1995) the research team identified the items, format and the instrument for the current study. The diagnosis of dependence was arrived at using ICD-10 categories (WHO 1992). The instrument had four sections and the highlights are depicted in Box 3.3. Various questions addressed “ever use<sup>\*</sup>” as well as “current use<sup>#</sup>” and inquired into details needed to make a diagnosis

for abuse and dependence on tobacco, alcohol, opiates, cannabis and tranquillizers. The validity and reliability of the instrument was established through a pilot study.

**3.2 Drug Abuse Monitoring System (DAMS)**

In this component (see Box 3.4), data was obtained on persons seeking help from the centres funded by the Ministry of Social Justice and Empowerment (MSJE), the Ministry of Health and Family Welfare (MOHFW) and others providing services to drug users. For this purpose, all treatment centres funded by the MSJE, MOHFW and private psychiatrists were contacted. The data source was expanded to include Non-Governmental Organisations (NGOs) working with HIV/AIDS (henceforth NGO-HIV/AIDS), organisations working with children in difficult circumstances (henceforth NGO-children) and youth organisations - Nehru Yuva Kendras (NYKs). Prisons and psychiatric hospitals also participated.

These centres collected data pertaining to all new drug users seeking help over a period of three months through a specified format designed for this purpose. The form was to be filled on the first day of the contact. A suitable manual explaining the method of data collection, the codes and the other useful information was developed and supplied to all the participating agencies. Additionally, information about the

<sup>\*</sup> “Ever use” implies using the drug ever in the lifetime.

<sup>#</sup> “Current use” implies use in the previous one month

available services and staff position in these participating agencies providing treatment and after care services was obtained. For the purpose of analysis, information from the treatment centres run by GOs, NGOs and private psychiatrists have been clubbed together (Category A). The data from the remaining centres (Category B) have been analysed separately.

The DAMS obtained information on demographic parameters, drug use history, expenditure on drugs, drug-related arrests, previous treatment attempts, sexual history, family violence, family history of drug use and parental education. Staff from the participating NGO underwent training before the data collection phase.

### 3.3 Rapid Assessment Survey (RAS)

The multi-site RAS attempted to obtain data from hidden and otherwise inaccessible drug users in the community. The sample is non-random and the data thus cannot be generalised for the entire population. Despite this shortcoming, it provides valuable information on several aspects of drug abuse.

Rapid Assessment Surveys as envisaged by organisations such as WHO, UNAIDS and UNODC have been undertaken in many parts of South Asia including some cities in India, Nepal and Bangladesh (WHO 1998, WHO / UNAIDS 1998 and UNODCCP, 1999).

The study was conducted in the following 14 urban areas (see Map 3.1):

#### Box 3.5

##### Objectives

- Study the extent and nature of drug use in the identified urban sites
- Study the demographic characteristics, drug use patterns, risk behaviours, adverse health and social consequences of drug users
- Study the service demand of drug users and the existing treatment responses
- Recommend an action plan to reduce the adverse consequences of drug abuse

Amritsar (Punjab, North India), Jamshedpur (Jharkand erstwhile Bihar, East India), Shillong/Jowai (Meghalaya, North East India), Dimapur (Nagaland, North East India), Hyderabad (Andhra Pradesh, South India), Bangalore (Karnataka, South India), Thiruvananthapuram (Kerala, South India), Goa (West India), Ahmedabad (Gujarat, West India), Imphal (Manipur, North East India), Kolkata (West Bengal, East India), Chennai (Tamil Nadu, South India), Mumbai (Maharashtra, West India) and Delhi (North India). The study was jointly sponsored by UNODC and the United Nations Educational, Scientific and Cultural Organisation (UNESCO).

