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Office on Drugs and Crime

Regional Office for
South Asia

Women and Drug Use in India:

Substance, Women and High - Risk Assessment Study

Ministry of
Social Justice
and Empowerment

United Nations
Development Fund for Women
UNIFEM

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2008

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JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

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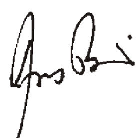
Foreword

The Ministry of Social Justice and Empowerment and the United Nations Office on Drugs and Crime, Regional Office for South Asia have been engaged in addressing the issues which face women drug users and women partners of drug users. It is imperative that the special gender concerns are appropriately recognized and specific interventions are developed for women in order to provide a comprehensive package of services for prevention of HIV among women affected and infected by drug use.

The project, viz. "Reducing substance use related HIV vulnerability among fermale drug users and female partners of male drug users", is a pilot initiative in this regard. The data collected by NGOs in various states from women respondents is important, as it indicates the various aspects and dimensions in which future work can be taken up. We recognize that it is a multi dimensional problem and requires multisectoral response.

It is critical that gender sensitive services appropriately designed towards women are provided by service providers in addressing the increasing vulnerability of women to HIV and dual burden of drug use as a user and partner. The report provides a qualitative insight into the minds of women afflicted and affected by drug use through the life narratives. The fact that so many women have shared their life stories shows a new aspect of the comumunity where women are now courageously coming forward to claim their rightful place in society and it is incumbent on all of us to ensure this.



Dr. Arbind Prasad
Joint Secretary (SD)
Ministry of Social Justice and Empowerment

Preface

Substance use and HIV are serious health concerns in India and present significant challenges for the civil society, public health authorities and the national government.

Women are hit hard by drug abuse in two main ways. First is when they use drugs themselves. These risks are obvious. However, secondly, even if they do not use themselves but are the wives or partners of drug users who may also be injecting, they face severe problems. When this happens, the burdens that women are forced to bear include financial and emotional difficulties. Children are neglected. Often they themselves are beaten. Their dignity is compromised.

Women are often not in a position to negotiate safe sex with their partners and especially under the influence of drugs and alcohol. The health risks associated with substance use adds to their burden. They are often not able to access services for drug treatment as well as for HIV care and support. Gender sensitive services for drug use and HIV are limited in most countries and required attention by both policy makers and service providers.

In order to have more information on the nature of the problem of drug use among females and partners of drug users in India, UNODC commissioned this study in partnership with the Ministry of Social Justice and Empowerment, Government of India under a project called ***'Reducing Substance Use Related HIV Vulnerability in Female Drug Users and Female Partners of Male Drug Users (INDI49)'.*** Our other partners were UNIFEM, UNAIDS and DFID. The work involved active participation of 109 NGOs who interviewed 4401 female partners and 1865 female drug users, with 137 life history narratives. All this provided the valuable data which makes this report possible.

This document provides a comprehensive assessment of the burden which women carry either as drug users or as partners of drug users. The report has brought out the urgent need to design interventions specifically for women and it is our hope that the recommendations will provide a foundation for such work in the future. I hope that this wealth of knowledge will prove useful to planners, policy makers, researchers and academicians.

We would like to thank out technical experts for undertaking this study and giving us an insight into this complex issue and valuable suggestions on possible interventions which can be developed to meet the special needs of females in the overall substance use and HIV response in the country. We sincerely acknowledge the work of the service providers who ceaselessly work in communities to prevent the spread of HIV among drug users and their partners.

Ashita Mittal
Deputy Representative and Officer-In Charge
UNODC Regional Office for South Asia

Prelude

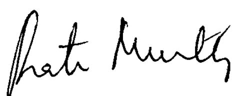
The picture of substance use in India keeps changing rapidly. Among men, the traditional patterns of cannabis and opium use have been replaced by the use of processed, synthetic or semi-synthetic drugs of abuse. Pharmaceutical drug misuse is becoming more prevalent. Another visible change is the emergence, in substantial numbers, of women using substances. A decade ago, women were left out of epidemiological surveys of drug use, because they were too difficult to find. Now, the trends are changing, as the use of various psychoactive substances, including injecting patterns of use, is becoming more and more evident among women.

Women carers bear the brunt of drug misuse by family members. The first in-depth evaluation of women carers, published in a UNODC report in 2002, revealed that drug use in the family burdens these women with enormous mental, physical and financial stress. Substance use patterns among the few women evaluated at that time indicated a close connection between substance use and risky sexual practices.

The 'Substance, Women and High Risk Assessment study' is a stark revelation that there are many more women using drugs and alcohol than was believed before. It reveals the close relationship between the use of licit and illicit drugs (collectively referred to as substance use). It highlights the need to consider the consequences of substance use in women against the complex psychosocial and economic-political disadvantages that many South Asian women face. It attempts to recreate the circumstances that drive women to initiate substance use, the consequences of both the partner and the woman using substances. It examines the role of substances in violence, sex, reproductive well-being, HIV vulnerability and childcare, and draws attention to its ravaging effects on women's mental health. Just as poverty and gender inequalities drive the HIV epidemic, they propel the substance use 'epidemic' as well. And substance use, just like the HIV situation, is recognized as becoming feminized as well. When the two occur together, as they do often, the results are devastating.

The study underscores the need to understand and address substance use and related vulnerabilities in women, in a holistic and gender-sensitive manner.

The term 'substance use' in the document refers to non-prescriptive use of mind-altering substances.



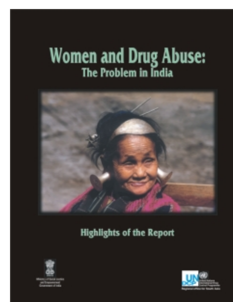
Pratima Murthy

Executive Summary

Women are dually affected by substances, both as partners of men using substances and their own use. Since, more often than not, women using substances are also partners of users they have a double disadvantage. Any consideration of the consequences of substances for women in India must take into consideration the enormous social adversities they face, quite apart from the consequences of substance use itself. In 2002, small sub-studies, including one about the burden on those caring for substance using family members, and the other on women substance users themselves, highlighted these problems. These findings, along with the conclusions of a subsequent rapid assessment study were compiled into a UNODC publication: 'Women and Drug Abuse - the Problem in India'. While helping to develop a deeper understanding of the complex problems caused by substance use, this publication emphasized the need for a shift from a simplistic, single-cause, linear model to a multi-cause, interactive model to understand women's vulnerability to this problem.

The new study aims to understand the socio-economic conditions, patterns and consequences of psychoactive substance use on health, particularly reproductive health, STI/HIV vulnerability, and the psychological well being of women affected by substance use, directly or as partners. It evaluates existing support systems and the overall needs of women partners, and women using psychoactive substances.

109 NGOs across India participated in this study. Women partners of men using substances and women currently using substances were identified through purposive sampling using a key informant and snowballing approach. A total of 6266 respondents, 4401 women partners not using substances (Non substance using partner or NSUP) and 1865 using substances (Female substance user or FSU) were identified. Detailed life history narratives were also recorded from 137 respondents to understand various interactive factors in their lives. The personal narratives of women involved with substances bear testimony to their deep pain and suffering.



Highlights of earlier studies on women and drug abuse in India

Women partners (179 across 8 cities)

- Nearly half between 20 to 40 years
- Significant financial problems
- Physical violence -43%
- Symptoms of
  - anxiety -55%
  - depression- 47%
  - suicidal thoughts -35%

Women substance users (75 across 3 cities)

- Mostly in 20s and 30s, one-third single
- In remunerative employment-67%
- Nearly half initiated into drugs by friends
- Women in this study were mostly opiate users
- Injecting drug use reported in 41%

The Study

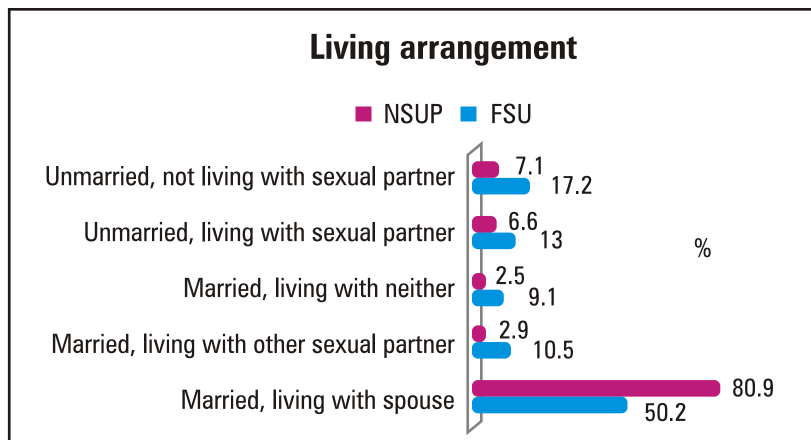
- Involved 109 NGOs throughout India
- Covers 4401 women partners of male substance users (non substance using partners or NSUPs) and 1865 women substance users (female substance users or FSUs)
- About one-fourth of respondents from rural areas
- Includes 137 detailed life history narratives

Background

NSUPs (Non substance using partners)

Though 75 %of NSUPs are in their 20s or 30s, 150 (3.5%) are below the age of 20. More than half were married before the age of 18 years. The majority (92.6%) live with their spouses while 9.5% live with a sexual partner. Nearly one in five is illiterate. Nearly one in ten of their substance using male partners is unemployed. Nearly half their partners travel away from home three or more times in a year. A large number of NSUPs (41%) perceive their partners as being indifferent, unsupportive or hostile towards them. Nearly one in three have to take their partner's permission to buy groceries or attend an NGO activity; and more than 40% have to seek permission to consult a doctor or visit their parent's home. More than half are homemakers with no independent income. The average monthly household income is Rs 3000 and an additional Rs 9500 is raised through loans, pawning or mortgage. Tobacco use is high among the in-laws (60.7%), parents (63.5%) and siblings (55%) with whom they live. Nearly a third of their family members consume alcohol. The rate of other substance use among family members besides their partners is low.

FSUs (Female substance users)



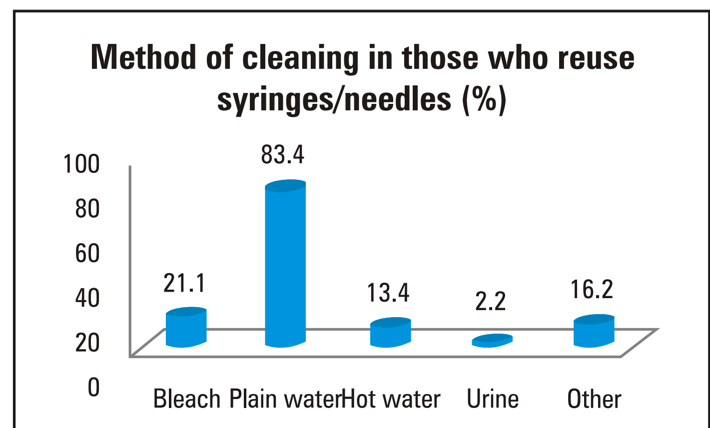
Though the FSUs in the study are mostly in their twenties or thirties, 113 (6.2%) are below 20 years of age. Nearly one in three is illiterate. Their life history narratives show that nearly one in four lost her father in early childhood. While a majority (63.9%) is married, 16.5% are single and 19% have never been married. Of those married, more than half were married before the age of 18. Nearly one in four (23.5%) lives with a sexual partner other than the spouse. 16.4% FSU partners are unemployed. More than half the partners are away from home three or more times in the year, and 72 (4.8%) live away from home. 38% feel their partners are indifferent, unsupportive or hostile. FSUs are more likely to have grown up in circumstances of poverty, but currently, more than 60% have some form of remunerative employment. Nearly a third (32.3%) earn their livelihood from sex work and/or peddling. FSUs have relatively greater autonomy in decision-making. Their average monthly household income is Rs 4000, and Rs 8850 is raised every month, through loans, pawning and mortgage. Tobacco use is high among the relatives they live with, such as in-laws (60.7%), parents (59.4%) and siblings (54.8%). About one-third parents, nearly one-third siblings and more than half the in-laws with whom they live, consume alcohol. 6.3% of their in-laws and 15.5% of their siblings use other substances.

Partner's use of substances

Partners' use of substance resembles known patterns of substance use in the community. One in 4-5 partners reports lifetime injecting use. 25% of NSUPs and 45.6% of FSUs financially support their partner's substance use. 68.1% of NSUPs and 72.5% of FSUs perceive their partner's substance use places a financial burden on them.

Substance use patterns

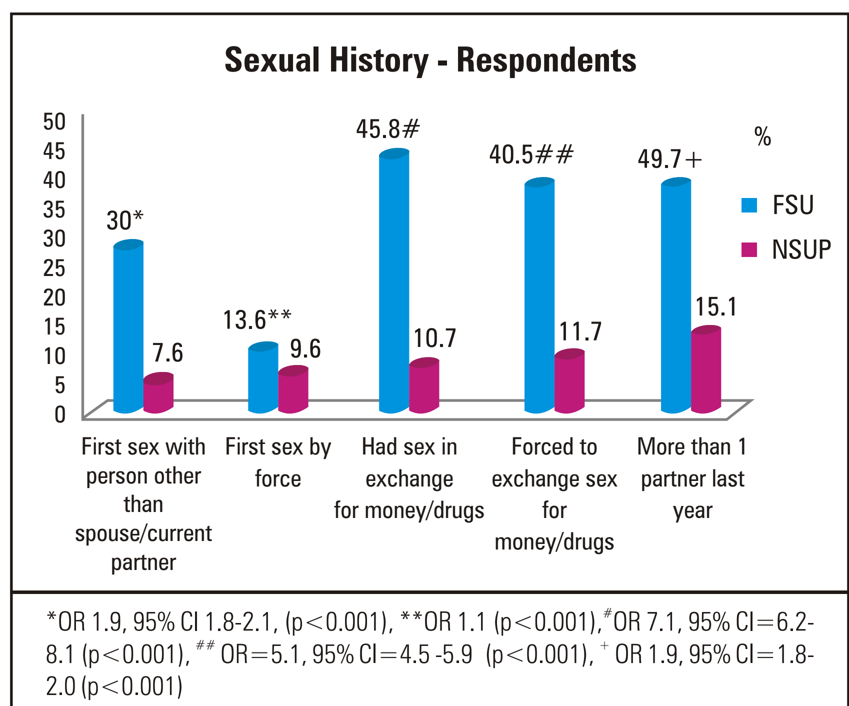
NSUPs have low lifetime rates of tobacco, alcohol and other substance use. FSUs have high rates of lifetime use of tobacco (79.1%), alcohol (77.4%), heroin (33.5%), dextropropoxyphene (25.9%), sleeping pills (22.4%) and cannabis (22.7%). Tobacco use precedes the use of most substances except solvents and is initiated in the late teens (mean age 18.4 years) but the transition to other drugs is rapid. Mean age of solvent initiation (5% of FSUs ever users) is 16.5 years. Currently, nearly 75% of heroin users, 50% users of sleeping pills, cannabis and alcohol and one-third of solvent users use the substance daily/ nearly every day.



Apart from tobacco and alcohol, the commonest substances used are heroin, dextropropoxyphene, sedatives/hypnotics and cannabis. The usual reasons for initiation include childhood difficulties, peer/partner influence, physical and emotional distress and iatrogenic causes. Tobacco and sleeping pills are commonly taken alone, alcohol and opiates with partners or alone, but solvents primarily in groups. A majority of the opiate users are from the Northeast, followed by the East and North. Women from the South more commonly use solvents and cannabis, apart from alcohol. Though injecting drug use is most visible in the Northeast, it has been reported from all parts of the country. Reasons for shifting to injecting use include peer pressure and economic difficulties. Physical ill health, inability to take responsibility and violence towards family members, especially the spouse, are some of the common consequences of use. Unsafe injecting practices are clearly evident.

Sex and Substance

Substance use among women is associated with early initiation into sex, which is often coerced. FSUs are more likely to have faced sexual abuse, premarital/ extramarital sex, exchanged sex for money voluntarily or under coercion and had more sexual partners than non-users. Nearly 60% of FSUs have positive feelings about substance use and sex, feel it is more enjoyable and makes sex less painful. About one in three FSUs and NSUPs feel that their partner's substance use makes sex more enjoyable. Condom use during sex with partners is very uncommon.



*OR 1.9, 95% CI 1.8-2.1, ($p<0.001$), **OR 1.1 ($p<0.001$), #OR 7.1, 95% CI=6.2-8.1 ($p<0.001$), ## OR=5.1, 95% CI=4.5 -5.9 ($p<0.001$), + OR 1.9, 95% CI=1.8-2.0 ($p<0.001$)

About one in three NSUPs and FSUs has no idea of her partner's extramarital life. One in four NSUPs and one in three FSUs is aware that her partner has an ongoing extramarital relationship/ another sex partner. Partners often coerce the women to have sex, and one in three demand other forms of sex under intoxication.

- During the last year:
  - One in two FSUs has had sex under the influence of substances
  - More than 75% of NSUPs and FSUs have had sex with a partner who was under the influence of alcohol
  - About two-thirds have had sex with a partner who was under the influence of other drugs
- In nearly two-thirds of the above situations, no condom has been used
- NSUPs are even less likely to be using condoms in such situations compared to FSUs

- Women using substances report significantly higher levels of violence, both physical and sexual
- More than two-third of NSUPs and nearly two-third of FSUs have sustained physical injuries from violence
- FSUs are 5 times more likely to experience physical or sexual violence under the influence of substance
- NSUPs are even less likely than FSUs to use a condom during coerced sex and to seek help when the partner is violent

Violence and substance

Women in both groups report high levels of violence, particularly from spouses/partners. More than 75% FSUs and 60% NSUPs have sustained physical injuries because of violence. The most common perpetrators are the spouse/partner, parents and in-laws. Most common perpetrators against FSUs are spouse/partner, neighbours, parents, friends and pimps. Some precedents of violence from the partner include refusal to provide money for substance, asking partner to refrain from use, or refusal to use the substance together. Condoms are seldom used during sexual coercion. About 50% of respondents do not seek help for intimate partner violence. While non-substance users tend to rely on families for help during violence, FSUs rely more on friends and neighbors. Formal services available in the community and service providers are rarely accessed for help.

- NSUPs are more likely to approach family members for help during violence
- FSUs are more likely to approach friends and neighbors for help
- Utilization of community based services for help during violence is very low in both groups

Reproductive health and substance

A significant number of respondents were unable to indicate what family planning practices they adopted or their preferred choice. Less than 50% used any form of family planning. FSUs are less likely than NSUPs to use any family planning methods. Among those able to express their choice, more than one in three preferred a female form of contraception or a combination of female and male methods. Qualitative interviews suggested that male partners do not like to use condoms because they perceive that sexual pleasure diminishes with its use. FSUs have more genito-urinary problems. Nearly one in five NSUPs and one in four FSUs report one or more induced abortions.

- Only one in two respondents among both NSUPs and FSUs has ever used any form of family planning
- FSUs are even less likely to use family planning methods
- About 40% of respondents are unable to indicate choice of family planning

FSUs more commonly report:

- Boils/warts around vulva
- Pain during sexual intercourse
- Bleeding after sexual intercourse
- Frequent urination
- Significant weight loss

HIV and substance

While a majority of women in both groups have heard about HIV/AIDS, their knowledge of transmission routes, contributory risky behavior, and ways of reducing risk is poor. Overall, the knowledge of non-users is even lower than that of FSUs. Despite being at greater risk through unsafe behaviors, more than one in two NSUPs and FSUs do not feel they are at risk for HIV. Nearly 50% respondents in both groups did not perceive that their partner was at risk. Only one in three FSUs and less than one in five NSUPs have been tested for HIV. Non-substance users are less willing to share information about their HIV status. Among those willing to reveal their status, more NSUPs report having tested positive for HIV. There is a great divide between knowledge of HIV risk and its prevention and the employment of safe sex and injecting practices. Some respondents who have received HIV counseling, report a sea change in their lives.

- Less than one in five NSUPs has ever been tested for HIV
- Nearly one in five NSUPs is unaware whether her partner has been tested
- Less than one in five NSUPs has ever been tested
- Only one in three FSUs reports ever having been tested
- Nearly 30% of FSUs are unaware if their partner has been tested
- Less than one in five FSU partners has ever been tested

- A majority of both NSUPs (76%) and FSUs (83%) have heard of HIV/AIDS
- They obtain the information mostly from the media or from others
- NSUPs have a significantly poorer knowledge about modes of HIV transmission

Children and substance

The study finds low female: male ratios among children of both FSUs and NSUPs raising continuing concerns of gender imbalance. Children of FSU's have greater illiteracy and school dropout rates. In families where both partners use substances, the responsibility of parenting falls on the grandparents.

Children of both mothers commonly experience emotional, behavioural and academic problems. These problems are significantly greater in dual substance using households (mother and father are both users). Substance misuse is higher among sons than daughters in both households. Non-substance using mothers have greater concerns about their children's' health and well-being. Concern about children is a primary motivating factor for change among FSUs.

Emotional Problems present in:

- More than one in two NSUP daughters and nearly one in two sons
- Over 40% of FSU daughters and more than one third sons

Academic Problems present in:

- About one in four NSUP daughters and sons
- One in three FSU daughters and one in four sons

Behavioral problems present in:

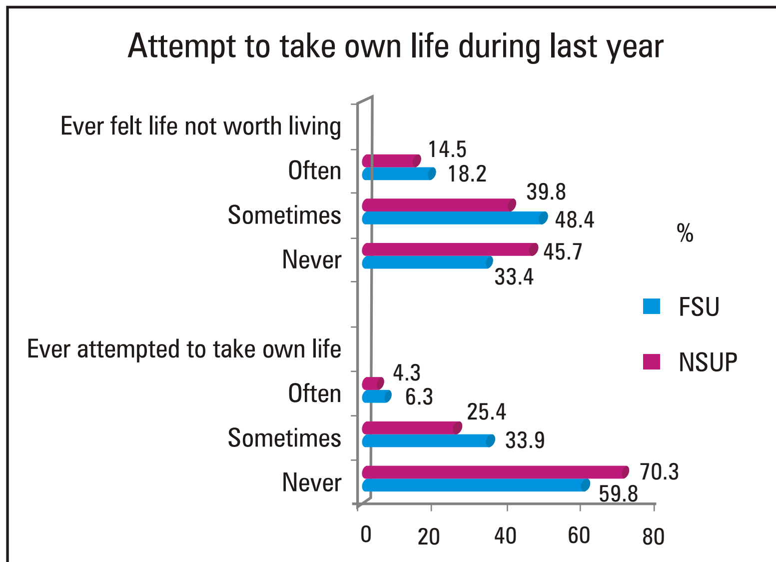
- One in five NSUP daughters and sons
- One in four FSU daughters and about one in five sons

Substance use:

- FSU sons have significantly higher rates of tobacco, alcohol and other drug use compared to NSUP sons
- FSU daughters have relatively higher rates of tobacco and alcohol use than NSUP daughters
- Substance use rates among children, especially sons, is higher in dual substance using households

Mental health and substance

A majority of FSUs and NSUPs had high scores on the General Health Questionnaire, which is a measure of emotional distress.



- About three out of four FSUs and NSUPs have scores above 11 on the GHQ 12 indicating diagnosable psychiatric illness
- During the last year more than 60% of FSUs and more than 50% NSUPs felt life was not worth living
- During the last year, nearly 40% FSUs and 30% NSUPs attempted to end their life
- In more than half to two-thirds of respondents in both groups, symptoms of emotional distress have been present for more than one year

Mean GHQ scores were significantly higher among FSUs than NSUPs. FSUs had a significantly higher frequency of suicidal attempts in the last year.

