

## 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

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**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
Psychological	● Anaemia
	● Headaches
	● Insomnia
Social	● Depression
	● Anxiety
	● Reduced family support
	● Family rejection
	● Deviant lifestyle



*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

**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

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%).

### 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

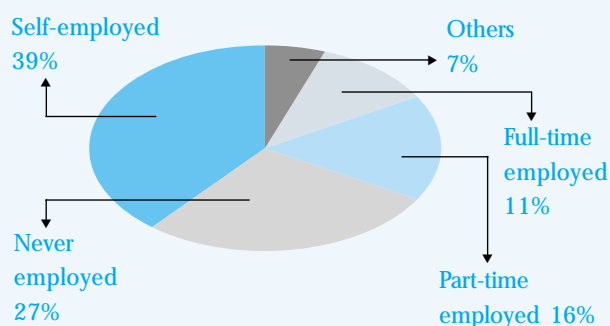


**Table 6. Education (Number of Subjects)**

	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

**Figure 8. Employment Status (Percentage)**



'never employed' group was almost exclusively from Aizawl (19/25).

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

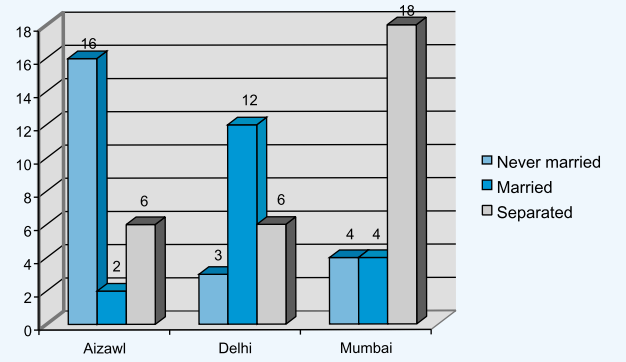
begging, especially among those with physical problems. Respondents who spoke English and were able to attract upper middle class clients, and those who were willing to offer fellatio or sex without condoms, had higher daily incomes.

**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.

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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

Drug Abuse by Family Members	
Alcohol	30.7%
Heroin	25.3%
Propoxyphene	6.7%

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 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

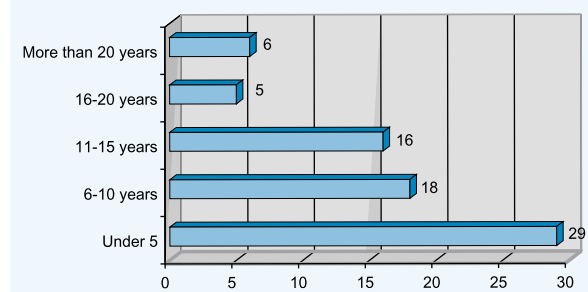
had been initiated before the age of 10 years, while at the other end three from the Delhi sample had started drug use after the age of 40.

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).

#### 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

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

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.

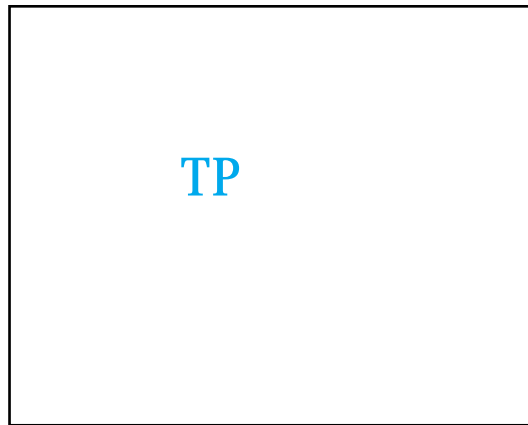
### Drug Abuse and Health Consequences

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.

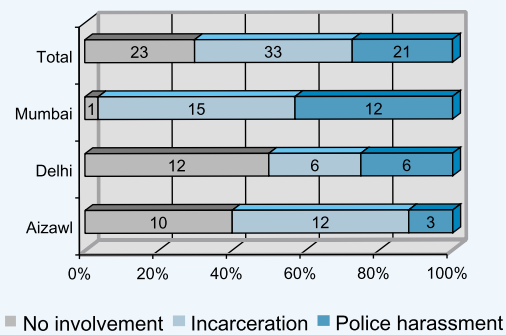


Menstrual problems were reported by seven (9.3%) respondents. At least nine women had undergone surgery, each for a different reason, and a similar number reported abortions. Five women from Mumbai had each lost a child below one year of age.

### Legal Problems

Only 23 respondents reported no legal involvement (Figure 11). These were mostly from Delhi and Aizawl. 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

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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.*