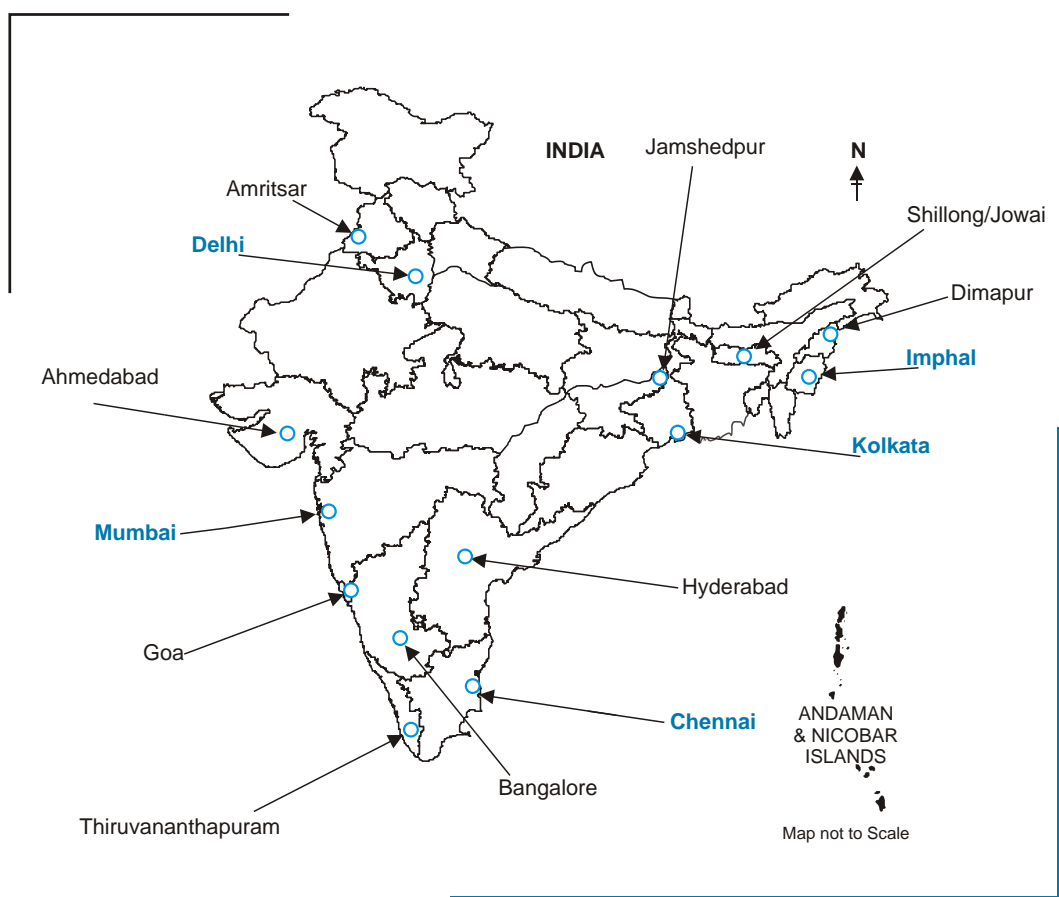
#### Box 3.6

##### Core Data Items

- Description of clients / patients
- Family background
- Types of drugs being abused
- Methods of consumption
- Legal history
- Treatment history
- Sexual behaviour

Map 3.1

### RAS Sites



Sites in Group A: Amritsar, Jamshedpur, Dimapur, Shillong/Jowai, Hyderabad, Bangalore, Thiruvananthapuram, Goa and Ahmedabad (sponsored by UNODC, N=9)

Sites in Group B: Kolkata, Mumbai, Delhi, Chennai and Imphal (sponsored by UNESCO, N=5)

*The boundaries and names showed in this map do not imply official endorsement or acceptance by the United Nations*

The field researchers for the project recruited at each site helped in identifying the drug-using locales and drug-using population. The sample was chosen through (1) initial mapping of city-level indicators of injecting drug use (2) ethnographic mapping of certain

neighbourhoods and geographical locations identified to have high prevalence of drug injecting.

The information was collected through several methods. Following their identification, the drug users were interviewed in detail. The interviews

were mostly open ended, though a few areas were assessed through a structured interview schedule. In addition, focus group discussions were conducted to collect information quickly and at less cost than individual interviews. These were useful for identifying and exploring beliefs, attitudes, opinions, and behaviours and for identifying questions for later use in individual interviews.

**Box 3.7**

**Implementation**

- Establish core rapid assessment team
- Community consultation
- Training of research staff
- Fieldwork data collection

*Box 3.8*

**Data Collection Strategies**

- Sample selection
- Ethnographic mapping
- Participant observation
- In-depth interviews with drug users
- Interview of key informants
- Focus group discussion

Finally, several key informants (KIs) - such as law enforcement officers, treatment providers, ex-drug users, drug dealers and media persons - were interviewed (see Box 3.9). Field reports were produced based on observations made by the research staff. Four categories of key informants, namely policy makers, treatment centre personnel, drug users and drug dealers, and community leaders, were interviewed.

The field research staff, following extensive training obtained both quantitative and qualitative data as described in Boxes 3.10 and 3.11.