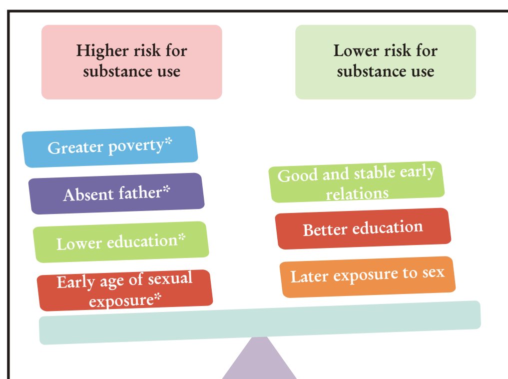
Symptoms of mental distress had been present for a long duration in many respondents.

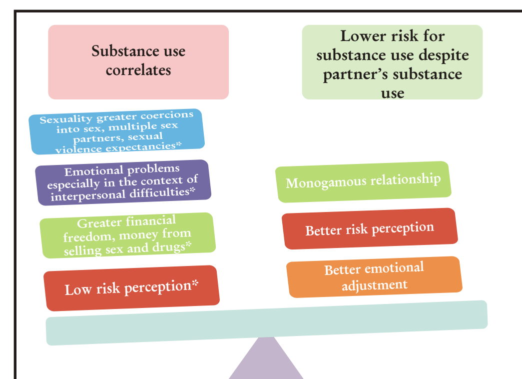
Treatment and support

Most FSUs had not received any treatment. Many perceive their families were hostile or uncaring. NSUPs, on the other hand, are more supportive of their partners. Non-governmental organizations were the most frequently accessed service providers for treatment. Both NSUPs and FSUs regarded NGOs as important sources of support whereas Government support facilities were rated very low.

- More than 80% of FSUs had not received any formal treatment for substance use
- NGOs have been the primary service providers for the few that have accessed treatment

Among both groups, the knowledge about support facilities such as mental health services, de-addiction services for women, substitution treatment, female condoms, microfinance schemes, legal and advocacy services was extremely low. This lack of knowledge reflects the paucity of such services in the community; a fact supported by their relatively better knowledge of HIV testing and counselling services, which have increasingly become more visible throughout the country.





Women and subtance use in context

Certain remote and proximal associations emerge between substance use and women from the SWAHA study. Childhood adversity, lower levels of education, absence of father and sexual exposure at an early age are remote antecedents of substance use among women. More proximal associations include relationship difficulties, peer/partner influence, sexual violence, and income through selling sex and peddling drugs. There is also a close association between lifetime use of tobacco and alcohol and present use of substances. Risk perception to HIV and potential difficulties faced by children is lower among substance users. Despite being in monogamous relationships, NSUPs are more vulnerable to HIV. Mental distress is extremely high in both groups.

Addressing the issue

Interventions for FSUs need to be comprehensive and address both remote and proximal antecedents of the issue. NSUPs are an extremely vulnerable group and their needs must be addressed in all substance use treatment and prevention settings. Specific interventions for both women partners and users include gender sensitive treatment services, which focus on reducing vulnerabilities to HIV, STIs, violence and mental health problems and address partners' risks and vulnerabilities. When male substance users are offered treatment, their partners must be actively engaged, and addressed. Children in households with substance use, especially in dual substance using families are at great risk of emotional, behavioural and academic problems, and getting influenced to become users. Therefore, they need urgent attention. Special groups like pregnant/elderly women using substances, street girls and women in institutional settings have specific needs.

Services should be community based and easily accessible. The NGO sector needs to be further strengthened to provide such services. Government health facilities need a complete turn around to develop gender sensitive, user-friendly approaches for women. In the community, networks for referral and care especially integrated into the general medical services, gynecological facilities, HIV counseling and treatment centers and mental health services need to be established and strengthened. While the involvement of civil society is necessary, the sensitization of local leaders, police, judiciary and media to gender sensitive issues is critical. Life skills education, vocation-based training and empowerment of women starting from adolescence, strengthening of families, de-normalization of any substance use in the community, and progressive laws protecting women and reducing discrimination are necessary to address the gender inequities that perpetuate many problems in society, including substance use. This involves collaborative networking amongst various governmental, nongovernmental and private sectors particularly those concerned with health, social development, welfare and education.

1 Introduction

You can tell the condition of a nation by looking at the status of its women

- Jawaharlal Nehru

Women presently form 49.7% of the world's citizens and will constitute 50.1% of the world by 2045 (World Bank 2005). Although the proportion of women globally, is likely to exceed that of men by 2045, in many parts of the world and particularly in the developing countries, women are fewer and face gross disparities. In India, women presently constitute 48.3% of the total population of 1,027,015,247 and gender disparity is still overwhelmingly evident.

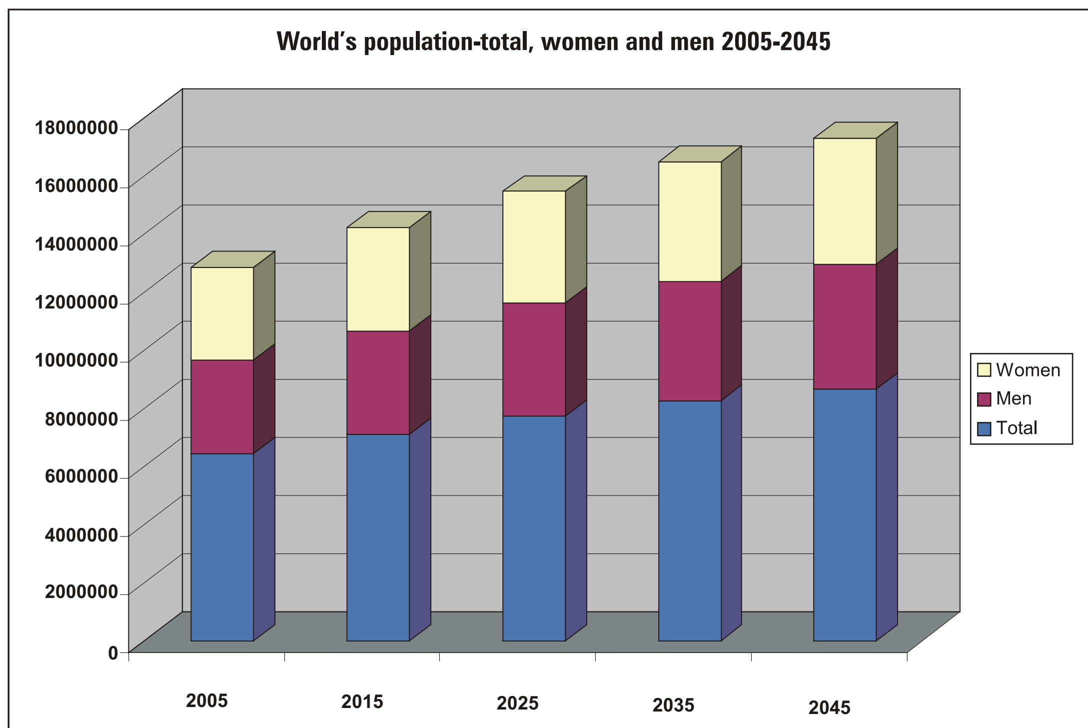


Figure 1: Projected world population

Interestingly, the sheer weight of the population of the four Asian countries, particularly China (944) and India (933) with their low sex ratios, contributes to the present preponderance of males over females in the world. 'Missing women revisited'(Sen 2003) is a theme that will be revisited in Chapter 12.

As the world becomes more and more aware of gender disparities and the need to protect the rights of women and empower them, the veil lifts from newer problems faced by women and the complexities that result from them. One of these is the impact of male drug misuse on their women partners.

Figure 2: Female: male ratio over decades, in India

Another paradoxical development is that gender empowerment, which seeks to improve financial and social status, social equity and the stress of multiple roles sometimes results in newer problems. One such problem associated with gender repression and gender 'emancipation' is psychoactive substance use (alcohol and other drugs), which makes women extremely vulnerable to a host of consequences related to health, social and economic issues.

This document, based on the findings of the study, attempts to address these dual concerns among women in India, by gaining deeper insights into the complex lives of NSUPs and FSUPs. It seeks to contextualize their problems in contemporary society, where gender, economics, stress, support or the lack of it, and HIV vulnerability further compound the issue.

2 Women and Substance Use: The Dual Dimension

Women have no immunity from substances

Substance use poses various kinds of problems that not only impact the individual user, but also affect the family and community.

Women as partners of male substance users

The adverse impact of substance use on families, usually on women caregivers, is immense. Relationships suffer; financial resources get depleted, health care costs and employment problems escalate. Roles previously adopted by the user have to be taken over by other family members - often the women partners or caregivers - resulting in increased stress burden. Substance use, often associated with domestic violence, aggravates distress within the family. High-risk sexual behaviour among drug using partners leads to increased HIV vulnerability for women partners. In large parts of the country where women have a significant gender disadvantage, and for those living in poverty, the impact may be more striking.

The Burden Study

- The major burdens on women living with drug users are financial drain, social blame and isolation
- Many women with drug using family members are subject to physical and verbal abuse
- Despite significant psychological distress, a majority never receive any professional support

In 2002, as part of the 'National Survey on Extent, Patterns and Trends of Drug Abuse in India', the United Nations Drug Control Programme Regional Office in South Asia and the Ministry of Social Justice and Empowerment, Government of India, commissioned a sub study: 'Burden on Women due to Drug Abuse by Family Members' (Shankardass 2002). This study attempted to document the burden perceived by women relatives of male drug users and understand the social, familial, economic and psychological consequences for these women. In this exploratory and qualitative study, 179 women carers of male drug users across 8 centers in India - Bangalore, Chennai, Delhi, Haryana, Himachal Pradesh, Manipur, Pune and Thiruvanthapuram - were interviewed. Nearly half the respondents were between 20 and 40 years of age. A majority reported financial problems. Physical violence was reported by 43% of the women. A significant number reported mental distress in the form of anxiety (55%), depression (47%) and suicidal thoughts (35%). The study highlights the financial and emotional burden that arises from caring for a drug-using member in the family (Murthy 2002). It is now recognized that women suffer, substantially, having to shoulder the burden of physical and psychological abuse perpetrated by close male relatives (usually spouses, partners and sons). In addition, they are increasingly forced to become the family's breadwinners following the illness/ death of their HIV/AIDS-infected drug using partners. This aspect of the drug use burden on women and related HIV vulnerabilities, has received scant attention in India. The study raises the need for an in-depth understanding of issues such as exploitation, vulnerability, stigmatization and lack of support for women caring for drug abusing men. It emphasizes the need to look at women partners' own health, safety and economic security needs and the need for education about potential risks of exposure to HIV and other sexually transmitted illnesses. It also highlights the need for greater sensitivity to families of persons with addiction, especially the women.

Non-drug using women are considered to be at 'low-risk' to HIV but this low risk perception may actually place them at higher risk, as they receive very few targeted interventions.

Women using substances

Substance use (alcohol and other drugs) and injecting drug use (IDU) among women, well documented in the developed world, is now emerging in the developing world, particularly in Asia (Reid and Costigan 2002). However, drug use among women in Asia is still considered a minor problem because the number of women classified as IDUs is estimated at 10% or less (UNAIDS 2000), and these figures are lower in India for both sexes. However, it has been suggested that this figure will increase and improved monitoring of the situation is necessary.

A focused thematic study on drug abuse among women (Kapoor et al 2001) and a Rapid Assessment Study (RAS) (Kumar 2002) draw serious attention to substance misuse among women.

In a small study of women drug users (75 across Mumbai, Aizawl and Delhi) by Kapoor et al (2001), women substance users were mostly in their twenties and thirties and friends had initiated almost 50% into drugs. 30% were single. A majority of the women were opiate users, primarily brown sugar (heroin). The women from Mumbai were all commercial sex workers. Injecting drug use was reported in 41% of the respondents.

In the RAS, 8% (371) of the 4648 drug users interviewed across 14 urban cities, were women. Most had been introduced to drugs at an early age (under 20 years) and the main drugs used by women were opiates (heroin and dextropropoxyphene), alcohol and minor tranquillizers. Of the female drug users identified in the RSA, 40% were IDUs. Typically, FSUs in the study were single, educated, employed and had taken to drugs early. They were also engaged in unsafe practices such as early initiation into sex and sharing injecting equipment. Women's primary reasons for initiation into drugs were the influence of friends - including spouse or partner, stress and tension. Almost 50% had engaged in sex work to support this habit and more than a third were selling drugs (Kumar 2002).

Substance use as a solution rather than a problem

For many women, substances are a way of self medicating for emotional problems or the experience of living under conditions of extreme distress. For example, some women are in relationships that are characterized by shared substance use, physical and sexual abuse, HIV and other infectious diseases, and sometimes, coercion into sex work or the illicit drug trade. In such situations, women may feel overwhelmed by their life circumstances and unable to see a way out

UNODC 2004

Both the focused thematic study on women drug users and the RAS component on women users highlight the need to focus on substance use among women, in India.

Female drug users are particularly vulnerable on the route to drug dependence. They are a hard to reach population as evidenced by their under representation both in traditional drug surveys and in treatment facilities. Overwhelming family responsibilities often make their own needs a lower priority so their drug dependence remains untreated. Societal disapproval, fear of exposure, lack of support also influence access to and utilization of treatment.

Several questions can be raised with regard to drug use among women:

- Do they continue to be 'hidden populations'?
- What are the pathways to drug dependence?
- What are the vulnerability issues that impact FSUs?
- What are the gender specific vulnerabilities faced by women with respect to HIV/AIDS and STIs

Mediating factors for substance use among women

'Women and Drug Abuse: The Problem in India' (Murthy 2002), was perhaps, the first comprehensive publication that documented the various dimensions of drug use impacting women in India. It was a preliminary step towards understanding the complex and dynamic issues influencing the use of drugs among women, treatment seeking, support and prevention. Although the findings could not be generalized for the entire country, the document definitely highlighted the need to shift from an individual, single cause linear model to a multi-cause interactive model to understand women's vulnerability in this situation.

Interacting factors leading to substance use among women

Social Disadvantage and Social isolation

Predisposition, Modelling

Role Transition and lifestyle changes

Drug Availability

Stigma, lack of support

Lack of knowledge of harm

Physical and emotional problems and ignorance about treatment

Drug Use

Murthy 2002

Figure 3: Women's substance use

Predisposition includes genetic predisposition. Modeling encompasses drug use by family members, peers and partners. When HIV is added to this already complex matrix, the adverse effects spiral and create an even more complex matrix of health, social, emotional and economic consequences. There is a need to focus on services that cater to these needs and look at why women require targeted interventions.

Thus, the problem of drug use among women has to be contextualized within their social and economic status, and India's matrix of poverty, low empowerment in decision-making, exploitation and erratic access to health and welfare. Generally, FSUs have fewer resources (education, employment, and income) than men, are more likely to be living with a drug-using partner, are responsible for dependent children, and experience greater problems when treatment starts. They also have higher levels of trauma resulting from physical and sexual abuse, higher rates of concurrent psychiatric disorders, particularly post-traumatic stress disorders and other mood and anxiety disorders (UNODC 2004)

Summary

Women face problems related to substance use either as partners of males using substances, or as substance users themselves

As partners of male substance users, they face severe financial, emotional, social and psychological consequences

There are several poorly understood issues regarding women drug users, including the progression of their substance use, vulnerabilities, and treatment needs

A comprehensive understanding of substance use among women requires a multi-linear interactive approach, which looks at the problem from socio-economic and gender status perspectives

3 A Risk Assessment

It takes a thousand voices to tell a single story.

This study attempts to explore issues of women entrapped in psychoactive substance use either as partners of men using these substances or as substance users themselves.

Objectives

It focuses on understanding the socio-economic conditions, patterns and consequences of psychoactive substance use, health - particularly reproductive health and STI/HIV vulnerability, psychological consequences, support systems and needs of women using these substances and women partners of men using substances. This study is part of the Project I 49 to address gender concerns with respect to substances and related HIV prevention. The initiative has two broad components:

- A situation assessment on substance use related HIV vulnerabilities among FSUs and NSUPs (The Study)
- Strengthening technical capacities of civil society organizations, women's groups and positive women's representatives towards addressing substance use related HIV vulnerabilities among women partners of male substance users.

The current monograph focuses on the findings from the study.

Methodology

The field staff of non-governmental organizations working in the area of substance abuse treatment and rehabilitation across India conducted the study. These NGOs were selected on the bases of their work, expertise and track record in the area of substance use intervention and were invited to participate.

The two approaches used for the assessment were semi-structured interviews and life history narratives.

Semi-structured interview

A comprehensive semi-structured interview covering several areas was developed and finalized after a peer review. The interview questionnaire was translated and back translated into Hindi, Bengali, Oriya, Khasi, Manipuri, Mizo, Marathi, Kannada, Telugu and Malayalam.

Life history narrative

A broad framework was developed to elicit life history narratives. This included details of family of origin (birth), early childhood, sexual

Areas covered in Questionnaire:

- Personal and household Information
- Respondent substance use
- Partner information including substance use
- Information regarding children
- Reproductive health
- Sexual Practice
- Violence
- HIV/AIDS awareness
- Emotional State
- Treatment and hospitalization
- Support

initiation and relationships, marital history, relationship with spouse and/or sexual partner, sources of support for the family/ sources of expenditure, exploitation, sources of emotional support, issues relating to children, reproductive and gynecological health, perception of risk to STI and HIV, details of substance use in self and partner, including onset, initiating factors, progress and consequences, perceived need, access and utilization of support systems in the community. The narratives were recorded in the local language, and then translated by the interviewers into English. The names of the respondents have been changed.

Training for the study

Representatives from the PNGOs (usually the project coordinator) participated in regional training workshops held at Delhi, Calcutta, Pune and Shillong. Initial sessions focused on providing training inputs for data collection.

Training workshop for the study

- Overview of the study
- Introduction to substance abuse
- Situation assessment
- Life narrative format
- Interviewing techniques
- Mock interviews
- Monitoring of interviews
- Verification of completed questionnaires
- Translation of life history narrative

The format included interactive discussions, PowerPoint presentations, role-plays, and mock interviews. Specific emphasis was laid on sensitivity in interviewing, obtaining informed consent, issues of confidentiality, likely difficulties in the field and ways to overcome them. In the latter part of the workshop, participants were trained in health issues of women drug users with a special focus on teaching life skills for reproductive health, preventing and protecting them from high-risk sexual and injecting behavior.

In turn, the PNGO representatives trained the field workers (mostly women) in administering the questionnaires. The coordinator was asked to personally supervise 4-5 pilot interviews, verify every questionnaire, and provide an English translation for the life history narratives recorded in the local languages. Potential respondents (NSUPs and FSUs) were identified through purposive sampling using key informant and snowballing methodologies. At least two-thirds of the respondents from each centre were required to be newly identified

respondents within the community. Wherever multiple NGOs worked in the same city, care was taken to ensure that the same respondent was not interviewed twice. All interviews were carried out after providing prior information about the study and obtaining written informed consent. During the interview, privacy was ensured to the maximum extent possible. Respondents were classified as Female Substance User (FSU - currently using a psychoactive substance (during the last month, apart from tobacco), and Non Substance Using Partner (NSUP - women partners of male substance users).

The data was centrally tabulated and analyzed. The percentages presented in the tables represent valid percentages, unless specified otherwise. The Odds Ratios are unadjusted ORs.

Sites for the study

An attempt was made to identify NGOs working in the area of drug de-addiction throughout the country. The accompanying map shows their distribution. There were no participating NGOs from Gujarat, Uttaranchal and Goa. The list of partner NGOs is provided in the appendix. Each NGO interviewed either up to 60 female partners of male substance users (NSUPs)and/or up to 40 female substance users (FSUs). Wherever it was possible to locate intravenous drug users (IDUs), each NGO attempted to interview up to 20 IDUs. Therefore, some NGOS only interviewed NSUPs, and some interviewed both FSUs and NSUPs.

Figure 4: NGOs participating in the Study

Summary Points

The Study : Part of the I 49 initiative

Focused on understanding the socio-economic conditions, patterns and consequences of psychoactive substance use, health, particularly reproductive health and STI/HIV vulnerability, psychological consequences, support systems and needs of women using psychoactive substances and women partners of men using substances

Used semi-structured interview and life history narrative format

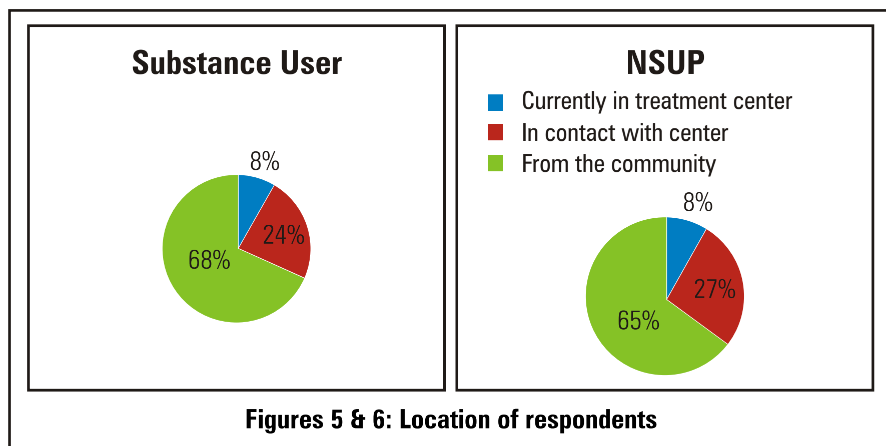
Partner NGOs participating in intensively trained in regional workshops

Respondents (Women partners of male substance users and women substance users) identified primarily from the community the NGO worked in

4 Women and Substance - Backgrounds & Bare Facts

Women do need studies and statistics to tell the world about the impact of substance use on their lives.

Under thestudy, a total of 6266 respondents were interviewed. Five thousand were initially identified as NSUPs, and 1266 as FSUs, which included injecting drug users.



Figures 5 & 6: Location of respondents

As 699 women, originally identified as women partners reported current substance use (use within the last month) they were reclassified as substance users. Thus, there were 4401 NSUPs who were currently not using any substance themselves and 1865 FSUs.