*Box 3.9*

**Sample of Key Informants**

- Drug users
- Law enforcement officers
- Service providers
- Ex-users
- Drug dealers
- Pharmacists
- Media personnel

*Both quantitative and qualitative information was obtained*

*Box 3.10*

**Core Data Items Quantitative**

- Section A - Socio-demography of users
- Section B - Drug use history
- Section C - Information on injecting practice
- Section D - Disease
- Section E - Sexual behaviour
- Section F - AIDS knowledge
- Section G - Existing services
- Section H - Context of drug use

*Box 3.11*

**Core Data Items Qualitative**

- Trends, pattern and changes in drug abuse
- Sexual behaviour
- Drug use and prison
- Human rights
- Action plan
- Issues related to treatment
- Case vignettes
- Trafficking of drugs
- Role of media

In addition to the above three components, certain special populations were studied through focussed studies to obtain a glimpse of drug abuse among women, burden on women due to drug abuse by their family members, drug abuse among rural population, in border areas and among prison population.

Box 3.12

**Objectives**

- Reconstruct substance use history
- Document special characteristics
- Document consequences of substance use
- Identify issues regarding treatment and gender sensitive treatment facilities
- Obtain views of the key informants

Box 3.13

**Core Data Items**

- Socio-demography of users
- Substance use history
- Social stability
- Health status
- Self esteem
- Household characteristics
- Marital history
- Social support system, resources and help seeking behaviour

**3.4 Focussed Thematic Study: Drug Abuse among Women**

The study on Drug Abuse among Women examined individual characteristics, household characteristics and social support systems available to and accessed by these women users.

The data items (see Box 3.13) comprised demographic features, substance use history, health status, social stability, self-esteem, household composition, health status of the family, current living arrangements, household interactions, cohesion, adaptability, communication, decision-making and history of substance use in the family and available help for treatment of drug dependence.

Women drug users (purposive sample) were selected from three sites, namely Delhi (NCR), Mumbai (Maharashtra) and Aizawl (Mizoram). The sample from Aizawl was comprised of women users who were in treatment. The Delhi sample was comprised of working women and the Mumbai sample was restricted to street women who were involved in commercial sex work. The subjects were included following their informed consent. In addition, key informants from various settings such as treatment centres, the community or the workplace were included. The key informants from drug-treatment services and public hospitals, police departments, self-help group members, general practitioners and lawyers were interviewed.

**3.5 Focussed Thematic Study: Burden on Women Due to Drug Abuse by Family Members**

The sample in the study on Burden on Women interviewed were adult women subjects who were living with an affected close family member who was a current regular (daily or near daily) user of drug(s) other than exclusively alcohol or tobacco. The women themselves were not regular users of any dependence producing substances.

The subjects were recruited from eight urban centres namely Bangalore (Karnataka), Chennai (Tamil Nadu), Delhi (NCR), Chandigarh (Haryana), Solan and Shimla (Himachal Pradesh),

Box 3.14

**Objectives**

- Document social, familial, economic, health and psychological consequences on women due to drug abuse by family members
- Document burden and impact as experienced by the women themselves
- Document burden on women as reported by the key informants

Box 3.15

**Core Data Items**

- Socio-demography
- Household characteristics
- Substance use history of the affected family member
- Respondent's involvement in drug use by the family member
- Treatment history
- Impact-physical, psychological, social complications and violence
- Help seeking
- Overall subjective report of burden (Analog scale 0-100)

Imphal (Manipur), Pune (Maharashtra) and Thiruvananthapuram (Kerala), as well as from various settings such as treatment centres, the community or the workplace. Key informants from these eight sites were also interviewed.

### 3.6 Focussed Thematic Study: Drug Abuse among Rural Population

The study carried out in-depth interviews with drug users by trained research staff and from various settings in rural areas, such as treatment centres.

The study was carried out in six sites and obtained information from drug users in the following districts / states: Bikaner (Rajasthan), Barabanki (Uttar Pradesh), Jabalpur (Madhya Pradesh), Kurukshetra (Haryana), Kullu (Himachal Pradesh) and Cuttack (Orissa). The data comprised both quantitative and qualitative information obtained by trained field investigators in one-to-one

Box 3.16

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| <p><b>Objectives</b></p> <ul style="list-style-type: none"> <li>• Document the extent, patterns and trends of drug abuse among rural subjects</li> <li>• Document the consequences of drug abuse on them</li> <li>• Obtain views of key informants on drug abuse in rural India</li> </ul> |
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Box 3.17

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| <p><b>Core Data Items</b></p> <ul style="list-style-type: none"> <li>• Socio-demography of users</li> <li>• Family background</li> <li>• Patterns of drug use</li> <li>• Impact of drug use</li> <li>• Drug use-situation and context</li> <li>• Help seeking</li> </ul> |
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situation from the subjects of the study (see Box 3.17). Informed consent was obtained from the respondents. During this period the field staff also collected secondary data and information from several key informants (experts) from the sites. These key informants included locals and community leaders, government officials, police personnel and service providers.

### 3.7 Focussed Thematic Study: Availability and Consumption of Drugs in Border Areas

Several reports including the report of the International Narcotics Control Board (INCB 2000), suggested that the trafficking of drugs takes place through the international borders and this could influence availability and consumption in these areas. The present study explored drug trafficking across the international borders of India and availability and consumption of various drugs in these border areas. It examined both supply and demand of various drugs in these sites.

The study was conducted in the following sites covering different international borders of India:

Indo-Pakistan Border (three sites)

1. Ranbir Singh Pura (R.S. Pura), Suchetgarh border, (Jammu Region, Jammu and Kashmir)
2. Attari, Wagah border (Amritsar district, Punjab)
3. Barmer, Chohtan Border (Barmer district, Rajasthan)

Box 3.18

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| <p><b>Objectives</b></p> <ul style="list-style-type: none"> <li>• Document the availability, seizure and trafficking of various drugs in border areas</li> <li>• Document the extent, pattern and consequences of drug abuse in border areas</li> <li>• Document the linkage between supply, availability and consumption of drug abuse in border areas</li> </ul> |
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Box 3.19

**Core Data Items**

- Socio-demography of users
- Description of the border town/ district
- Pattern of drug consumption
- Hazards of drug use
- Treatment services
- Others - relationship between availability and consumption

Indo-Nepal Border (one site)

4. Sonauli-Nautanwa (Maharaj Ganj district, Uttar Pradesh)

Indo-Bangladesh (one site)

5. Lal g o l a , B h a g a w a n g o l a (Murshidabad district, West Bengal)

Indo-Myanmar (two sites)

6. Tuensang, Noklak (Tuensang district, Nagaland)

7. Moreh (Chandel district, Manipur)

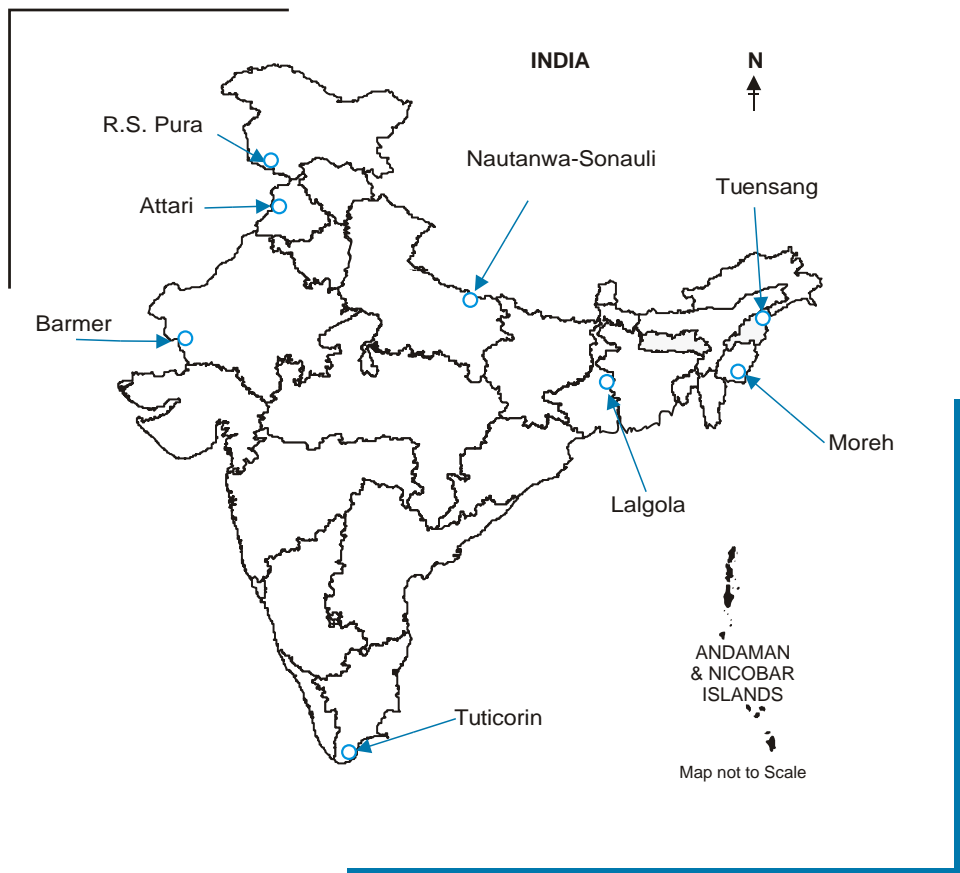
Indo-Sri Lanka (one site)