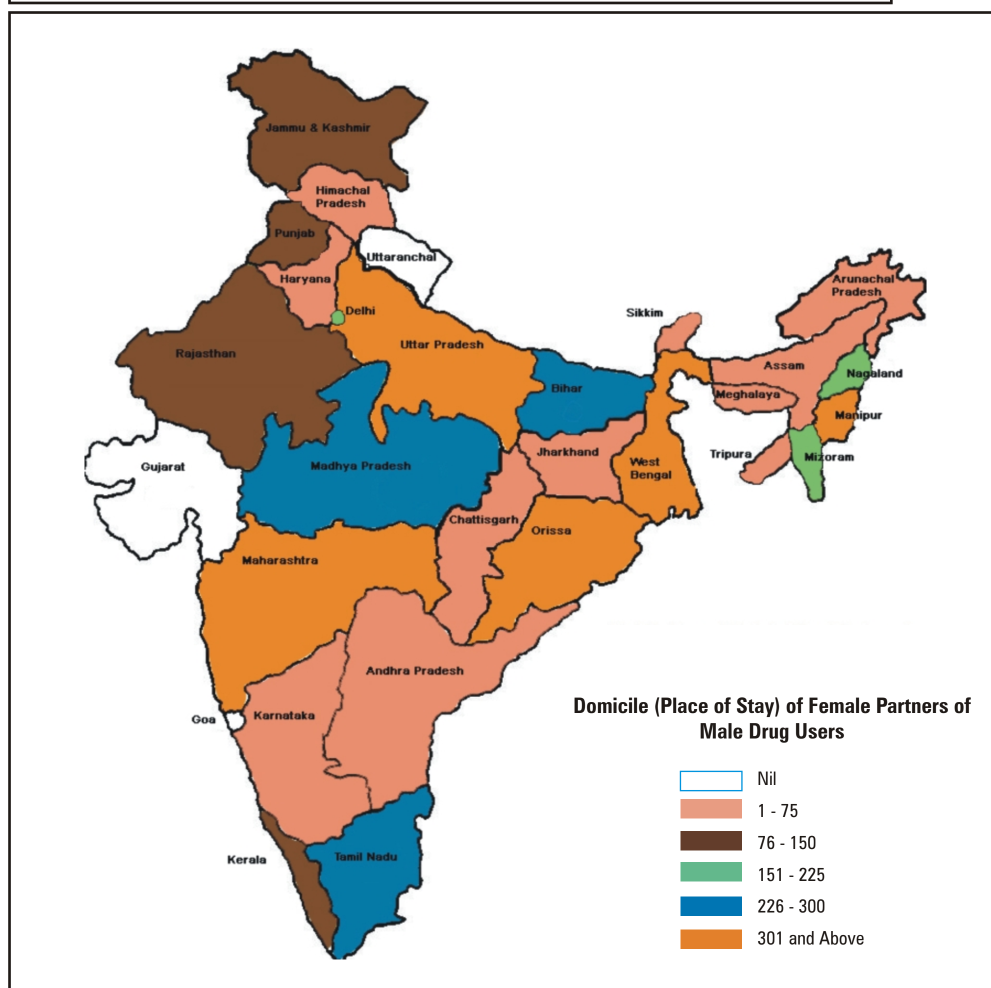


Figure 7: Distribution of Non Substance Using Partners (NSUPs)

A majority of both substance users and non-substance users were newly identified from the community.

Approximately one-third of both sets of respondents, had prior contact with the treatment centers run by the respective NGOs.

Life history narratives were obtained from 137 respondents over one to four sessions. 35 were from NSUPs, and 102 from FSUs of whom 21 were solely alcohol users and 81 used other substances. Among the other FSUs, 28 were injecting drug users.

Among the NSUPs interviewed, 19.7% were from the North-East, 27.7% from the Eastern part of the country, 12% from the West, 29.3% from the North and 11.2% from the South.

Female substance users

Of the FSUs interviewed, a higher proportion were from the Northeast (38.7%) and East (23.1%). FSUs continue to remain a hard to reach population in many parts of the country.

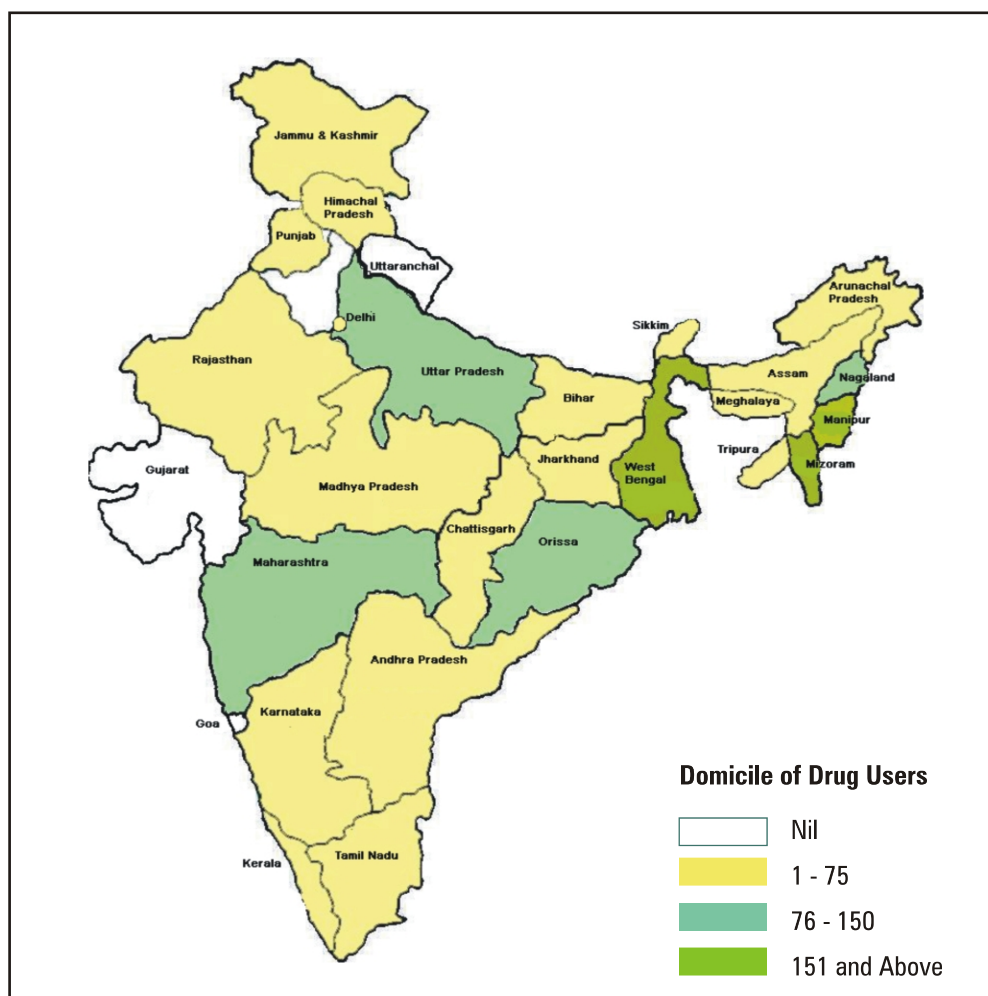


Figure 8: Distribution of female substance users (FSUs)

Socio-demographic background

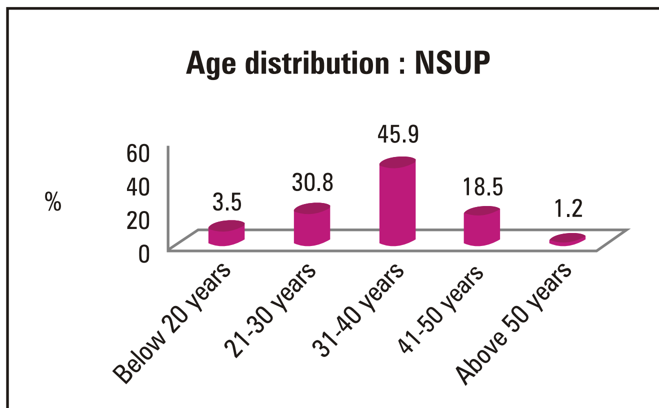
A majority of the respondents belong to an urban background. Christians are over-represented in the sample as a considerable number of substance using respondents are from the Northeast.

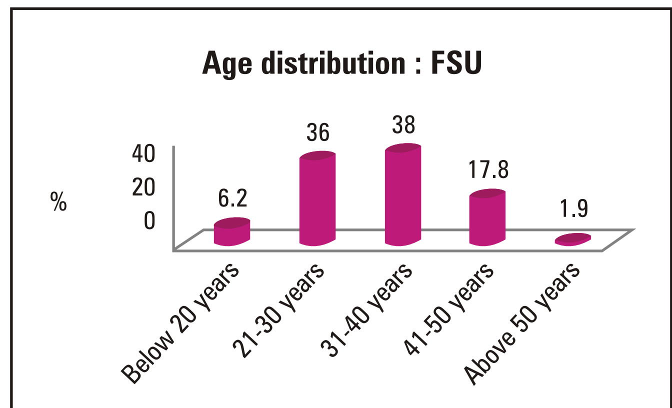
Table 1: Socio-demographic details

	FSU		NSUP	
Religion	N	%	N	%
Hindu	967	52.1	2963	67.6
Muslim	186	10.0	539	12.3
Christian	638	34.4	704	16.1
Other	65	3.5	174	4.0
Residence				
Urban	1359	74.3	3135	72.3
Rural	471	25.7	1193	27.5

Age Distribution

Women partners are most likely to be in their 30s and 40s. Although, in this study there are few women partners below 20 years of age in terms of numbers, the study was able to identify 150 women (3.5%) below 20 years, who are sexual partners of male substance users.





Figures 9 & 10: Age distribution of respondents

Nearly 75% of FSUs are in their 20s and 30s. One hundred and thirteen FSUs (6.2%) were below 20 years of age.

Overall, in the study, FSUs are younger than NSUPs [31.9(8.0) and 32.7(7.3) years respectively, $p<0.01$]. A higher percentage of FSUs are below 20 years of age. A majority of women partners and women substance users are in the reproductive, sexually active group.

A majority of NSUPs and FSUs are in the sexually active, reproductive group

About one in five NSUPs is illiterate

Nearly one in three FSUs is illiterate

Education status

Among the NSUPs, about one in five is illiterate. Nearly 42% have completed high school or higher education. Nearly one in three FSUs is illiterate, significantly higher compared to the NSUP's among whom 22.2% are illiterate [OR 1.6 (95% CI=1.4-1.8, $p<0.001$)].

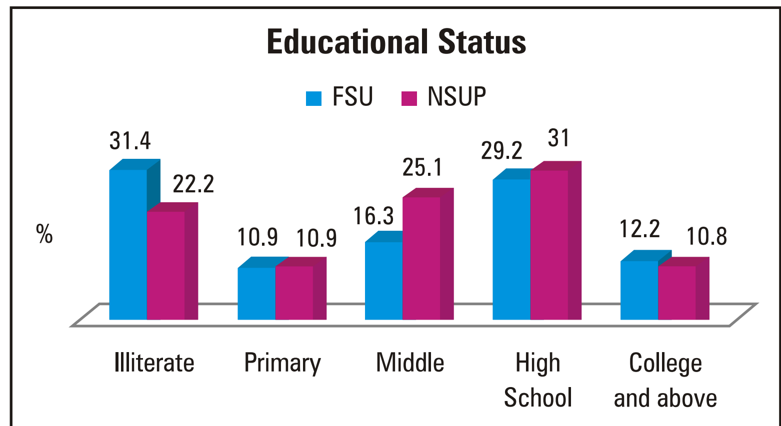


Figure 11: Education of respondents

Education no bar

I was born in Kalyanpur district in Lucknow. My parents are good people. My father is in the business of property dealing and earns Rs 7000 to Rs 15000 per month. I have two sisters; one is older than me the other is younger. My relationship with my family was very good. At present, it is not good due to my bad habit. In my family no one takes alcohol or any kind of drugs. I completed my MA in psychology. I have no experience of any sexual relations but I am an injecting drug user since the age of 22 years. My friend insisted I use injections to relax properly. I took it out of curiosity at her home. Now, I take tidigesic (buprenorphine) injection once daily. When I take it, I felt calm, relaxed and without worries in the beginning. Now it has become a habit and I feel depressed and uninterested in anything. I never share it with anyone and always use a new syringe and needle. I sometimes tried to drop the habit only because my parents do not like it. But when I try and stop I suffer from physical and mental problems.

Rajani Sinha, 24-year-old from Lucknow

Housing: Among NSUPs, 70.7% live in pucca/ semi-pucca houses. 104 (2.4%) of them report living on the streets. A majority of female substance users (64.5%) live in pucca (permanent roof) or semi-pucca houses (temporary roof). One hundred and twenty three FSUs (6.6%) live on the streets. The mean family size is significantly greater among NSUPs [4.8(1.6)] than among FSUs [3.8(1.8)] ($p<0.001$).

> FSUs are more likely to be living with a sexual partner than NSUPs
>
> More than a third of NSUP and FSU partners are daily wage laborers
>
> Unemployment is higher among partners of FSUs than partners of NSUPs

Marital status and living arrangement

A majority of the NSUPs (3836,92.6%) are married and live with their spouses. 203 (4.9%) are presently single (widowed, divorced, separated or deserted). A small number (96, 2.3%) has never married. Among FSU's, 1149 (63.9%) are married, 296 (16.5%) are presently single, and 342 (19%) have never married. Compared to NSUPs, more FSUs are likely to be never married, or are single, presently.

> More than half the NSUPs report being married before the age of 18.
>
> A majority of NSUPs are married and live with their spouses.
>
> More than half the FSUs also report being married before the age of 18

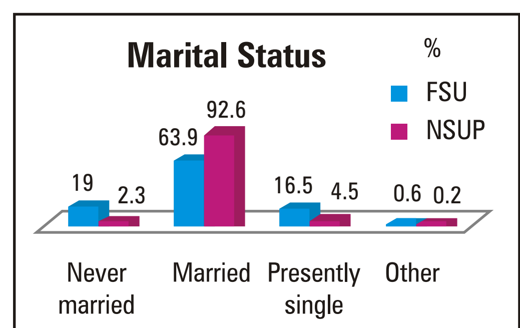


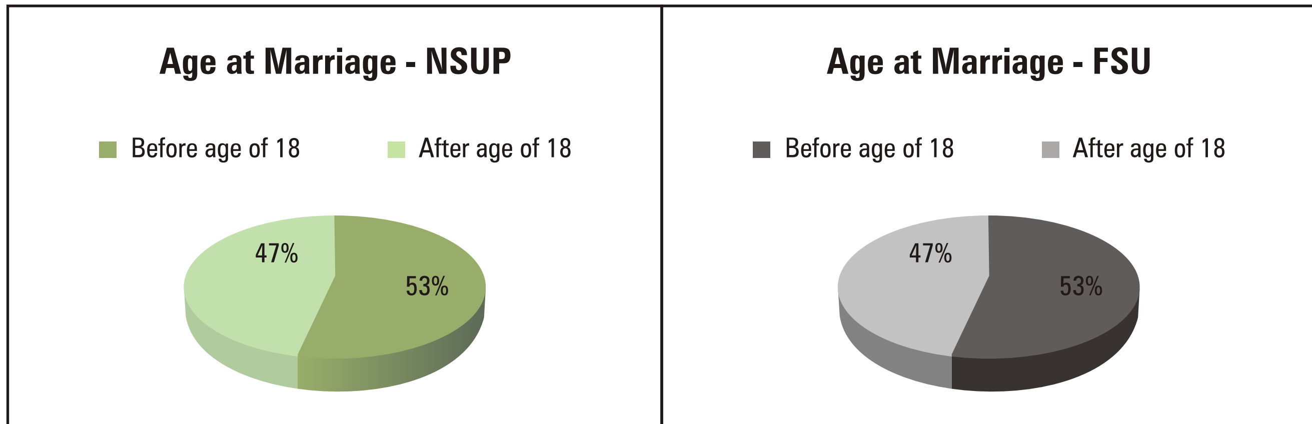
Figure 12: Marital status

Age at marriage

Among the NSUPs who are married (n=4255), 2270 (53.3%) were married before the age of 18 years.

Among the married women using substances (n=1504), 868 (57.7%) report being married before 18 years of age.

The mean age at marriage for FSUs [18.5(3.6) years] does not differ significantly from NSUPs [18.7(3.9)years].



Figures 13 & 14: Age at marriage of respondents

One in five FSUs is likely to be living with a sexual partner (either unmarried or if married, presently living with a different sexual partner). FSU's are significantly more likely to be living with a sexual partner than the NSUPs [OR 2.84 (95% CI= 2.4-3.3), p <0.001].

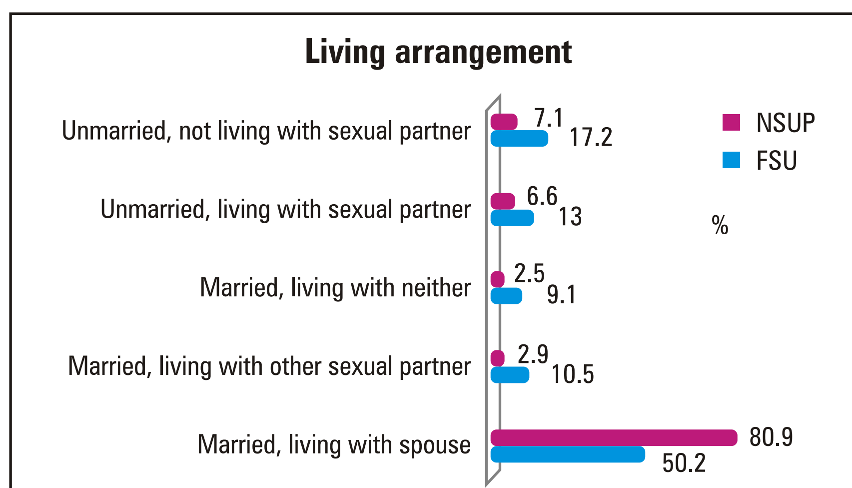


Figure 15: Living arrangement of respondents

Partners

The male partners of NSUPs are mostly engaged in some form of remunerative employment, with about one-third earning daily wages, and nearly one-fourth running a small business or self-employed.

More than 16% of FSU partners are unemployed and the odds of FSU partners being unemployed are higher than NSUP partners [OR 1.49 (95% CI= 1.26-1.76), p<0.001].

About half the partners of both NSUPs and FSUs have travelled out of town in the past year.

Partners of FSUs are more likely to have stayed away from home during the last year.

Table 2: Partner's employment status

	FSU Partner		NSUP Partner	
	N	%	N	%
Salaried	207	13.4	934	21.7
Daily wage earner	609	39.3	1713	39.8
Business/self employed	280	18.1	1061	24.7
Unemployed	254	16.4	422	9.8
Other	200	12.9	172	4.0

Partner's absence from home

Approximately half the partners of both FSUs and NSUPs have travelled out of town in the past year. However, more partners of FSU's are likely to have stayed away during the entire year [OR 2.8 (95% CI 2.0-3.9), $p<0.001$].

	Partner of FSU		**Partner of NSUP**	
	N	**%**	**N**	**%**
Never	747	49.5	2163	51.8
3-4 times per year	452	30.5	1252	30.0
5-10 times per year	123	8.2	383	9.2
More than 10 times per year	114	7.6	305	7.3
Stays away from home	72	4.8	73	1.7
Total	1508	100	4176	100

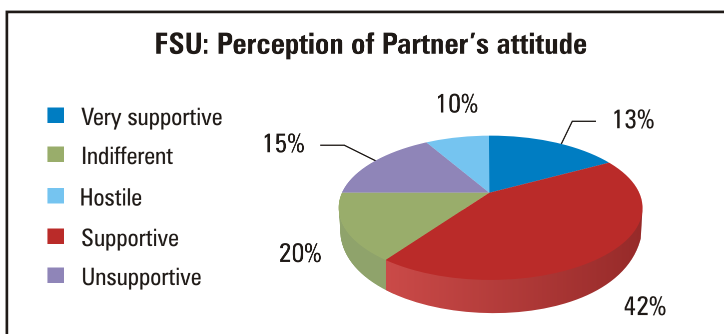
Table 3: Frequency of partner's absence from home

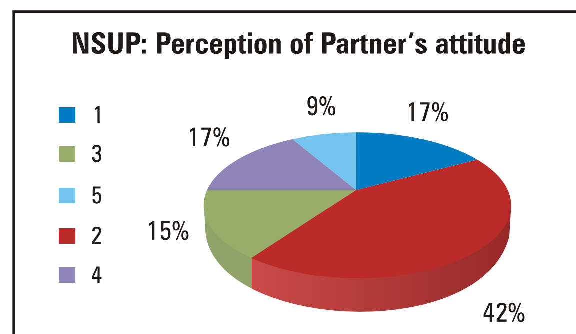
Perception of partner's attitude

Among NSUP partners, 59 % perceive their partners are supportive, as do 55% of FSUs. However, feelings that the partner is indifferent, unsupportive, or hostile, are higher among NSUPs (43%) than FSUs (38%).

About 40% of both NSUPs and FSUs feel that their spouses/ partners are indifferent, unsupportive or hostile towards them

Figures 16 and 17: Respondent's perception of partner's attitude





Non Substance Using Partners

Percentage that always seeks spouse's permission to: %

	%
• buy grocery	32.4
• buy jewelry	43.9
• consult a doctor	41.2
• visit neighbors/friends	26.9
• visit family of birth	44.6
• attend NGO activity	34.0

Autonomy in decision making

NSUPs more frequently seek their spouse/partner's permission for activities like buying groceries, visiting parents, friends and neighbours, buying jewellry and going to the hospital.

FSUs appear to make decisions more independently than their non-substance using counterparts. Thus, FSUs are significantly less likely than NSUPs to ask the spouse/partner's permission to buy groceries [OR 0.40 (95% CI=0.36-0.45) $p<0.001$) or to participate in NGO activities [OR 0.49 (95% CI=0.44-0.55), $p<0.001$].

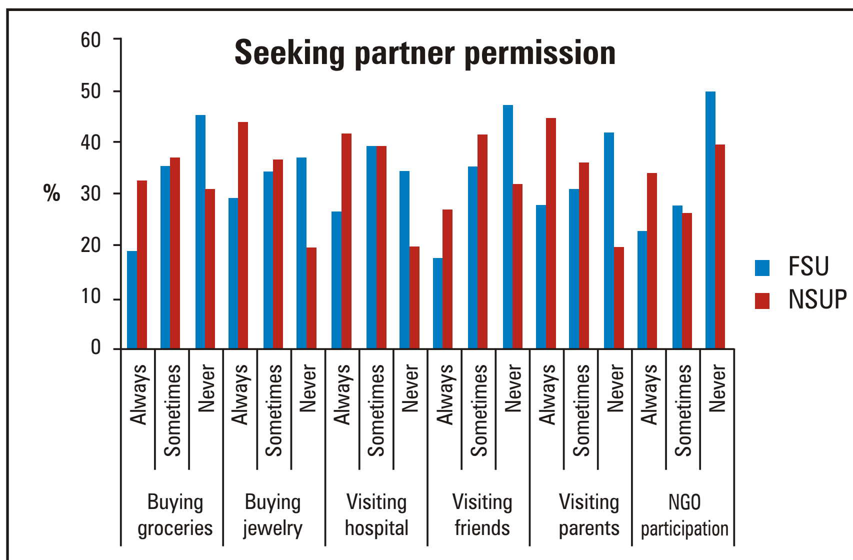
More than 50% of NSUPs are home- makers

FSUs are more likely to have an independent earning

Income from sex work and drug peddling is higher among FSUs

Few students have been involved in this community survey

Figure 18: Autonomy in decision-making



Women partners have low autonomy in decision-making even on common day-to-day issues

Women using substances appear to have greater autonomy in decision-making

Work and remuneration

More than half the NSUPs are home- makers.

A greater number of FSUs (1173, 66.4%) report an independent earning in the last six months compared to NSUPs [(1735, 44.3%), OR 2.4 (95% CI 2.1-2.6) $p<0.001$]. Income from sex work [OR 8.4 (95% CI= 6.9-10.2), $p<0.001$] and drug peddling [OR 9.9 (95% CI=6.7-14.6), $p<0.001$] is significantly greater among FSUs.

Life history narratives also indicate that stealing and peddling are important sources of income for FSUs as compared to NSUPs (14/102 versus 0/35 respectively, =5.35, $p<0.05$.

NSUPs have comparatively lower household incomes as well as individual incomes compared to FSUs

Both NSUPs and FSUs raise money through borrowing and pawning as much as or in excess of the amount obtained through their household income

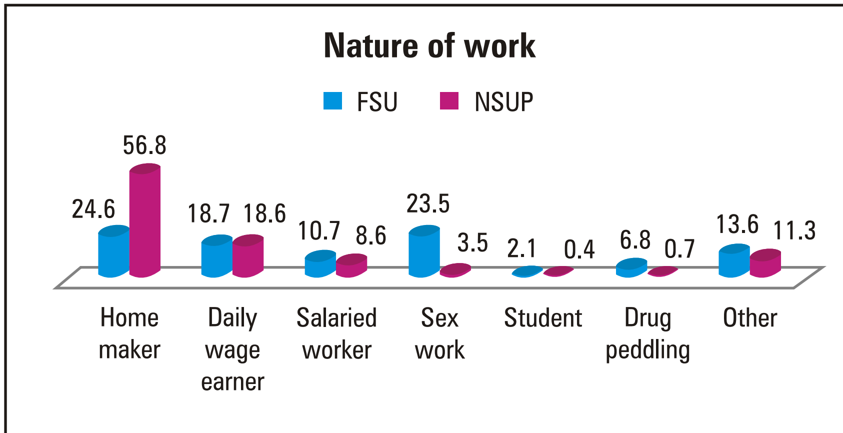


Figure 19: Respondent's nature of work

A majority of the working women in both groups report poor pay (60.7% of FSUs and 58.6% of NSUPs). A greater number of NSUPs (53.2%) are satisfied with their work conditions compared to FSUs (39.4%), though their comparative earnings per month are lower.

For me, my spouse is a burden, because, instead of his supporting me, we are surviving through my earnings. Moreover, he harasses me physically and verbally. There is no communication between us, and if there is, it is only about money and drugs because both of us are regular drug users. There is no problem-sharing, no affection, no care and support from him. Moreover, I am hurt because he got married again, though he is still married to me. His coming back to me solves our problems/fights because I am the sole earner and he is able to get his daily dose of drugs only with my earnings. Let me narrate a recent incident: I caught my spouse with another woman two days ago and there was a major argument and fight among the three of us. My spouse beat me up. But I know my spouse will come back to me, as it is only through me that he gets money for his drugs.

- Brown Sugar user from Nagaon, Assam

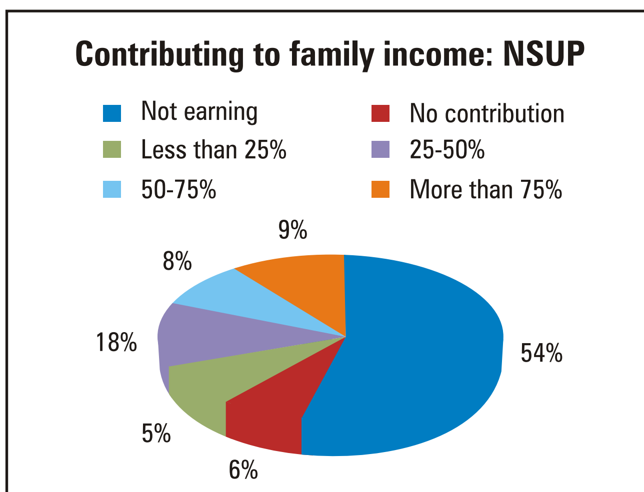
Contribution to family income

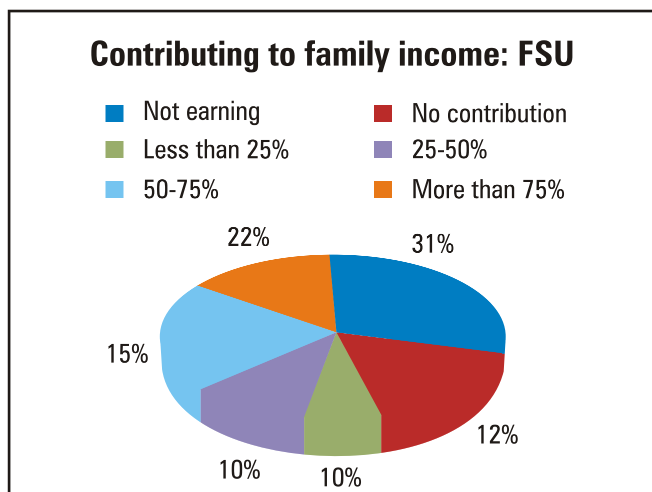
Among NSUPs, more than half do not have any independent income. 35% contribute more than half their earnings towards the family.

Nearly one-third of FSUs do not have an independent income and 12% percent do not make any contribution to the family income.

More than half the NSUPs have no independent financial income

FSUs spend a greater proportion of their income on the family and on themselves





Figures 20 & 21: Contribution to family income

Independently earning FSU's are more likely to contribute to more than half the family's income [OR 1.62 (95% CI=1.45-1.80), p<0.001). They are also significantly more likely to spend a greater proportion of their income on themselves [OR 4.75 (95% CI = 4.1 -5.5), p<0.001].

	FSU		NSUP		OR
Contributing to more than half of the family income	696	37.3	1178	26.8	1.62***
Spending more than half the income on self	614	32.9	412	9.4	4.75***

Table 4: Contribution to family income

*** significant at p<0.001

Household and individual income

Median household incomes and median individual incomes are higher for FSUs. Median amounts taken in loans are higher among NSUPs. For both groups, the amount collected from loans, pawning and mortgaging jewellry and household items far exceeds the household income.

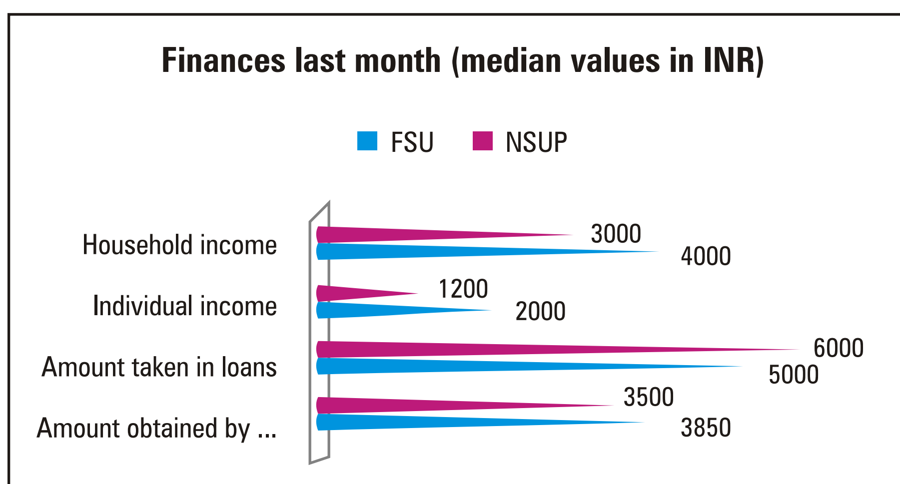


Figure 22: Income during the last month

Major emergent themes

In any country, there are several indicators of women's status and empowerment. Some commonly used ones are summarized in the accompanying box and discussed in various chapters.

Indicators of women's status and empowerment

- Literacy and educational attainment
- Employment and occupation
- Control over their own earnings
- Age at first marriage
- Age at first birth
- Contraceptive use
- Spousal age and educational difference
- Women's participation in household decisions

The study highlights some socio-economic realities, which reflect the status and empowerment of women in India, today. Illiteracy and poverty,

combined with early marriage, are sources of great social adversity for women. Their ability to handle the consequences of their partners' substance use and their own use must be viewed in this context.

- Women's attitude to wife beating by spouses
- Women's views on whether a woman can refuse sex to her spouse
- Hurdles faced by women in accessing health care for themselves
- Choice of spouse
- Natal family support
- Asset ownership
- Control over money for different purposes
- Knowledge and use of micro-credit
- Attitude towards gender roles
- Freedom of movement
- Membership of any association
- Having a bank account

Accessed at: http://www.measuredhs.com

Indian women and autonomy

Social disadvantage translates into low autonomy and empowerment. The 'CHARCA' (Co-ordinated HIV/AIDS response through Capacity Building and Awareness) study (Singh et al 2004), a joint UN initiative, carried out a baseline survey of knowledge attitude, behaviour and practices related to STDs/HIV among subpopulations in the five selected districts of Aizawl (Mizoram), Bellary (Karnataka), Guntur (Andhra Pradesh), Kanpur (Uttar Pradesh) and Kishanganj (Bihar). The study included a quantitative household survey through a structured questionnaire given to selected female adolescents between 13 and 24 years of age. A systematic multistage sampling design, with a target sample of 450 eligible females from each district, with both rural and urban representation, was selected. The study had qualitative techniques which included mapping of community based resources for women, interviews with key informants and focus group discussions.

One of the areas examined was the degree of autonomy women have in day-to-day decision-making. In many states, women generally do not have any decision-making autonomy. In certain states like Madhya Pradesh and Rajasthan, less than 50% of women have access to money in their households.

In the study, NSUPs show a significantly greater lack of autonomy in day-to-day decision-making such as buying groceries as compared to FSUs. More NSUPs regularly take their spouses' permission to access health care, visit relatives and friends and even for minor day-to-day running of the household. Many do not have independent incomes and are economically dependent on their spouses/partners. The majority is from urban households and borrowing, often in excess of family earnings, is a common feature of their lives. While this sample may not represent the very poor population, nevertheless financial difficulties, including impoverishment as a result of substance use, are evident. Despite a greater likelihood of an independent income, the financial situation for FSUs is grim.

Against the background of socio-economic adversity, the impact of substance use among men on women partners is enormous

The problems are further compounded when women themselves use substances

Summary Points

More NSUPs are likely to be homemakers
NSUPs have less autonomy in decision-making
Greater borrowing in NSUP households
FSUs likely to be younger than NSUPs, illiterate, never married and living with a sexual partner
FSUs live in smaller families
FSUs are more likely to have grown up in circumstances of poverty
More FSUs work outside the house and have remunerative incomes
Substance use more likely to be associated with sex work and peddling
FSUs earn more than NSUPs and are likely to spend significantly more on themselves
Large amounts taken in loans and raised through pawning, selling and mortgaging by NSUPs and FSUs

4.1 A Rag Picker's Story

Bhagyamma, 22-year-old from Tamil Nadu

I was born in Vellore in Tamil Nadu. We were a large family of sixteen children. My father died from using substances. My mother works in the mango business but she is not in good health. I studied up to class three in a government school till my mother forced me to leave and work in the paddy fields. I used to earn Rs 60 per day and give the money to her. As a child life was difficult. My mother used to beat me everyday. However, I do have one cherished memory of my childhood which I really enjoyed, spending time on the riverbank with my friends.

I am now a rag picker in Tirupati. We have a kind employer who understands our needs and takes good care of us. Sometimes, other workers pull me into liquor parties and try to take advantage of me but I can take care of myself.

I was married when I was 13. Though it was arranged by my mother, my husband's family was not offered any dowry. My spouse is a construction worker who earns Rs 300 per day. In the early days of our marriage he took good care of me. When we had free time we would go to the movies and the temple. He also helped in the cooking. Later, his mother and sister turned him against me. Whenever I had problems I would confide in him but he would not tell me about his affairs with other girls. He used to tease and beat me and my sisters-in-law also beat me because I would not wash their clothes. My married life was unhappy just like my childhood. I think I would have been happier if I had not got married.

One year after we were married my spouse started a relationship with another woman. We quarreled about this so he left me and married her. I have a son and a daughter. Now I am involved in a relationship with a young man - just one. He is a good man and I am happier with him than I was with my spouse.

A lady introduced me to drugs and drinks after I came to Tirupati. Now I use erazex (typewriter fluid) solution, bhang (cannabis), alcohol and pills. I take intoxicants alone. If it is erazex, I take four bottles per day. Otherwise I drink alcohol, everyday. I buy them from other people. I spend Rs 300 on intoxicants from my earnings of Rs 500 per day. I save the remaining Rs 200 for my children. When I am intoxicated, I get into a different state of mind. Though I do not feel sexually aroused, I feel like having fun and watching movies. I also want to cause trouble and kill people. Even when things around me are calm I feel like stirring up trouble. These tendencies arise only when I am intoxicated. I feel like stealing and getting into fights and even inflicting cuts on myself. I have tried to commit suicide twice. Once I was sexually assaulted when I was intoxicated.

Normally I work hard and earn an honest living. However, I have resorted to stealing whenever I am short of money for alcohol. I used to steal from iron and copper scrap dealers and was even caught once, handed over to the police and later released.

I want to give up alcohol but I am unable to give it up completely. Earlier I used to have a bottle a day, now I take it only once in four to five days. I drink to forget my problems. My spouse has deserted me. My children are living with my mother away from me; I feel that my children have been orphaned. So, I drink to forget these problems.

In the next five years, I want to set up my own scrap iron shop and make a better life. It needs an investment of Rs 5000. My mother and aunt are willing to help me set it up. I have also lent some money so I can earn interest on it. I plan to invest that in setting up my own business. There are some changes I would like to make in my life. For instance, I do not want people to hold me in low esteem. I should change and become a role model for others.

4.2 The Burden of Substance Use
Geeta Devi, 36-year-old from Delhi

I have been living in Chattarpur village, Delhi for more than a decade. I was considered lucky for my family, as my father won a case on the day I was born. My parents had a good relationship. I have four brothers and two sisters who are housewives. My brothers are contractors and are always supportive during a crisis. They are both social drinkers and have never faced any serious health or financial difficulties.

I studied up to the fourth standard in a government primary school in the village and completed my fifth standard with the help of a tutor at home. During my childhood, if I saw anyone beating his wife under the influence of alcohol, I used to blame his wife for not retaliating. But now I am responding to the same trauma with the same submissiveness.

When we were married, both of us were 18 years old. No dowry was given. My father-in-law took care of all our financial needs. We enjoyed a good relationship until his death. My spouse then started to seek revenge for his father's murder, spending time with friends taking drugs and alcohol. He took no responsibility in the house. Often, he would run away from home or threaten that he would commit suicide. Under the influence of drugs he abuses me physically and verbally. He has been a multiple drug user and his choice of drugs range from smack (heroin) to cannabis. He also uses injections with his friends.

I have never worked, but I have a steady income from the house rent and a small interest from my savings. Though I take all the financial responsibility, I feel sorry that I am unable to do anything more for my two sons and daughter. My elder son was shifted from a public to a government school because of financial difficulties. In the last twelve months I have taken a loan of Rs 50,000. There is no regular saving except a chit fund. My spouse takes money for his drug use from his sister or me.

Ten years ago, my spouse had physical relations with our tenant's wife. He stayed with her and used to give her money. My sister- in- law and brother- in -law intervened and resolved the issue. I do not know if he still visits her. At times he molests my daughter and then feels guilty. I feel so worried and try to prevent it, but never discuss this issue with anyone.

I learnt about sex for the first time when I was sixteen, from a friend who told me it was pleasant. My first experience was when my spouse forced me to have sex on the second day of our marriage, under the influence of sleeping pills, and it was not pleasant. He never considers my physical health and forces me all the time. He says he has never enjoyed sex with me as he does with others and suspects I have other physical relationships. I am not aware of STD but I am aware of HIV/AIDS from the newspapers and advertisements. I worry that I could be infected with HIV/AIDS.

I have already had two abortions though no doctor was consulted. I am aware of family planning methods and have used both contraceptive pills and condoms. Now, both of us have undergone sterilization.

My health suffers because of his addiction. Both of us remain depressed most of the time. I am continuously nervous and disinterested in life, but for the sake of my children, I stay alive.

5 Substance Use among Family Members

Substance loses families....and lost families gain substances

Introduction

Many Indian families are extended. While married couples tend to live with in-laws, single children, female or male, most often continue to live with their families, unless they have moved away for work. Information about respondents' families showed that there are more parents and siblings in the FSU group compared to the NSUP group, and a greater number of unmarried respondents among FSUs, live with their parents. NSUPs, on the other hand, can provide information about their in-laws, with whom they tend to stay after marriage.

The Substance, Women and High Risk Assessment Study

Substance use among respondent's family members

Women partners living with male substance users report high rates of tobacco use among family members with whom they live: in-laws (60.7%), siblings (55%) and parents (63.5%). NSUPs report significantly higher rates of alcohol use among their in-laws (53.4%) compared to in-laws of FSUs (33.3%).

Tobacco use is also high among family members of FSUs (60.7% among in-laws, 54.8% among siblings and 59.4% among parents). Approximately one-third report use of alcohol and/or drugs among their parents, siblings and in-laws. FSU respondents report significantly higher rates of alcohol use among their siblings compared to NSUP siblings.

	FSU		NSUP			
	N	%	N	%	x^2	p
Tobacco ever use						
Parents	286	59.4	146	63.5	1.1	ns
In laws	102	60.7	490	60.7	0	ns
Siblings	217	54.8	132	55.0	0.1	ns
Alcohol ever use						
Parents	171	35.6	79	33.9	0.2	ns
In laws	56	33.3	281	53.4	36.5	<0.001
Siblings	126	31.8	70	29.3	10.0	<0.001
Other drug ever use						
Parents	24	5.0	6	2.2	2.2	ns
In laws	10	6.3	36	4.5	0.7	ns
Siblings	53	13.5	37	15.5	0.5	ns

Table 5: Substance use among family members *calculations only for family members residing with respondent at time of interview

Missing fathers

In the life history narratives, 24 out of 102 (23.5%) FSUs said that their father died when they were children, as against none among the NSUPs (35). Thus, there is significant reporting of loss of fathers, by FSUs, in early childhood (=9.98,p<0.01). While 22.5% of FSUs report alcohol use by their fathers compared to 16.7% of NSUPs, this is not statistically significant.

We live in a slum. My father- in- law, mother- in- law and brother- in- law died of using substances. I use country liquor and my spouse uses alcohol. My son uses alcohol and ganja.

- Rani, an alcohol user from Bhubaneswar

My family comprises of my sick father, mother and a 19-year-old mentally challenged brother. My father used to drink and smoke ganja regularly, from a young age. He could not continue drinking due to bad health, but he still smokes ganja. I believe he has become sick due to drugs.

- Mercy, 24-year-old drug user from Kottayam,

Family members, with whom both NSUPs and FSUs live, have high rates of tobacco use

Alcohol use is significantly higher in siblings of FSUs

In-laws of NSUPs have higher rates of current alcohol use than FSU in-laws

Substance use among partners

Spouses or male partners of non-substance using women have high rates of tobacco and alcohol use. Apart from these, the commonest drugs used by them are cannabinoids, heroin and dextropropoxyphene. About one in five partners of NSUPs reports injecting drug use.

According to the respondents, FSU partners have significantly higher current use of tobacco, alcohol, cannabis, heroin and injecting drug use.

Partners of NSUPs have higher current rates of sleeping pill use.

Male partners have high rates of ever and current tobacco and alcohol use.

Other common substances used by both NSUP and FSU partners are Cannabis, Brown sugar (heroin), Dextropropoxyphene, Sleeping pills

Injecting drug use is reported in about one in four to five partners

	FSU		NSUP	
	N	%	N	%
Tobacco	1328	85.6	3533	82.0
Alcohol	1416	91.7	3804	88.4
Cannabinoids	781	50.7	635	47.4
Heroin (Brown Sugar)	609	39.6	512	33.8
Dextropropoxyphene	371	24.1	316	25.5
Buprenorphine	139	9.0	100	6.5
Cough Syrup	234	15.2	158	11.0

Table 6: Substance use patterns among partners (ever use)

Sleeping Pills	381	24.8	280	28.3
Solvents	30	1.9	19	1.2
Hallucinogens	15	1.0	14	0.6
Cocaine	10	0.6	6	1.1
Any injecting use	386	25.0	331	21.6

Use last month	**FSU**		**NSUP**		**95% CI**	**OR**
	N	%	N	%	N	%
Tobacco	1262	82.6	3378	79.9	1.0-1.4	1.2*
Alcohol	1299	87.3	3409	81.0	1.4-1.9	1.6***
Cannabis	635	44.7	1481	34.8	1.1-1.4	1.3***
Sleeping Pills	280	20.3	882	23.6	0.7-1.0	0.8*
Cough Syrup	158	11.4	363	10.0	1.0-1.4	1.2
Buprenorphine	100	7.3	299	8.4	0.7-1.1	0.9
Dextropropoxyphene	316	22.7	910	23.5	0.8-1.1	1.0
Heroin	512	36.6	1111	29.2	1.2-1.6	1.4***
Solvents	19	1.4	28	1.6	0.5-1.5	0.9
Any injecting	331	24.2	722	19.7	1.1-1.5	1.3***

Table7 : Current substance use: comparison across partners of FSUs and NSUPs

significant at $^{*}p<0.05$ and $^{***}p<0.001$

Support for partner's substance use

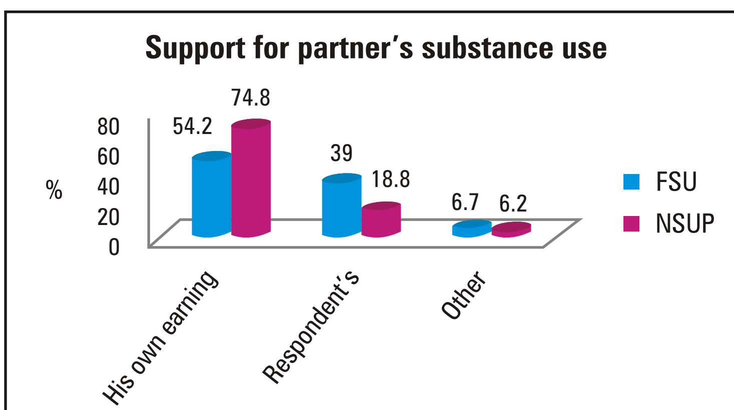


Figure 23: Financing of partner's subtance use

Women substance users are significantly more likely to be funding spouse/partner's substance use

Respondent's are significantly more likely to be supporting the partner's drug habit [OR 2.0 (95% CI= 1.8-2.3), $p<0.001$]. The likelihood of FSU's supporting partner's substance use was significantly greater than NSUPs [OR = 2.04 (95% CI = 1.80-2.31), $p<0.001$].

I am one of five sisters and three brothers living in Chattarpur village, Delhi. My father was a Hindu priest and that was the only source of income for our family. After he died eleven years ago, my mother also died of a prolonged illness. A housewife and regular smoker, she was continuously depressed and always felt lonely. I had a cordial relationship with my family. I studied up to the 10th class and now work as an anganwadi worker in the ICDS, earning Rs 1500 per month. I was married at the age of 20. My spouse, who has only one functional eye, studied up to the 8th class but is presently unemployed. I have four sons, of whom two are married. All my sons are smokers and two also consume alcohol socially. My spouse uses up to five or six Proxyvon capsules daily. He sells household items to buy his drugs and even sold his son's gym equipment without the family's knowledge.

I have already taken a loan of Rs 20,000. I think that people who use drugs are irresponsible and weak. Use of drugs makes a person mentally unbalanced and insensitive. Substances badly affect children's upbringing, education, health, and security. Initially he was using all kinds of drugs before marriage including alcohol and smack. But now, he only uses Proxyvon. In the beginning he was using his own money but now, I am paying for it. He tried to quit drugs many times, but never received treatment in a de-addiction centre. When his family tried to pressurise him for treatment he tried to commit suicide. So he has succeeded in terrorising the family so no one will raise the issue of treatment again. I have great hopes for my children but am skeptical about how much they will contribute to my happiness.