8. Tuticorin (Tuticorin district- Tamil Nadu)

The universe of the study was a border district at each selected site having international boundary. The unit of the study was a town/cluster of villages located near the international border. The chosen sites (Map 3.2) provided a fair

Map 3.2

**Sites : Availability and Consumption of Drugs in Border Areas**



*The boundaries and names showed in this map do not imply official endorsement or acceptance by the United Nations*



representation of the border areas/towns with neighbouring countries. It is hoped that the information collected from these various sites provides a comprehensive picture on this theme.

The research staff comprised one social scientist trained by UNODC. The task was to collect primary as well as secondary data from these eight sites under the overall supervision of a site supervisor. The information was collected through an interview schedule / questionnaire. The subjects (non-probability sample) of the study were included with their consent. Additionally, community resource persons and law enforcement experts were also interviewed.

The four thematic studies described above (3.4-3.7) utilised non-probability sampling and snowball technique to identify the subjects. The criteria for sample selection and items for data collection were discussed and finalised during the Planning and Training Workshop held at UNODC, in New Delhi. The information was collected through in-depth face-to-face interviews with the subjects / respondents. Both quantitative and qualitative data were obtained. The research staff took field notes and also maintained personal diaries. The interview schedules were pre-tested and revised during the training workshop.

The primary data obtained in both these studies was complemented with the collection of available secondary data from the various sites.

*Box 3.20*

**Objectives**

- Document the extent, pattern, trends and consequences of drug abuse
- Profile of the subjects over last four years
- A brief description of treatment facilities in the prison-AASRA

*Box 3.21*

**Core Data Items**

- Demographic features
- Types of drugs being abused
- Frequency of consumption
- Route of administration
- Duration of drug use
- Age of initiation
- Severity of drug problem
- Previous treatment history
- Arrests

**3.8. Focussed Thematic Study: Drug Abuse among the Prison Population**

The component on Drug Abuse among the Prison Population was designed to document the extent and pattern of drug abuse among prisoners in a large prison in the country.

In this study, the information was collected using a standardised format. The data items covered were: demography, treatment services and pattern of drug use and were collected by AASRA (An Association for Scientific Research on the Addictions) which was one of the organisations active in prison reform during the period 1997-2000. AASRA had been involved in providing care to the drug users in the Tihar Jail using a modified therapeutic community approach

**Common Data Items**

The three major components (NHS, DAMS and RAS) of the survey had some common data items. In addition, each component also had unique and exclusive information on various aspects on drug abuse from the particular city / state / region. The following items were

common to all the three components:

- a. *Socio-demography*: age, sex, residence, marital status, religion, education, occupation, employment and income.
- b. *Drug use pattern*: age of first use, drugs used - lifetime and current, family history of drug use, injecting drug use (IDU - ever use and current use) and sharing of needles and syringes.
- c. *Sexual behaviour and knowledge on AIDS*: sexual partners, sex with commercial sex worker (CSW) and practice of safe sex.
- d. *Treatment history*: ever and last treatment taken.
- e. *Legal aspects*: imprisonment, arrest by police, drug related violence.

Information on members of the household and profiles of non-users is available only from the NHS component. Information on reasons for drug use is available both from the NHS and the RAS component.

Detailed information on the situation of first drug use (initiation) is available from the RAS component as verbatim responses from the users. Elaborate information on injecting drug use in the form of reasons, reasons for shifting to IDU, frequency of sharing, cleaning habits, etc. is available from the NHS and the RAS components. With regard to disease and treatment history, both the NHS and RAS components provide data on illnesses suffered since onset of drug use, available health services, accessing these services and satisfaction with the treatment received. Thus, some information is common to two or more of the components. However, each component also provides some special and unique information. In-depth qualitative information on various aspects of drug abuse is available only from the RAS component.

Some of the conclusions drawn from the above studies can also be supplemented by the data from the focussed thematic studies.