- Malini, 54-year-old NSUP

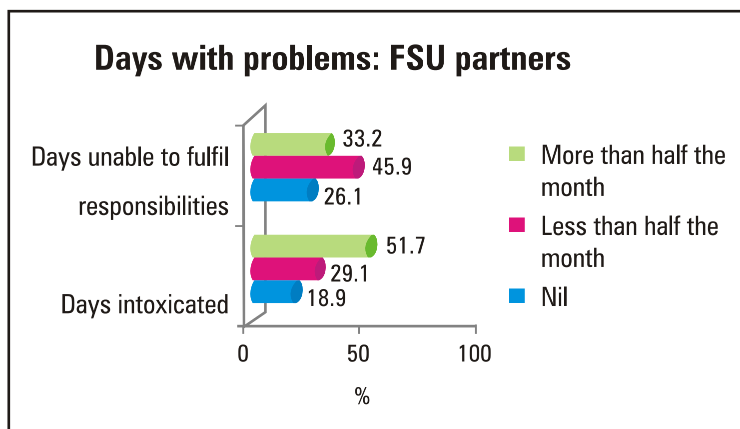
Consequences of substance use among partners

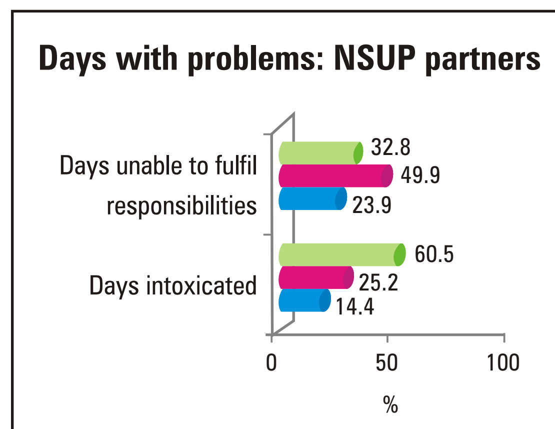
A large number of NSUPs reported problems related to intoxication in the last month (85.7%) as well as physical problems (60.7%) among their partners. A significant number(68.1%) also reported financial problems. Similarly, FSUs also reported problems related to intoxication (81.1%) and physical difficulties (54.3%) among their partners. In addition, FSUs consistently reported more financial (72.5%) and legal problems (21.3% as compared to 12.2% among NSUP partners).

NSUPs reported problems during last month related to substance use, intoxication and physical difficulties with partners

A significant number reported financial problems

More FSUs report financial and legal problems among their partners as compared to NSUPs





Figures 24 and 25: Consequences of partner's substance use

Patterns of substance use in India

Tobacco is the commonest substance of abuse in India. Estimates based on the National Sample Survey 52nd round (1995-96) and the National Family Health Survey 2 (1998-99) indicate that 46.5 to 51.3% of all males aged 15 years and above, use tobacco in some form or other.

	19-30 years	31-40 years	41-50 years	51-50 years
Sample (n)	8587	13216	5920	5168
Tobacco users (n)	1860	7026	4193	3638
Prevalence	55.8	54.9	72.0	71.5

Table 8: Tobacco use among males in India **Source: NHSDA 2002 in Reddy and Gupta 2004**

Age specific estimates from the National Household Survey on Drug and Alcohol Abuse (Srivastava et al 2002), show an increase in the prevalence of tobacco use with age. The high rates of tobacco use among parents and in-laws appear to be consistent with the national trends in tobacco use.

There is very little data from India, about family studies among women using substances. A small, retrospective review of women substance users in treatment, shows that 20% of family members had substance dependence histories, but does not specify which substances (Grover et al 2005).

Apart from alcohol and tobacco, partners of both FSUs and NSUPs most commonly use cannabis, heroin, dextropropoxyphene, sleeping pills (sedative/hypnotics), buprenorphine and cough syrup. These patterns are similar to those reported in the National Household Survey (Srivastava et al 2002) and the Rapid Assessment Survey (Kumar 2002), which reported heroin as the commonest drug followed by cannabis, among 4648 drug using respondents across 14 centers in the country. 2.9% of FSU partners and 1.6% of NSUP partners reported current use of other drugs, including amphetamines. A higher percentage of FSU's reported higher ever injecting and current injecting rates among their partners compared to NSUPs. In a recent Rapid

Situation and Response Assessment (RSRA) Study (UNODC 2007), drug use patterns among 5742 males showed opiates, including heroin, dextropropoxyphene and buprenorphine, as the most commonly used drugs and ever injecting drugs reported in more than 60% of male drug users. The higher rates can be attributed to purposive sampling of IDUs in that study.

Summary Points

NSUPs report very high rates of tobacco use among family members with whom they stay

Among NSUP family members, more than half report alcohol use among in-laws

Parents and in-laws living with FSUs also have high rates of current tobacco use

Alcohol use among FSU siblings is significantly higher than NSUP siblings

Qualitative interviews suggest that many fathers of FSUs have died during the respondent's childhood

Partners have high rates of tobacco and alcohol use

The most common drugs of abuse among partners, include cannabis, heroin, dextropropoxyphene, sleeping pills and buprenorphine

The patterns of substance use among partners is similar to substance use patterns found in other studies in India

One in 4-5 male partners in the study, report lifetime intravenous drug use

FSUs are significantly more likely to be supporting their partner's substance use, financially

5.1 Sex and Drugs-an Early Introduction

Ancy, 24 years, Kottayam, Kerala

I work as a supermarket sales girl. My family comprises of my sick father, my mother and a mentally challenged brother. My father used to drink and smoke ganja regularly from a young age. He continues to smoke ganja and I am convinced he has become so ill because of drugs. My mother struggled for my education and future. My mother used to go to different houses to work in the kitchen. Here, I witnessed her having sex with a house owner when I was only 10 years old. At the age of 17, my mother sent me to a house for cleaning. I was very happy to go to there as it had a TV and video player. One day, the house owner asked me to clean his room when his wife and children were out of town. While cleaning, I found a lot of vulgar books on his bed and realized they were for me to see. As I had thought, he came to me and I enjoyed sex with him. Later, he helped me financially so I could complete my graduation. For the last two and a half years, I am in contact with S, who has studied up to the tenth standard and works in a hotel. He cared for me a lot and was even concerned about my smallest worries. One day he invited me to the cinema, but we went to his room, instead. I had been expecting his call for weeks and finally it happened. I really enjoyed his lovemaking. He used to give me a lot of money after each visit, without my asking for it. Soon, I found that he had many eccentricities. Sometimes he seemed very depressed and at other times he was over enthusiastic. I found he was more interested in sexual deviations rather than normal sexual activites.

When I got bored with his experiments I tried to avoid him. One day, he showed me some injection materials and forced me to share them with him. First, he injected his own vein, then mine with another needle. It was my first ever drug injecting experience. I felt a sense of pleasure and found myself forgetting all my worries and problems. I also started getting a kind of cooling effect in my ears, nose and anus. I spent the whole night and the next day enjoying sex with him. We lived like married people. He was very affectionate and never allowed me to have intercourse without a condom. After this incident, I became a regular drugs user, sometimes along with ganja. Our drug demand increased so he contacted other drug peddlers and started supplying drugs to tourists.

A year ago, he fled Kumily to avoid the police. I suffered a great deal without drugs. So, I approached his friend, also an addict, and he gave me enough for a fix. Naturally, I was forced to have sex with him and his friends. From that time, he brought many men to me and I had to satisfy them all. He made a lot of money at my expense. This continued till S returned but when he discovered the situation he started torturing me. His health had become weak and I had to provide him money, drugs and food. By this time I had become a regular call girl. When I came to know that S had tested HIV+ positive I tried to avoid him. I stopped having sexual relations and sharing with needles him. I like having sex with his friend and with a few people not for money but for enjoyment.

6 Substance Use among Women

Dual stigmatization

Introduction

Earlier studies on substance use in India indicate that the proportion of women using drugs was minimal in the 1980's and 1990's (Kumar and Sharma 2008). Many surveys excluded women, as the numbers were too few they were difficult to pick up in epidemiological studies. Thus the first National Household Survey of Drug and Alcohol Use in India (Srivastava et al 2002) exclusively surveyed the male population. Treatment centre data (Drug Abuse Monitoring System or DAMS) in 1989-91 revealed that 1-3% of patients admitted at treatment centers were female. In a subsequent DAMS conducted in 2001, which analyzed information on 16,942 patients admitted at treatment centers, women constituted 3% of admissions (Siddiqui 2002).

What we already know

Early studies of drug use in women emerged from the Northeast (Roy and Rizvi 1986). These researchers examined the distribution of drug use among women and men in two villages, one close to a town and the other in a remote location. The study found that non-traditional drug use (smoking 'kani powder' or heroin) did not differ much among men and women. At the time of the study, heroin was the preferred drug.

In a study of 75 women drug users (Kapoor et al 2001), enrolled through a snowballing technique, three different groups were sampled: sex workers from Mumbai, working women in Delhi and drug abusers in treatment at Aizawl. These were selective samples, with a majority of women in their 20s and 30s. The predominant drugs used were heroin, propoxyphene, alcohol and minor tranquilizers.

In the Rapid Assessment Study of 371 (8%) women among a total of 4648 respondents identified from 14 cities throughout the country, heroin, alcohol, cannabis and pain killers were the most common currently used drugs (Kumar 2002).

Unpublished data from the H13 RSRA study (UNODC 2007), addressing the prevention of HIV among drug users in SAARC countries, which engaged 5742 drug users and 3221 sex partners across 22 demonstration sites, found that 6% of the respondents interviewed were females.

With respect to injecting drug use, studies carried out in the Northeast, in the late 1980's and early 1990's, revealed that approximately 5% of IDUs recruited from the community, addiction treatment centers, remand homes and jails in Manipur and Nagaland were women. Women constituted 15% of the samples in Mizoram (Sarkar et al 1993). A subsequent study of 69 FSUs also involved in sex work, Panda et al (2001), found that 55% of this group was injecting drug users; a majority was having sex with non-regular sex partners and reported sex work in exchange for money and drugs.

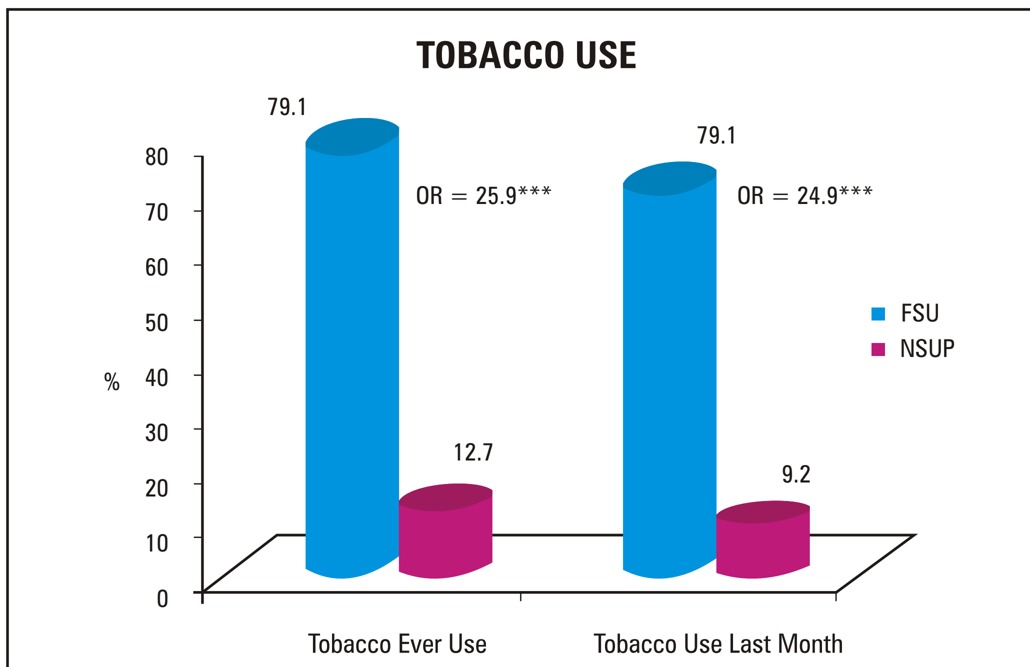
Little is known about injecting drug users in other parts of the country.

The Study

This study examined the patterns of tobacco use (smoking and chewing), alcohol, cannabinoids (ganja, charas, hashish, marijuana), sleeping pills (diazepam, alprazolam, nitrazepam), cough syrup (with codeine), buprenorphine, dextropropoxyphene, heroin (brown sugar), hallucinogens (LSD, magic mushrooms), solvents (petrol, erasex), cocaine and other drugs.

Tobacco use

Figure 26: Respondents' tobacco use



The association between current drug use and the use of tobacco is striking. NSUPs are more similar to the general population in terms of tobacco use. An analysis of the National Family Health Survey (NFHS II) data by Rani et al (2003) suggests that 14% of women in India smoke or chew tobacco, primarily in the chewing form. Based on the same data, the IIPS reported that 20.5% of women chew tobacco and 16.2% are smokers (Reddy and Gupta 2004). FSUs, as evidenced in the SWAHA study, have significantly high rates of tobacco use and a higher lifetime history [OR 25.9 (95% CI=22.4-30.1), p<0.001) and current history [OR 24.9 (95% CI=21.6-28.8), p<0.001] of tobacco use compared to NSUPs.

Among FSU tobacco users, 62.9% use the smoking form and 21.9% primarily use the smokeless forms of tobacco. Among NSUPs who use tobacco, half use the smoking form and the other half use the smokeless forms.

Although the debate of tobacco being a gateway drug to other drugs is not entirely conclusive, the relationship of starting to smoke early with later drug use (Hanna and Grant 1999) and the exposure that tobacco and alcohol provide to later illegal drug involvement (Wagner and Anthony 2002) simply cannot be overlooked. This phenomenon can probably be best researched in populations such as ours, where illegal substance use is still relatively low. Are traditional forms of

tobacco use - such as chewing - less likely to be associated with progression to other drug use in comparison to smoking? This is another important area that merits attention.

Table 9: Substance use patterns (excluding tobacco) - Lifetime and last year

	Female Substance User				Non substance using partner			
	Ever Use		Use last year		Ever Use		Use last year	
	N	%	N	%	N	%	N	%
Alcohol	1412	77.4	1258	67.5	73	1.9	24	0.6
Cannabis	383	22.7	259	15.4	8	0.2	1	0
Heroin (Brown Sugar)	565	33.5	447	26.5	25	0.7	12	0.3
Dextropropoxyphene	439	25.9	323	19.1	8	0.2	2	0
Buprenorphine	113	6.8	79	4.2	2	0.1	0	0
Cough syrup	234	13.9	152	9.1	12	0.3	1	0
Sleeping Pills (Benzodiazepines)	378	22.4	288	17.1	17	0.5	10	0.3
Solvents	82	5	49	3.0	1	0	1	0
Hallucinogens	11	0.7	7	0.4	0	0	0	0
Cocaine	2	0.1	1	0.1	0	0	0	0

Among NSUPs, lifetime and use of all drugs during the last year is negligible. However, it must be stated a priori, that most of the women classified as substance users may have initially been partners of male substance users. It is also possible that some respondents presently classified as NSUPs, may at a later time, shift to become substance users.

Current substance use

Among FSUs, 1258 (67.5%) report current use of alcohol (in the previous month). However, only 6% are solely alcohol users, most use alcohol concomitantly, with other substances of abuse. Earlier studies suggest abstinence as a rule among women. Sharma and Mohan (1999) reported abstinence rates of 90% among women in the general population. However, among tribal groups and tea plantation workers, a substantial number of women use alcohol, with prevalence rates ranging from 28% to 48% (Mohan and Dhawan 2000). The Genacis Study (Benegal et al 2003) found a prevalence of 5.8% during the previous year. In the SWAHA study, while ever use and use in the last year are extremely low among NSUPs, nearly 80% of FSUs report ever use of alcohol.

Current use of heroin (brown sugar) is reported by 472 (25.3% respondents), dextropropoxyphene by 341 (18.3%), cough syrup by 154 (8.3%), buprenorphine by 79 (4.2%), cannabis by 287 (15.4%), sleeping pills by 292 (15.7%) and solvents by 57 (3.1%). Thus, most respondents who reported use in the last year are also current users.

Age groups and substances

Tobacco and alcohol use appears ubiquitous among all age groups. As pointed out earlier, solvent use is more common in younger age groups. All other substances, including injecting practices, are most common among respondents in their 20s and 30s, a time of peak productivity and risk. Solvent use occurs at a relatively young age and mirrors solvent use among male populations (Murthy et al 2003). Tobacco and alcohol use precedes the use of other drugs.

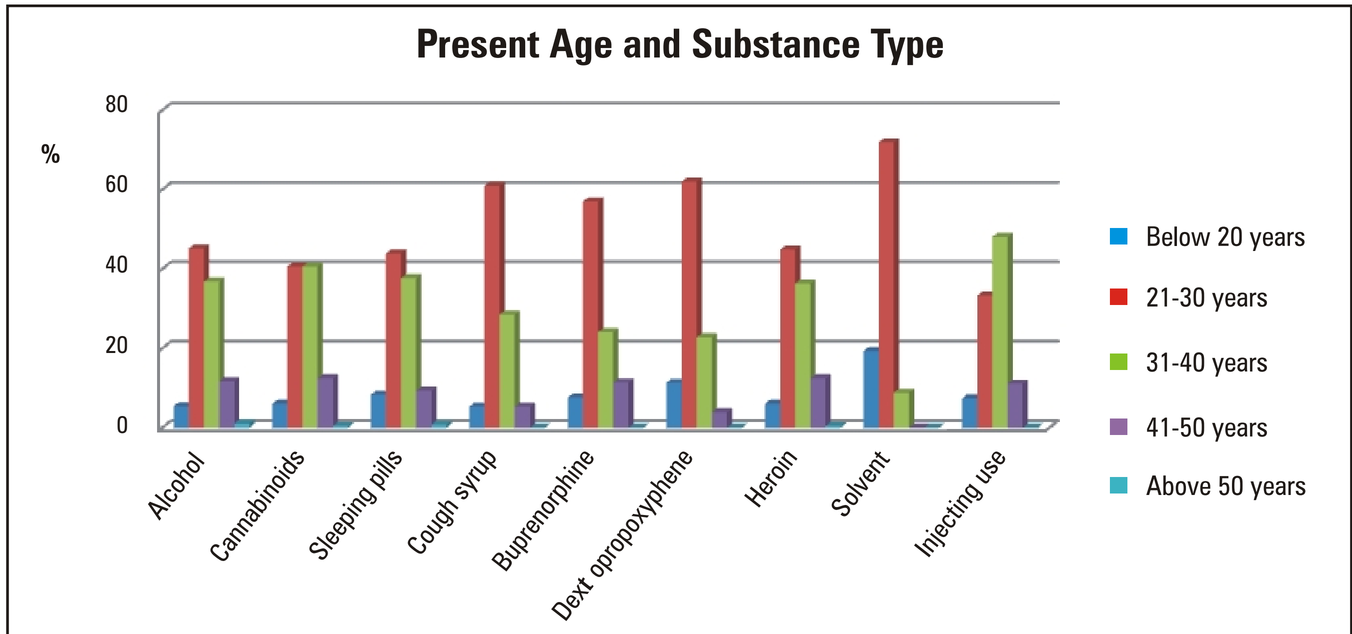


Figure 27: Age distribution of women substance users in SWAHA

Age at initiation

Tobacco use precedes other substance use (except solvents). However the transition to other drugs including alcohol and opiates, occurs fairly rapidly.

Substance	N	Mean age at first use	SD
Tobacco	1436	18.4	5.5
Alcohol	1393	20.9	5.7
Cannabis	371	21.8	6.2
Sleeping pills	363	22.0	6.4
Cough syrup	233	19.3	5.1
Buprenorphine	111	22.5	5.9
Proxyvon	431	20.3	4.6
Brown Sugar (heroin)	556	22.7	5.4
Hallucinogens	11	20.6	2.3
Solvents	82	16.5	3.3
Cocaine	2	19.5	3.5

Table10: Mean age at first use

Tobacco use precedes use of most substances among FSUs

They rapidly shift to use of other substances

Solvent use by women is initiated at a relatively younger age among the few users in the SWAHA study

Reasons for use

Reasons and circumstances of initiation were assessed in the life history narratives. Common reasons listed in the accompanying box are ordered at random and are, by no means, exhaustive.

An early start … or a parent trap?

Neelofar is 13 years old, lives in Bhopal and belongs to a Muslim family. She is uneducated and her methods of earning include begging, pick- pocketing and stealing. She stays with her parents and two brothers. Her father, also a drug user, has sex with several sex workers. He first introduced her to drugs when she was only 8 years old when he taught her to chase brown sugar. She vomited the first time but soon became habituated. Later, she started injecting drugs. Her 8-year-old brother is also an IDU.

Vulnerability to peer influence

Nothing was right in Rinpuii's life. Her poverty and parentlessness had made her 'timid, shy and not very sociable'. She had an inferiority complex and was unhappy at home. Emulating the carefree life of her easy going, irresponsible accomplices, she left home and entered the world of hallucinations and intoxicants

- Rinpuii, 25-year-old from Aizawl

Pleasure

Priya was introduced to heroin by a young drug vendor who was emotionally supportive. 'He pressed me to chew heroin to increase my sexual power and enjoyment. That's how I started the heroin habit.'

- Priya, 20-year-old from Chandauli

Relief from physical pain

'During pregnancy, I started taking morphine injections for mild pains. Gradually, I became used to them and started taking injections three to four times a day.'

- Kumari, 28-year-old nurse from Gurdaspur

'I was quite tense because of my family problems and developed migraine attacks. My sleep was disturbed so I started taking proxyvon tablets to help me sleep.'

- Radha, 26-year-old from Muradabad

Mental sub-normality

Srimathi could not complete her schooling because of difficulty in her studies. So she started hanging around with both boys and girls in the street, and got addicted to erasex (solvent)

- Srimathi, 19-year-old from Karnataka

Stress/depression

Sumathi's spouse and in-laws are supportive and she has no problems. 'But God doesn't want us to be happy. After so many years of marriage, He has not given me any children'. When she was 27, she took her first dose of alprax (alprazolam) on the advice of a friend, to relax, since she was very tired. She has been addicted since then.

- Sumathi, 30-year-old from Gonda

Iatrogenic

Prema Devi, a happily married woman, developed an acidity problem for which she went to the village doctor. 'He gave me medicine and an injection and assured me full recovery. I recovered temporarily and thereafter whenever I had trouble I used to go to him and he would give me the same injection and I used to get relief. This situation continued till I became completely addicted to these injections'.

- Prema Devi, 40-year-old from Gurdaspur

Patterns of use in the last month

Opiate users, especially those using heroin and dextropropoxyphene are primarily daily users. Nearly half the alcohol, cannabis and sleeping pill users report daily use of these substances.

	Daily or nearly daily (%)	At least once a week (%)	Less than once a week (%)	Other pattern/ Unclear (%)
Alcohol	46.3	40.7	10.9	2.1
Cannabinoids	47.4	33.6	13.5	5.6
Brown Sugar (Heroin)	74.4	14.6	5.4	5.6
Dextropropoxyphene	61.4	22.7	9.3	6.6
Buprenorphine	49.4	30.6	12.9	7.1
Sleeping Pills (Benzodiazepines)	46.4	35.2	14.5	3.9
Solvents	30.0	48.3	16.7	5.0

Table 11: Pattern of substance use in the last month

Context of use

Tobacco and sleeping pills are more commonly used alone. Alcohol, cannabis and opiates (cough syrup, buprenorphine dextropropoxyphene, and heroin) all tend to be commonly used with partners or alone. Women generally use solvents primarily in group situations. They also use alcohol, cannabis and all opiates in group situations.

Nearly 75% of FSUs using heroin and a large number using other opiates report use daily/ nearly daily

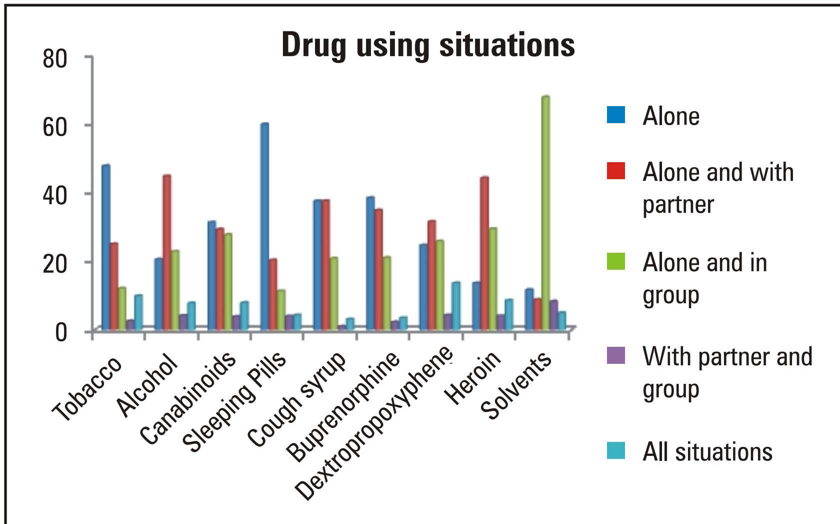
Nearly 50% of sleeping pill, cannabis and alcohol users use them daily/ nearly daily

Nearly one-third of the solvent users use them daily/nearly daily

Tobacco and sleeping pills are mainly used alone

Alcohol, cannabis and opiates are used with partners, in groups and alone

Solvents are mostly used in group situations



Patterns of substance use among FSUs from the East parallel those from the Northeast

Buprenorphine users have been mostly identified from the North, East and North East

Higher numbers of FSUs using cannabis and solvents have been identified in the South

Figure 28: Drug using situations

The life history narratives show that nearly 50% respondents have been initiated into substance use by friends or peers and 25% by regular partners or spouses.

Regional patterns

All substance use (current use) is higher in the Northeast, as respondents are overrepresented from this region. Patterns in the Eastern regions parallel those in the Northeast, except for a lower use of dextropropoxyphene, and a higher use of solvents. Nearly a third of buprenorphine users are from the North, East and Northeast. Opiate use among women is lower in the West and South. The South has a relatively higher use of cannabis and solvents.

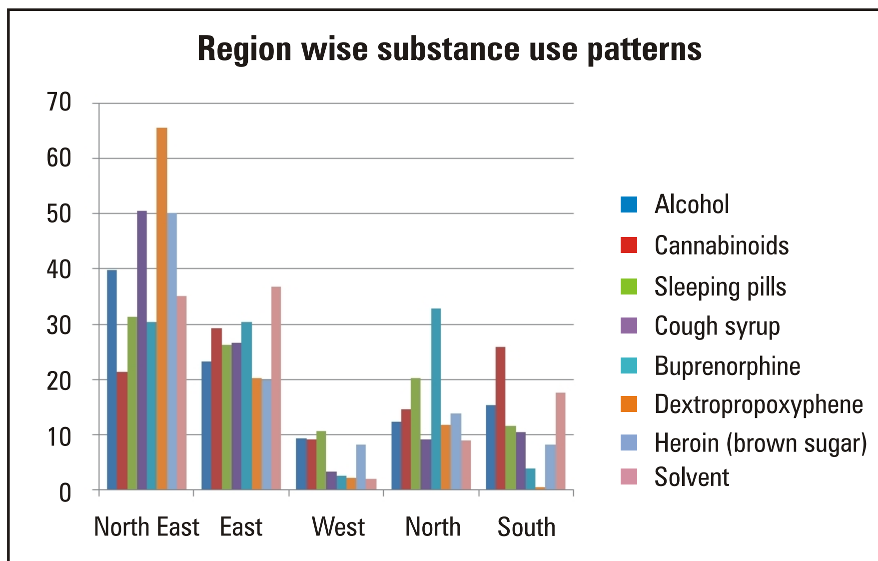


Figure 29: Substance use patterns across regions

Rural urban comparisons

Among rural substance users (N=471), 31.8% were from the Northeast, 26.1% from the East, 2.1% from the West, 25.9% from the North and 14.1% from the South.

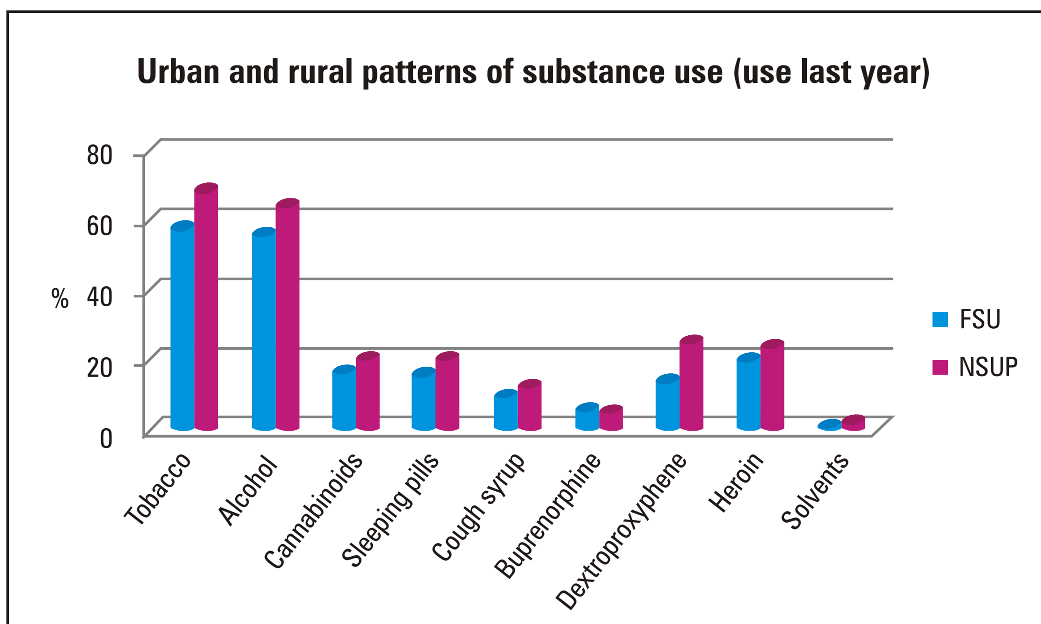


Figure 30: Urban and rural distribution of FSUs

While use of all substances by FSUs, during the last year, is higher in urban women compared to the rural populations, all categories of substances, both legal (alcohol and tobacco) and illegal (cannabis, heroin), sedative/hypnotic use and opiate medications are reported by rural users. Dextropropoxyphene use is comparatively lower in the rural group probably due to its to cost and availability. Solvent use among the rural population was reported in 7 respondents (1.5%) compared to nearly 3% of the urban users.

Rural substance users use all the common substances that urban women use

Injecting drug use

A total of 587(31.5%) FSUs reported ever injecting. The following region-wise table provides a comparison between ever injecting women users and their ever injecting partners. Though IDUs among male partners have been identified throughout the country, nearly two-thirds of the FIDUs have been identified in the Northeast indicating that it has become a fairly visible phenomenon there.

	FSU		FSU Male Partner	
	N	%	N	%
North-East	359	61.5	125	32.4
East	85	14.6	95	24.6
West	30	5.1	41	10.6
North	51	8.7	59	15.3
South	59	10.1	66	17.1

Table 12: Injecting use among FSUs and their partners - regional patterns

In the study, injecting use has been mainly reported from the Northeast. However, it is prevalent in many other parts of the country as well. A majority of heroin and dextropropoxyphene users report injecting.

Patterns of injecting among women are likely to mirror those of the men. As mentioned earlier, unpublished data from the RSRA reveals that more than 50% of drug users, predominantly male, from Manipur, Darjeeling, Tamil Nadu and Kerala, reported IV heroin use. A similar pattern was reported from Nagaland, Meghalaya and Darjeeling for dextropropoxyphene. With respect to injecting buprenorphine, high rates were reported from Delhi, Jharkand and Orissa.

Injecting use among the majority of women starts in the early 20s, and is perhaps similar to injecting patterns among males (Kumar 2002, Murthy et al 2003). What is evident from the age of initiation of non-injecting opiates and injecting use is that women respondent's progress very rapidly to injection or even start with injecting use.

Nearly two-thirds of the female injecting users identified are from the Northeast

Injecting use is emerging among FSUs in other parts of the country

Women seem to progress rapidly to injecting, and in some cases, initiate with injecting drug use

Unsafe injecting practices are common among women injecting drugs

	Mean	Median
Age at first injecting (n=587)	22.42 (6.0)	20.0
Injecting practice at last use (Current injectors, n=222)	n	%
Disposable needle and syringe	98	44.1
Washed syringe and needle in water before use	45	20.3
Boiled both at least 20 minutes before use	2	0.5
None of the above	25	11.3
No response	53	23.9

Table 13: Injecting practices

Injecting practices

Reasons for shifting to injecting drug use include peer pressure, economic constraints (cheaper than brown sugar, greater high with smaller amount) and significant health problems resulting from substances like alcohol.

With respect to methods of injecting, current injectors were asked whether they used a disposable needle or syringe during their last use. 44% used disposable needles and syringes. One-third used other methods, which included washing

in plain water. No clear response was forthcoming from nearly 25% of respondents.

Among those reporting use of 'clean' injecting equipment, the most common cleaning method is washing with plain water

Respondents reporting the use of disposable needles and syringes cannot be implicitly considered as using safe injecting practices. This is evident in the case of 30-year-old Laxmi Devi from Patna, who reuses the same disposable needle and syringe 4-5 times a day, after washing it with water.

Zoani, a 23-year-old daily wage laborer from a rural area became addicted to heroin (IV) at the age of 19. She sometimes used old needles and syringes after cleaning them with plain water, and even shared those belonging to friends, as she could not afford new ones. Although she was aware about drop-in-centers she never went there because of stigma and discrimination.

Methods of cleaning among respondents reusing injecting equipment

Among those who reported reusing needles and syringes, a majority washed with plain water. In the RSRA study which predominantly included males, 64% of those who reused injecting equipment also reported washing in plain water. This figure is higher in women injectors in the present study.

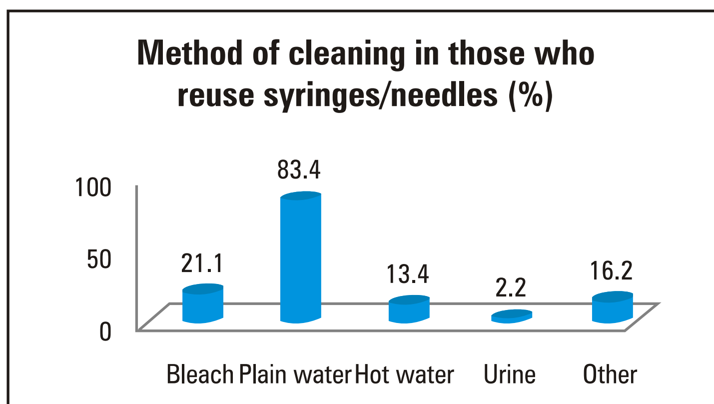


Figure 31: Cleaning methods in IDUs

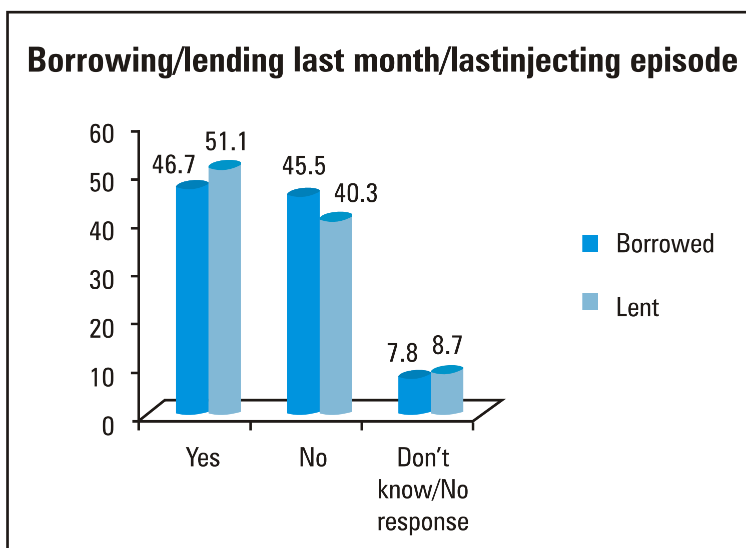


Figure 32: Borrowing and sharing among IDUs

Borrowing and lending syringes

Borrowing and/or lending injecting equipment is fairly common and takes place in nearly one in two injectors. While the earlier finding that many use disposable needles and syringes may be somewhat reassuring, the high rates of borrowing/ sharing raises the issue whether injecting users are sharing disposables. The earlier example of the respondent reusing the same syringe and needle multiple times suggests that self-reports of using disposables should be further evaluated.

Sharing

Among respondents reporting lifetime injecting, 286 respondents (48.7%) report ever having shared injections/syringes with others. Sharing practices are shown in the accompanying figure. Sharing injecting equipment with both regular and casual partners is extremely common. Nearly one in two respondents, who shares, does so in a group setting.

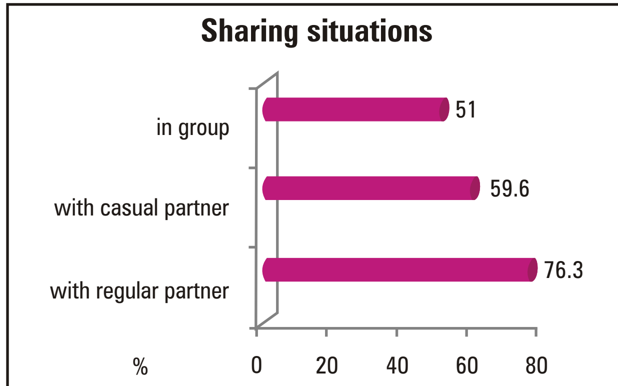


Figure 33: Sharing situations in IDUs

> More than 75% of injectors who share, report sharing with a regular partner
>
> Nearly 60% have shared with a casual partner
>
> One in two injectors has shared in a group

Of those sharing drugs in a group, 53% report use in groups comprising 2-4 members, and 24% report groups of 5 or more members.

Implications of injecting drug use

Women are likely to share injecting equipment with more people in their social network, compared to men (Sherman et al 2001). In a study from the Soviet Union, it was found that women might be the last ones to use the needle/syringe in a group injecting setting (Malinowska-Sempruch 2001). These behaviors also put women at risk for other diseases such as hepatitis and rates of Hepatitis C are very high among injecting drug users (European Monitoring Centre 2003). In a Canadian study of injecting drug users, being female was one of the risk factors (others included frequent injection and cocaine use) for HCV sero- conversion (Firestone et al 2007). A significantly higher mortality rate from diverse causes was found for women IDUs (Perucci et al 1991).

IDU and HIV risk

Intravenous drug use is a very effective way of transmitting the HIV virus (MAP 2005). While the proportion of AIDS cases due to IDU is relatively small, it must be emphasized that because of their high-risk practices, IDUs are at a greater risk for HIV infection. In the Northeastern states, the primary route of infection is through injecting drug use, chiefly concentrated among drug injectors and their sexual partners (Solomon et al 2004). HIV prevalence among female IDUs was 57% compared with 20% among non-IDUs (Panda et al 2001). A study from Manipur showed that 20% of commercial sex workers were also injecting drugs (NACP II 2002). In other northeastern states, half as many report injecting. The finding in Tamil Nadu that 64% of IDUs are HIV positive, is striking.

The overlap between IDU and unsafe sexual practices adds another dimension to the situation. As buying and selling sex is more common than drug injection, HIV transmission is greater through the sexual route than the injecting route. This issue is separately addressed.

Since injecting is an effective way of spreading the infection, IDUs need to be 100% sure of using safe injecting methods. However, ground realities indicate that in many cases, sterile needles are used but syringes are shared. IDUs at Manipur were not accessing sterile disposable syringes because they feared being caught by the police. Pisani (2003) noted that 88% of IDUs chose to continue using non-sterilized syringes despite knowing where to access the disposable ones. As discussed earlier, ignorance about why it is critical to use disposables (illustrated by Laxmi Devi's reuse of disposables) and the perceived high cost of using them combined with the perceived stigma of accessing disposables through limited outreach centers compound the risks of injecting drug use for women.

Consequences of substance use for women

In an earlier sub-study on the impact of male substance use on women partners, some partners reported that they were forced to part with their earnings to support their spouse/partner's drug habit (Shankardass 2002). Just as HIV causes problems in terms of health, finances and relationships, substance use too has the same consequences. Relationships suffer, financial resources are depleted and health costs increase. When the user stops taking on responsibilities because of substance use, the carers who are most often women, have to shoulder the additional burden of earning for the family (Murthy 2002).

Economic impact

The economic impact for FSUs and NSUPs is enormous, because the income is fractured to fund substance use costs. There is less money available for running the household and inadequate funds for the family's health and education needs.

Average expenditure on drugs

In the study, the median expenditure on drugs was calculated for the previous month. The maximum amount was spent on heroin, followed by dextropropoxyphene and buprenorphine, respectively.

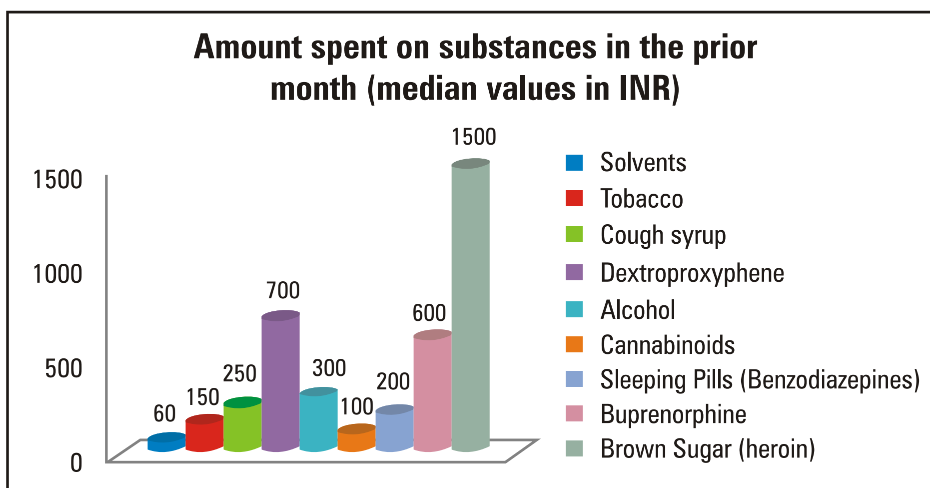


Figure 34: Expenditure on individual substances

> Women substance users spend more than two-thirds of their individual income on substances for personal use

It is evident that FSUs spend a significant proportion of their personal income on themselves. When the individual monthly income of all FSUs was added, including their cumulative spending on substances, it became clear that 68.5% of their individual income was being spent on procuring substances for personal use.

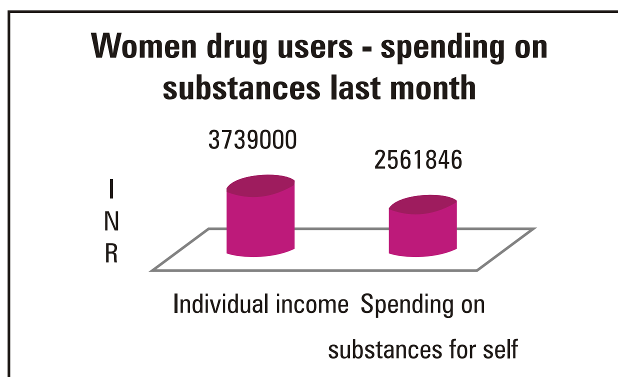


Figure 35: Total expenditure on substances

Aggression by women using substances

More than 50% of the substance users reported violence towards their spouses/partners. Nearly 42% reported violence towards other family members and 47% towards outsiders. More than one-third reported violence towards their children.

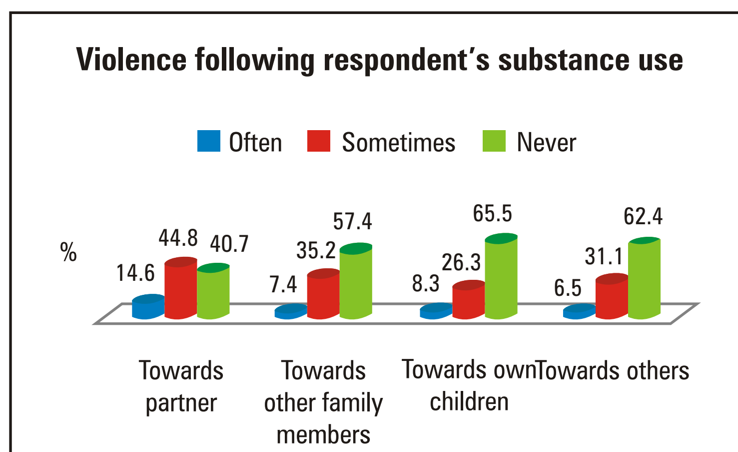


Figure 36: Violence by FSU

- One in two women substance users report violence towards their spouses/partners
- A significant number report violence towards other family members and outsiders
- More than one-third report violence towards their children

I started taking alcohol when I was 25 years old. My spouse forced me so I took it because I was scared of him. Now alcohol gives me much pleasure and a deep sleep. I have tried to stop drinking when I can't afford it, but the habit and my husband's compulsion make me go back to it. Alcohol affects the care of my home and my children. I also suffer from mental pressure. Besides, we quarrel with neighbours, friends and relatives and have several social problems. When we are intoxicated, there is physical violence between us; we throw our belongings outside or at each other. Sometimes, I have also been violent with my children.

- Meeta Das from Bhubanseswar

Sometimes I feel guilty and shameful about my life, but when I take the drugs I forget everything. Many times my in-laws have complained about me in the police station. I have spent many nights in custody. But the very next day I come back and fight with them. So many times, I have broken their windows and doors. One day, I don't know what happened; I opened my eyes and found myself in the police station so I slapped one of the police officers.

- Swinki, 28-year-old poly-substance user from Gangtok

Other problems during the last month

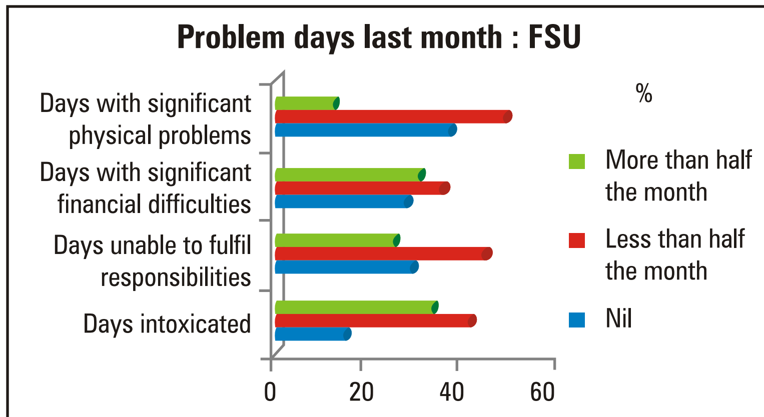


Figure 37: Problems faced by FSUs

During the previous month:

A majority has used substances to intoxication

Nearly 70% have been unable to fulfill responsibilities

73% have reported significant financial difficulties

62% reported significant physical problems

18% reported legal problems

More than 80% reported consuming substances to intoxication in the last month and more than 50% had consumed to intoxication more than half the month. Nearly 70% had been unable to fulfil their responsibilites for some part of the previous month, 73% had perceived significant financial difficulties, and 62% had significant physical problems during the last month. Relatively fewer respondents (18%) reported significant legal problems during this period.

As discussed earlier, the patterns of substance use among women reflect the pattern of male substance use in many ways. HIV research cautions about the feminization of the HIV/AIDS epidemic (spreading to bridge populations including women whose partners abuse substances). What is now apparent from the study, is the trend towards the feminization of the drug epidemic (patterns of substance use among women becoming more similar to men in the the narrowing of the gender gaps, an increase in injecting drug use and adverse social consequences including violence and crime) in the near future.

Summary Points

Focused studies and Rapid Assessment Surveys in the last decade have highlighted the emerging problem of substance use among women

The study reveals high rates of tobacco and alcohol ever and current use among women substance users

Among women, tobacco and solvents are used at an earlier age, but the tobacco users' transition to other drugs is rapid

The commonest substances used (apart from tobacco and alcohol) are heroin, dextropropoxyphene, sedative/hypnotics and cannabis

Reasons for initiation include remote events like childhood difficulties, peer influence, partner influence, physical and emotional distress, as well as iatrogenic causes

Tobacco and sleeping pills are commonly used alone, alcohol and opiates with partners as well as alone, and solvents predominantly in group situations.

A majority of opiate users in this study are from the Northeast, though injecting among male partners is reported from all regions of the country. FIDU is most visible in the Northeast, but emerging elsewhere

Among FSUs in South India, apart from tobacco and alcohol, cannabis and solvents are relatively more common

Reasons commonly quoted for shifting to injection are peer pressure and economic reasons (easier to buy pharmaceuticals than illicit substances)

Economic consequences, physical ill health, inability to take responsibility and violence towards family members, particularly the spouse, are common features among FSUs

Unsafe injecting practices are clearly evident

The next few decades are likely to witness a 'feminization' of the substance use epidemic among women (patterns closely mimicking male substance abuse, in the form of gradually narrowing gender ratios, increase in injecting, adverse social harm in the form of rising violence and crime)

6.1 "Sugar" on The Tea Estates

Rekha, 25-year-old from Assam

I was born near Nagaon in Assam. Both my parents were illiterate. My father was the sole breadwinner, but he was often unemployed. Though we were poor, we were a happy family. But, unfortunately, when I was very small, my mum expired due to an illness. After two years, my father remarried and had three daughters from his second marriage. Now I have four sisters, three stepsisters and one who is my own sister. My sister is happily married now and has good relations with her in-laws.

I did not go to school because my stepmother didn't allow it. I was made to do all the household work, was not given proper attention, love, care, clothing or food. I was also a very busy girl in my childhood, and did not get any time to play or have fun like other girls. I was beaten by my relatives because I refused to call my step mum 'mother'. My father sent me to work as a maidservant in a rich man's house to free me from my stepmother's harsh treatment. For three years I did all the household work there, without earning any money, but I was given free clothes and food.

My first sexual experience was with a man who promised to get me a job. But he raped me repeatedly instead, at a very young age. This man had actually bought me from my parents.

My marriage was arranged three years ago without a dowry. My spouse is an auto driver who earns Rs 4000 every month but his job is not regular. He has three elder sisters and one elder brother and is on good terms with them. We live with my in-laws. My spouse is a very caring and responsible person. Though I could not get along with my mother-in-law, we did not quarrel even once. My marriage is a good one. We don't have children, so I don't have much idea about parenting. We sometimes go to the movies, visit relatives, shop or watch TV and listen to music. My sister-in-law is responsible for controlling the expenditure at home. We have taken a loan from the government to buy land. Sometimes I have borrowed small amounts of money from friends and neighbours. I also lend money to others. I share my feelings/problems with my relatives.

I had my first experience of drugs at the age of 18, when my spouse and friends forced me. At first I felt like vomiting and became dizzy but after some time I felt very good and enjoyed the trip. I felt very strong, brave and my body felt light. I started taking brown sugar up to 3-4 grams per day; from the beginning I took it regularly and soon became addicted to it. I take drugs with my friends, sometimes at home, sometimes in the tea garden. I prefer brown sugar and have never changed the drug I use. In a day I spend more than Rs 300-Rs 400. When my spouse told me to give up drugs, I tried; but soon went back to it because a relative falsely accused me of being an addict. I may be under the influence of drugs, but I never neglect my household work. When I failed to give up the habit, I thought of ending my life and was in the process of hanging myself, but my spouse reached home in time, and stopped me.

At present, I am unemployed though I have become a sex worker earning Rs 10,000 per month. I started this profession not out of my own interest, but because I was sold to a man on the pretext of getting me a better job. When I have financial problems, there is no other option but to earn through sex or exchange drugs for sex. For the future, I do not have any plans to leave this work or change my life. But, it is my dream and hope that I will become a decent, clean woman, with a well-settled job one day.

6.2 Only Agony no Ecstacy

Sheela Rani, 30-year-old from Bihar

I was born at Maner, in Patna, to a poor Hindu family. Both my parents died while I was young so I have been earning since my childhood and never went to school. I worked in a nursing home and as a house sweeper for about Rs 300 a month.

I have been facing problems since childhood, even my parents used to beat me when I was a little girl. Someone tried to molest me where I worked, but I was rescued. I fell in love with this person who saved me and married him when I was just 16. My spouse is well educated and works as a compounder. His monthly income is Rs 6000-7000. He practices in the rural area where we live.

Sometime after our marriage, he married another woman under pressure from his family, without informing me. When I found out, I quarrelled with him. Though he still loves me he does not disclose any facts. After he married the other woman, he started beating me. He has a son from his second wife and lives with her for ten to twelve days in a month. I was blessed with two sons but one died; now the second is nine years old and lives with me. I have lived like a prisoner in my house after marriage. My source of income is my spouse's income. He keeps all the money, and I do not have any right to spend any of it. My first sexual encounter was with him six months before marriage. We do not use condoms, as my partner does not like them so I opted for sterilization.

At the age of 22, after my spouse's second marriage, I began to live in tension for my future. One day I decided to commit suicide by burning myself. Though I remained alive most of my body got burnt. My spouse treated me in the house. I was unable to move and sometimes mice would bite me. I had unbearable pain because of the burns. To relieve the pain and heal the wounds, I had to take daily injections of fortwyn (pentazocine) and phenergan (promethazine). As my wounds began to heal, I became addicted to the injections. I now take 8 to 10 ampoules daily and sleep all the time. I unsuccessfully tried to give up this habit many times and failed. Now I live in a miserable condition.

Three years ago my spouse admitted me to a drug de-addiction centre, where I had a 21-day treatment, which was successful. I did not take drugs for six months and began to recover my health. After sometime I was upset about being alone and began to feel anxious and worried, so I started injecting myself again. Now I take IV. I use one disposable every day, and wash it with water. I get knots in my body due this habit and when I don't get the injection, I itch and scratch all over. No one cares about me, not even my spouse. I feel ashamed and think it is better to die than live this sort of life. I have only one solution to relieve my tension, and that is injecting. Due to my addiction we have had to borrow money. Our economic condition is miserable. My spouse only wants to get me treated because of social pressure. The drug de-addiction centre in this city has told me that there is no facility to treat women in that hospital. Now I am looking for treatment in Patna. I want to get rid of this addiction, but family support is very essential.

7 Substance and Sex

Listen, learn ... link up the common connections

Introduction

Asangba, 30-year-old from Kiphire, Nagaland

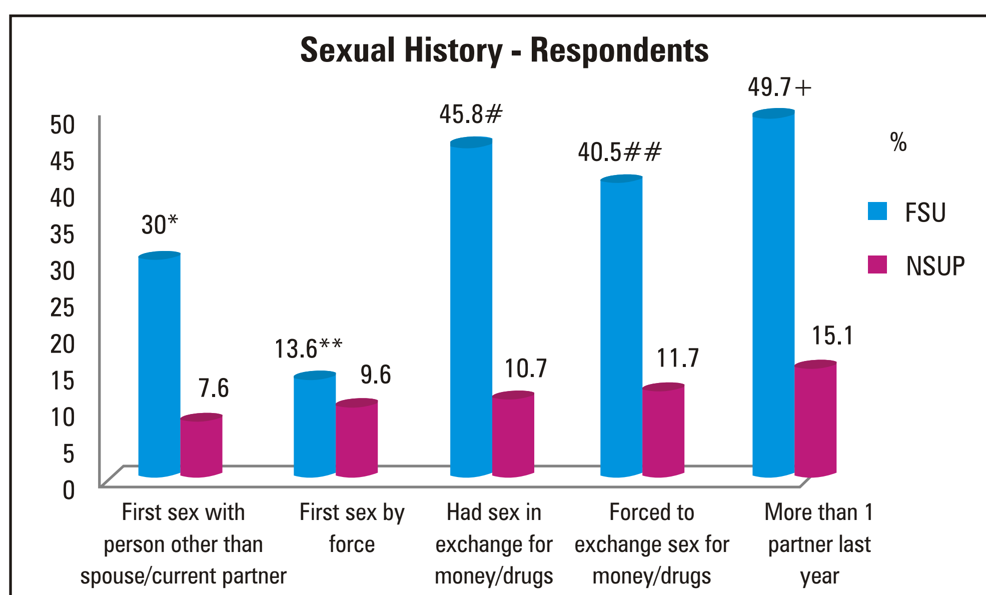
Two years after my spouse died of complications related to chronic alcohol use, I came to Dimapur with a friend in search of a decent job. We stayed at Lahorijan. Here, most women were into sex work and drugs, which I didn't know in the beginning so initially I was disgusted with everything and everyone. Then I got influenced and because I needed money I got involved in sex work. Initially, I never thought I would continue it for long, but when I started using brown sugar, giving up sex work and finding another job became impossible. So, till today, I am hooked to drugs and prostitution.

Substance use and sex share an intimate relationship. There are several common mediators that initiate females into these potentially risky practices - especially adolescents and young adults. Expectancies regarding the effect of substances on sex may play a critical role; substance use may mitigate the guilt or emotional trauma of sex, especially coerced sex or sex for survival (sex to earn money); and intoxication may lead to risky sexual behaviors. Limited studies suggest that these risk-taking behaviors are increasing among adolescents in Asian countries (Choe et al 2004).

There is an intimate relationship between sex and substance use, especially for women

The Substance, Women and High Risk Assessment Study

Mean age at first sexual experience among FSUs is 17.32 (3.2) years and among NSUPs is 18.2 (3.8) [$F=45.4$, $t=-8.9$, $p<0.001$]. 2.5% of FSUs and 0.7% of NSUPs had their first sexual experience with a customer.



*OR 1.9, 95% CI 1.8-2.1, ($p<0.001$), **OR 1.1 ($p<0.001$), #OR 7.1, 95% CI=6.2-8.1 ($p<0.001$), ## OR=5.1, 95% CI=4.5 -5.9 ($p<0.001$), + OR 1.9, 95% CI=1.8-2.0 ($p<0.001$)

Figure 38: Sexual history of respondents

FSUs are exposed to sex at a significantly younger age . They are more likely to have pre-marital sex (mean age of marriage among FSU's was 18.5 years), to have had sex with a person other than spouse/current partner, to have been coerced during their first sexual experience, to have had sex in exchange for money/ drugs and forced into such activities. Substance users are also significantly more likely to have had multiple partners in the previous year.

In their life history narratives, significantly more FSUs (22/102) than NSUPs (1/35) report sexual exposure before marriage ($=6.53$, $p<0.05$)

Women using substances are more likely than those not using substances to have:

- The first sexual experience at a younger age
- Coerced sex
- Premarital sex
- Sex with persons other than spouse/ regular partner
- Multiple partners
- Sex in exchange for money/ drugs

25-year-old Swapna was born in Lavpur village in Orissa. She is the older of two sisters. Her mother worked as a maid and died of snakebite when Swapna was just five. So she had to discontinue her schooling and help in the house. She fell in love with one of the village boys when she was a teenager and had her first sexual experience with him at the age of 16. Apart from her fears of unwanted pregnancy she enjoyed her sexual relationship. Her father terminated this relationship and married her off when she 18. The marriage lasted for two years. Her spouse consumed alcohol regularly, and subjected her to physical and sexual violence. Both he and his mother ill-treated her. He forced her to use alcohol and engage in non-conventional forms of sex.

After her separation, she resorted to sex work and was able to earn Rs 2000 per month. Then, she fell in love with one of her clients, who now stays with her and her father. She has a satisfying relationship with him except when he is intoxicated with alcohol and becomes verbally and physically abusive.

Although she resented being forced into alcohol use, initially, she finds that it gives her enjoyment and pleasure, though it affects her physically and mentally. Yet, sex for her and her spouse is more enjoyable after alcohol.

'Drug use increases my sexual arousal, desire and choice of partner. I always select a partner who cares for me and can help and listen to my problems. I am very selective. I take the drug before sex up to a certain limit and spend 10-15 minutes with one partner. Under its influence, I am sexually aroused so my partner gets more excited with my active participation. Thus, both of us are sexually satisfied'.

Circumstances of sex

Approximately one in two FSUs reports having had sex in the last year under the influence of alcohol or drugs. Both groups report a high occurrence of sex when the partners are intoxicated/ high, although FSUs are significantly more likely to have sex when the partner is under the influence of drugs. For FSU's, it is common to have sex when both partners are high. Nearly two thirds of respondents in both groups report that condoms are not used in such situations.

- During the last year:
    - o One in two FSUs has had sex under the influence of substances
    - o More than 75% of NSUPs and FSUs have had sex with a partner who was under the influence of alcohol
    - o About two-thirds have had sex with a partner who was under the influence of other drugs
- In nearly two-thirds of the above situations, no condom has been used
- NSUPs are even less likely to use condoms in such situations, compared to FSUs

	FSU		NSUP		
During last year, had sex when	N	%	N	%	Odds Ratio
Respondent was under influence of alcohol	1010	54.2	-	-	-
Respondent was under influence of drugs	858	46.0	-	-	-
Partner was under influence of alcohol	1459	78.2	3400	77.3	1.1
Partner was under influence of drugs	1212	65.0	2687	61.1	1.2**
Both under influence of alcohol	936	50.2	-	-	-
Both under influence of drugs	696	37.3	-	-	-
Condom was used in any of above situations	675	36.2	1420	32.3	1.2**

Table 14: Circumstances of sex

**p<0.01, **p<0.001

Substance use and sex: expectancies

Though, for nearly one-third of FSU's, substance use does not alter the sexual experience, for nearly two-thirds it has positive expectancies of making it more enjoyable and less painful. Even among NSUPs, nearly 25% perceive positive expectancies from its use. Approximately one-third of FSUs and NSUPs perceive that their partner's substance use makes sex more enjoyable for them. All these perceptions are significantly higher among FSUs. However, in both groups, respondents perceive that their spouse/partner makes unusual sexual demands under the influence of substances.

- Nearly 60% of FSUs have positive expectancies from substance use (sex more enjoyable or less painful)
- About one-third of FSUs and NSUPs feel that partners' substance use makes sex enjoyable
- In more than one in three FSUs and NSUPs, partners demand other forms of sex under influence

	FSU		NSUP			
Expectancies from respondent's substance use on sexual experience	N	%	N	%	95% C	Odds Ratio
Does not alter	597	32.0	1219	27.7	1.1-1.4	1.2**
Sex more enjoyable	683	36.6	769	17.5	2.4-3.1	2.7***
Sex less painful	536	28.7	334	7.6	4.2-5.7	4.9***
Expectancies from partner's substance use on sexual experience						
Does not alter	556	29.8	1064	24.2	1.2-1.5	1.3***
Sex more enjoyable	707	37.9	1388	31.5	1.2-1.5	1.3***
Sex less painful	499	26.8	757	17.2	1.6-2.0	1.8***
Partner demands other forms of sex	665	35.7	1620	36.8	0.9-1.1	0.95

Table 15: Substance use and sex - expectancies **p<0.01, **p<0.001

Partner's insistence for sex

Among nearly two-thirds of respondents in both groups, partners insist on sex even when the respondent is unwilling. A significant proportion of partners insist on sex even when the respondent actively refuses.

Partner insists on sex when respondent unwilling	Often %	Sometimes %	Never %	Not applicable %
FSU NSUP	18.1 20.2	49.8 50.5	22.6 25.4	9.5 3.9
Partner's response to respondent's refusal for sex	Lets it be	Insists	Other	
FSU NSUP	34.6 42.5	44.7 41.3	18.7 16.2	

Table 16: Partner coercion for sex

Coerced sex and sexual violence in intimate relationships are further discussed in the next chapter.

Partner's extramarital relationships

33.9% of FSUs and 24.5% NSUPs are aware that their spouse/partner is having another sexual relationship, 26% of FSUs and 39.8% of NSUPs are confident that their partner/spouse does not have any other sexual relationship and 35.7% and 31.2%, respectively, do not know whether their spouse/partner has another sexual relationship. In the life history narratives, 23% of FSUs reported that their partner was having an extramarital relationship as compared to 17% of NSUPs.

- One in four NSUP partners is aware of partner's extramarital relationships
- One in three FSUs is aware of partner's having another sexual relationship
- About one in three NSUPs and FSU's do not know whether partner has an extramarital relationship

Substance use and sex: tenuous relationships

Early sex and substance use

Sexual victimization has several negative effects, including a premature and exaggerated sexual interest and vulnerability to subsequent sexual exploitation (Moore 1998). The negative consequences range from a younger age of first voluntary sexual intercourse, higher frequency of sexual activity and greater number of sexual partners to higher use of drugs/ alcohol and mental health problems (Boyer and Fine 1992, Moore 1998). Behavioral surveillance on HIV/AIDS carried out by NACO, in 2001, reported that the median age of the first sexual encounter among the general population was 21 years for males. The CHARCA study, (Singh et al 2004) found that the median age for females varied from 16 to 19 years across five districts in India, Aizawl (Mizoram), Bellary (Karnataka), Guntur (Andhra Pradesh), Kanpur (Uttar Pradesh) and Kishanganj (Bihar). 35 -47% of girls from Bellary, Guntur and Kishanganj had sex before the age of 15 years. In the SWAHA study, respondents reported sexual exposure in their late teenage years, which coincides with the rest of the country.

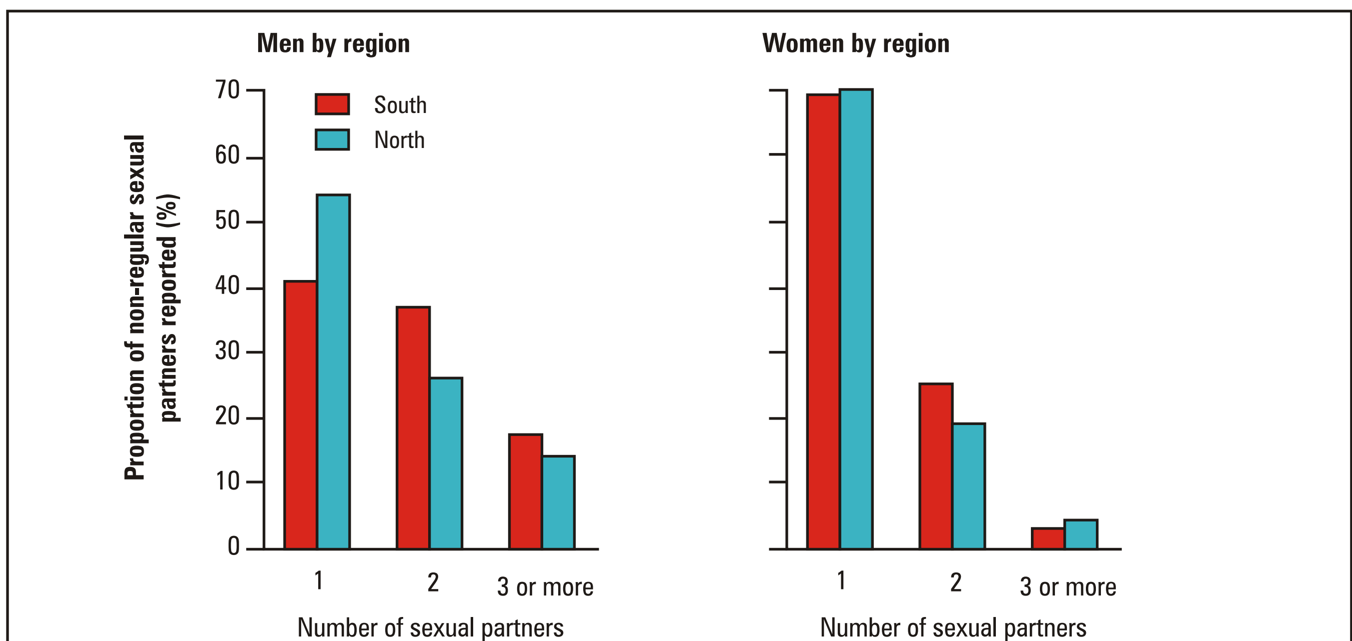


Figure 39: Sexual partners reported by men and women (Source: NACP II)

Non-substance using women's risk

NSUPs in the study resemble women in the general population, who largely have monogamous relationships. FSUPs are more likely to have multiple relationships.

Substance use and sex

In a Bangalore study among male alcohol users, 30% reported high-risk sexual behavior in the past two years. Common risk practices included multiple partners, paid sex and unprotected anal sex (Chandra et al 2003).

Sex work and substance use

A study in Imphal examined the interface between drug use and sex work (Panda et al 2001). Based on interviews of 69 FSUs who were also involved in sex work, the study revealed that two-thirds of the injectors and non-injecting drug users reported sex work in exchange for money/ drugs. 80% of the respondents had sex with non-regular partners.

Early relationships: contexts

A recent study from Pune, Maharashtra, examined the associations with premarital relationships of both genders between the ages of 15 and 24 years in urban, rural and slum settings. Among young women, 5-8% had a romantic relationship, 4-6% had engaged in some form of physical intimacy and 1-2 % had had sex. Exposure to alcohol, drugs or pornographic films and a more frequent interaction with peers were some factors positively associated with the romantic/ sexual relationships of these young women and men. For the women, educational attainment was negatively associated with both types of relationships, but in the case of men only with sexual relationships. Closeness to parents was negatively associated with relationships only for the women. Other studies suggest that young women whose father's beat their mother's, were more likely than other women to form romantic partnerships, and those beaten by their family had an elevated risk of entering romantic and sexual partnerships (Alexander et al 2007).

Summary Points

Substance use and early sex share an intimate relationship and may both be influenced by certain common factors

Expectancies can also influence the co-occurrence of these potentially risky behaviors

FSU's in the study have their first sexual exposure at a relatively younger age compared to NSUPs

FSUs are more likely to have faced sexual abuse, had sex with a male other than their spouse or current partner, exchanged sex for money, been forced to exchange sex for money and have more sexual partners than NSUPs

Women partners of male substance users often have sex when the partner is under the influence, and this is frequently unprotected

Many FSUs feel substance use makes sex more enjoyable and/or less painful

Many NSUPs feel their partner's use of substance prior to sex, makes sex more enjoyable and/or less painful

In both groups, partners often insist on sex even when respondent is unwilling

In both groups, partner often demands other forms of sex under influence

About one-third of FSUs and 25% of NSUPs are aware that their partner has an extra-marital relationship. Approximately one in three in each group, do not know

7.1 The Lure of Lucre

Jamila, 31-year-old from Kerala

I belong to a Christian family from Kerala and have completed my school education. My father, who was from a farmer's family, was not well educated. He became an alcoholic since his relatives used to make country liquor. In the beginning, he physically abused my mother saying she was barren, and went to other women. When she became pregnant, he said the baby was from someone else. Then he got into a lot of legal problems, became very sick and started using ganja. My mother worked very hard in the fields to earn a living. Since my father never accepted me as his child, I was very scared of him and wished he would die in an accident. My childhood was painful. Once, when I was in the 9th standard, I found my mother having sex with another man from the neighborhood. So I made it a point to watch this incident again and again and began to think of my mother's lover as my own father. He was also very affectionate towards me. My sexual feelings grew beyond my control. And one day when my mother was away I went to his house. That day I had my first sexual experience. There was uncontrolled bleeding so I was admitted to a clinic. When my mother came to know the truth, she beat me very badly.

During my school days, I was the most beautiful girl in my class. Boys always courted me and I used to seduce many in the college. One of them, the son of a rich businessman, gave me plenty of money whenever I asked for it.

I am very addicted to sex in a different way than other girls. I get satisfaction when I see that men are easily attracted to me. It is like taking revenge on my father and for all my hardships during childhood.

I joined a regular arts and science college. One day, the police caught me when they raided a lodge room but they did not register a case against me. In return, I had to spend a night with three arrogant, dirty policemen. This was the worst episode of my life. I became very depressed and was sacked from college at the age of 21. Soon after, I developed a severe pain in my womb so I was taken to see a gynecologist. My vaginal area was infected and it took me two years to recover from the shock. I was also taken to a psychiatrist.

When my father died we became very poor. I worked as a sales girl, earning Rs 1500 per month. The shop owner liked me very much and used to give me extra money for no reason. One day, he asked me to come to the shop on a holiday and had sex with me in the shop where we were caught red-handed by his wife. I was sacked from the job.

My mother became very sick. I got a job in a medical shop earning Rs 70 per day. The shop owner was very rich and owned tourist resorts, cardamom estates and many buildings. He asked me to manage a tourist resort a little distance away. One day, he took me to his estate and gave me high quality liquor. That was my first drinking episode. He had sex with me and told me that he had never had such a wonderful experience. He gave me Rs 20,000. One day he said some very close business partners were coming from abroad, so I would have to entertain them. I asked him frankly if he wanted me to sleep with them. He nervously said "yes". I refused.

The next day I did not go to work but around 11 am, I got a mobile alert that my bank balance had gone up to Rs 3 lakhs, with a Rs 50,000 deposit from him. I went to work the next day and was told to attend to two Arab guests. There were two other girls there who injected some drug into the guests and into my body. The Arabs videoed all the sexual activities they engaged in with us. I protested, but they did not bother. I was shut up in the villa for a week. The next morning, I found myself shivering and uneasy. I wanted to have the injection, so I bought some liquor and drank it. I was still feeling uneasy and getting withdrawal symptoms. The next day I went to the medical shop, and bought some injections and pills that included fortwyn, buprenorphine and other drugs. I tried to inject the medicine but failed.

I wanted to commit suicide. I met my boss the next day. He looked very cruel and asked me to do whatever he said or he would show my nude movies to others. I did as he asked. I joined two other girls for injections and started entertaining guests for money. Soon I was addicted to liquor and ganja. When I consulted a doctor he told me to use ganja or ganja oil instead of injecting. By 2006, I was very sick with an infection around my genital areas. The doctor sent me to the VCTC (Voluntary Counselling and Treatment Centre), where I tested HIV+. I became very weak and tired and was soon infected with TB. I had never been interested in using condoms and always shared injections with others. Today, I have 2 lakhs in my account but I have lost my beauty, my hair and sex appeal. Nobody is able to recognize me anymore. Nobody wants me now.

8 Substance and Violence

The drink habit destroys the soul of man and tends to turn him into beast, incapable of distinguishing between wife, mother and sister.

- Mohandas Karamchand Gandhi

Other drugs do too...

Introduction

Studies show that women with substance use problems are more likely to experience physical or sexual abuse (Wechsberg et al 1998, Westermeyer et al 2001). This in turn, can aggravate drug use and mental health problems. Substance use, in turn, makes the woman more vulnerable to further assault (Kilpatrick et al 1997).

The Substance, Women and High Risk Assessment Study

	FSU		NSUP	
Ever experienced violence	N	%	N	%
Yes	1270	67.7	2804	64.6
No	472	25.9	1290	29.7
Don't know/No response	80	4.4	248	5.7

Table 17: Violence

More than two-thirds of respondents in both groups have experienced violence of some kind in their lives. Verbal violence - being shouted at, called names and threatened are the most common forms, followed by physical violence, such as being slapped, beaten, kicked or pushed. More than one-third report sexual violence including rape, non-consensual sex and sexual assault.

Sudha from Kolkata

When Sudha was just 12 years old her uncle raped her while her brothers slept in the adjacent beds. After this incident, Sudha and her brothers were put into foster care. When she was 14 and high on acid, a 42-year-old man picked her up from a street corner. She recalls what happened that very day. 'He got me wired. He got me doing coke, by injecting me that very night. He was a user and a pimp, so he saw me and I guess he knew how easy it would be to get me out on a corner. At first it felt great because men wanted to pay to be with me'.

This man became like a father figure, showing her love she had never known. But then he began to beat her, and her urge for injected, powdered cocaine intensified. She tried to make some money and run, but he would track her down, inject and batter her, sparing only her face. Controlled by both fear and drugs, her vulnerability escalated. Today, at 28, though she has survived gang rape, incarceration, miscarriages and two suicide attempts (slashed wrists and a heroin overdose), she is infected with both HIV and Hepatitis C.

Perpetrators of violence

Violence was mostly perpetrated by spouses/partners.

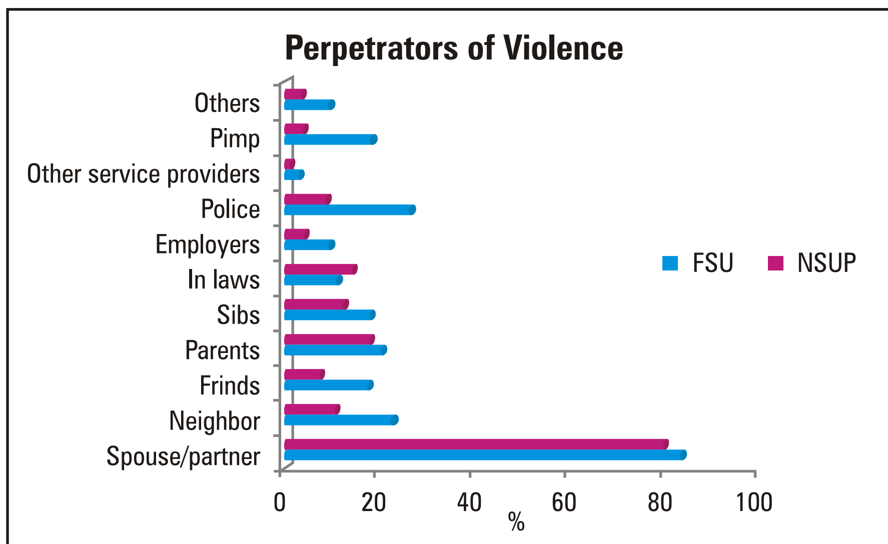


Figure 40: Violence against respodents-perpetrators

Common perpetrators of violence towards NSUPs are:

- Spouse/partner
- Parents
- In-laws

Common perpetrators of violence towards FSUs are:

- Spouse/partner
- Police
- Neighbors
- Parents
- Friends
- Pimps

Frequency of violence

	N FSU	% FSU	N NSUP	% NSUP	Odds Ratio
Any violence	1271	72.9	2804	68.5	1.2**
Type of violence (among those reporting violence)					
Verbal violence	1270	96.9	2937	97.6	0.77
Physical violence	1187	90.5	2415	80.4	2.3***
Sexual violence	667	52.5	856	30.3	2.5***
Perpetrator of violence					
Partner/spouse	745	84.3	1103	81.1	1.2
Parents	186	21.3	249	18.7	1.2
In laws	104	12.1	201	15.2	0.8*
Friends	159	18.4	108	8.2	2.5***
Employer	89	10.3	64	4.9	2.2***
Police	240	27.7	123	9.4	3.7***
Pimp	165	19	63	4.8	4.7***

Table 18: Frequency of violence

While both groups report high levels of violence, FSU's are significantly more likely to have experienced some form of violence [OR =1.2 (95% CI =1.1-1.4), $p<0.01$], physical violence [OR=2.3 (95% CI=1.9-2.8), $p<0.001$) and sexual violence [OR=2.5 (95% CI=2.2-2.9), $p<0.001$).

NSUPs and FSUs are equally likely to experience violence from partners and parents and 20% more likely to experience violence from their in-laws. FSUs are more likely to experience violence from friends [OR=2.5 (95% CI =1.9-3.3), $p<0.001$], employers [OR=2.2 (95% CI=1.6-3.1), $p<0.001$], police [OR=3.7 (95% CI=2.9-4.7), $p<0.001$, and pimps [OR= 4.7 (95% CI=3.4-6.3), $p<0.001$].

FSUs are significantly more likely to have experienced physical injury consequent to violence [OR =2.0 (95% CI=1.8-2.3), $p<0.001$].

Women using substances report significantly higher levels of violence, both physical and sexual

Of those who experienced violence among all respondents:

- 97.4% experienced verbal violence
- 83.4% experienced physical violence
- 37.2% experienced sexual violence

More than two-thirds of NSUPs and more than three-fifths FSUs have sustained physical injury from violence

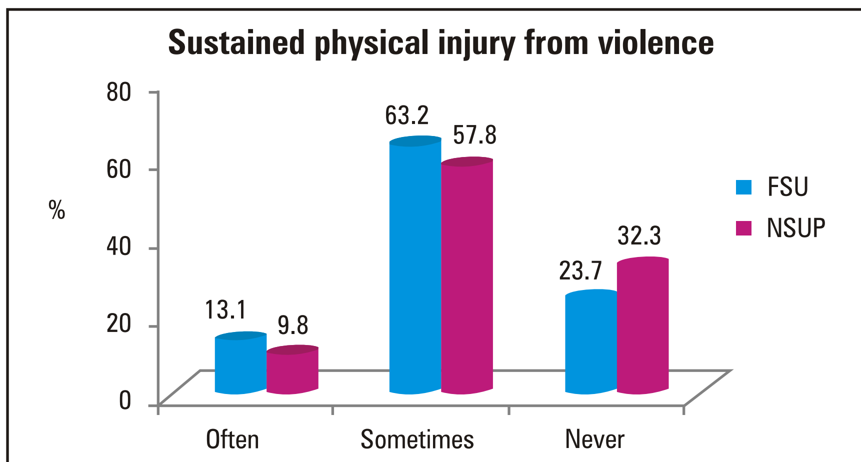


Figure 41: Physical injury from violence

Contexts of partner violence

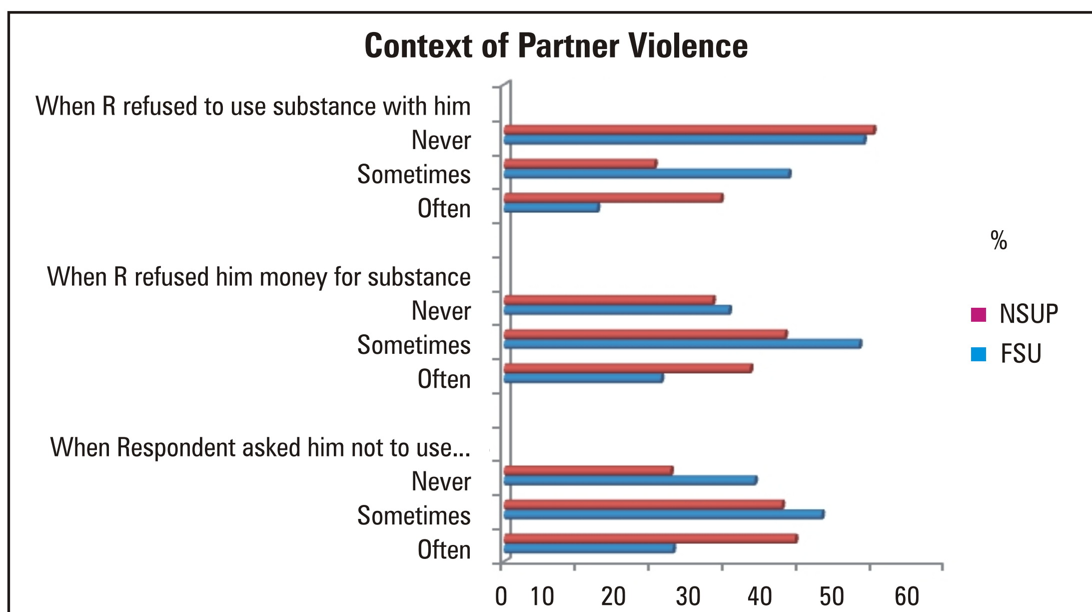


Figure 42: Contexts of partner violence

Partner violence and relationship to substance use

Common contexts of violence when:
- Respondent asks partner not to use substance
- Respondent denies money to procure substance

Violence generally occurs when the respondent refuses to give her partner money for using substances (commonly reported by all respondents), when the respondent asks spouse/partner not to use substances or has refused money for substances (more commonly reported by FSUs).

Although more than 50% of respondents in both groups, report sexual violence when the partner is under the influence of substances, more FSUs report sexual violence often or sometimes. More than 60% of FSUs report sexual violence when they are under the influence. Male condom use under circumstances of sexual violence from partner/ any other perpetrator is very low, especially among NSUPs (6.3% versus 13.9%).

Condom use in circumstances of sexual violence from partner is very low

	FSU		NSUP		95% CI	OR
	N	%	N	%		
Sexual violence when perpetrator under influence of substance	595	31.9	740	16.8	2.0-2.6	2.3***
Condom used during such an occurrence	259	13.9	277	6.3	2.0-2.9	2.4***
Experienced physical or sexual violence when respondent under influence	520	27.9	308	7.0	4.4-6.0	5.1***
Violence when R asked partner not to use substance	556	29.8	1027	23.3	1.2-1.6	1.4***
Violence when R refused partner money for substance	583	31.3	949	21.6	1.5-1.9	1.7***
Violence when R refused to use substance with partner	427	22.9	623	14.2	1.6-2.1	1.8***

Table 19: Contexts of violence

Significant at **$p<0.01$, *** $p<0.001$

Help seeking following violence

Nearly a third of respondents from both groups do not seek any help after there is any violence. Where partner violence is concerned, more than 50% of FSUs and nearly one in two NSUPs never seek help in such situations.

- FSUs are 5 times more likely to experience physical or sexual violence under the influence of substance
- NSUPs are even less likely than FSUs to report condom use by partner during coerced sex and to seek help when partner is violent

	FSU %	NSUP %
Did respondent seek help for any kind of violence		
Often	9.5	10.1
Sometimes	59.3	60.4
Never	31.2	29.3
Did respondent seek any kind of help for intimate partner violence		
Often	7.8	10.8
Sometimes	36.7	45.4
Never	55.4	43.7

Table 20: Seeking help following violence

NSUPs are significantly more likely to obtain help from family members, like parents, in-laws and siblings. FSUs are more likely to approach friends and neighbors. Nearly 90% have not sought any help from doctors, NGOs, police or local leaders. However, among the few who have accessed these resources, NSUPs have more often approached community leaders and FSUs are more likely to have approached NGOs, doctors, police and religious leaders for help. Help seeking patterns among respondents are presented here, in both a tabular and graphic form, for particular emphasis, as a guide to focused interventions for providing support to partners of both male substance users and FSUs.

- NSUPs are more likely to approach family members for help during violence
- FSUs are more likely to approach friends and neighbors for help
- Utilisation of community based services for help during violence is very low from both groups

	FSU		NSUP		95% CI	OR
	N	%	N	%		
Parents	483	25.9	1480	33.6	0.6-0.8	0.69***
In Laws	217	11.6	1023	23.2	0.3-0.5	0.4***
Friends	406	21.8	641	14.6	1.4-1.9	1.6***

Neighbors	439	23.5	796	18.1	1.2-1.6	1.4***
NGO/CBO	222	11.9	327	7.4	1.4-2.0	1.7***
Doctor	154	8.3	158	3.6	1.9-3.0	2.4***
Police	71	3.8	107	2.4	1.2-2.2	1.6***
					X^2	P
Siblings	353	35.3	1059	44.5	24.7	***
Community Elders	106	10.4	349	14.8	12.1	**
Religious Leaders	74	7.4	87	3.7	21.5	***
Others	90	9.1	170	7.2	4.2	NS

Table 21: Support providers in situations of violence ** significant at $p<0.01$, ***significant at $p<0.001$

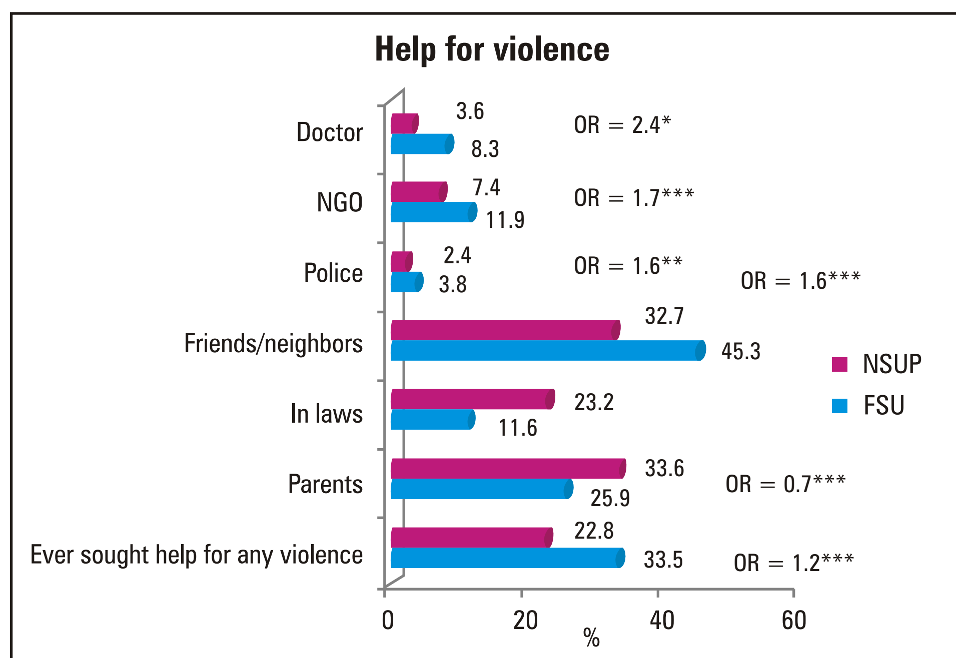


Figure 43: Help seeking for violence

Violence against women in India

Violence against women is a global phenomenon that cuts across all social and economic classes. Several studies have shown a close association between intimate partner violence, substance use (El-Basel et al 2003, Weinsheimer et al 2005) and sexually transmitted diseases (Bauer et al 2002, Lipsky et al 2005). A study was sponsored by the International Center for Research on Women between 1997 and 1999 at seven sites: Bhopal, Chennai, Delhi, Lucknow, Nagpur, Thiruvanthapuram and Vellore (ICRW 1999). One out of every four respondents had experienced being slapped, kicked, hit, beaten, threatened with or without the use of a weapon, and been forced to have sex in the last 12 months. The violence was perpetrated by their spouses. While the majority of spouses were teetotallers, nearly one-third drank

excessively in the past year and 16% drank occasionally. This study established that family violence against women is more prevalent among families in which the spouse uses alcohol. It was the second highest 'predictor' of violence, after dowry harassment. The study could not establish a relationship between drug use and domestic violence since few spouses of those surveyed used illicit substances. 45% of the women surveyed, needed health care due to the violence but only 50% received it. On an average, their injuries prevented them from attending to household chores for at least four and a half days and going to work for five days. In cases where severe injuries led to hospitalisation, the natal families frequently paid for the treatment. The economic costs of violence were substantial, apart from the physical and psychological trauma suffered by the women.

According to the NFHS data, 1998-99, 19% of women reported incidents of abuse in the form of kicking, beating or slapping (Ackerson et al 2007) and there was a significant association between violence and adult smoking. Violence was primarily (85%) from the spouse. Women who reported past and current abuse had 20-40% increased odds of tobacco use, compared to those reporting no abuse, even after controlling for income and educational status.

In a study of 180 women seeking prenatal care in rural South India, 20% of the women reported domestic violence and 94.5 % identified their spouses as aggressors. The spouse's alcohol consumption was a significant risk factor in incidents of domestic violence (Gururaj et al 2006). A study from Bangalore showed that the chance of emotional abuse from the spouse was 2.5 times, physical abuse nearly four times, and the odds of abuse resulting in physical injury extremely high (OR=30.4) (Benegal et al 2003). Over 40 % men consuming alcohol reported hitting their intimate partner, while 20% reported coaxing their partner verbally and physically, for sex (Panchananadeswaran et al 2004).

In a study carried out by UNIFEM, in 2001 (UNIFEM 2007), 10-50% of women in India have experienced violence from their spouses/sexual partners. The recent documents review violence against women and also examine the evaluation of the Domestic Violence Act of 2005. The CHARCA study reported that respondents being subjected to violence ranged from below 5% to 42% (Singh et al 2004). There are steep differences, across districts, of men getting sex whenever they want, irrespective of the women's approval. They were considerably high in Guntur, Bellary and Kishanganj (42-50%). A higher number of respondents in Bellary and Kishanganj reported forced, penetrative sex (38-41%) and felt that their spouses did not respect their unwillingness to have sex (24-46%). Substance-abusing male partners are more likely to be physically and sexually abusive towards their female partners.

In the Genacis Study examining alcohol use among women (Benegal et al 2005), 50% of male drinkers and 40% of female drinkers reported aggression after drinking. Women with alcohol-using spouses were significantly more likely to have faced violence than women with abstaining spouses (40% and 11 % respectively).

The US Full Report on the Prevalence, Incidence and Consequences of Violence Against Women (US Department of Justice 2000) examined alcohol and drug use among perpetrators and victims of rape and physical violence. 37% of perpetrators and 25% of female victims had been under the influence at the time of rape. 46% of perpetrators and 44.9% of women victims had been under the influence at the time of physical assault. In a cross sectional survey of women visiting a HIV Voluntary Counseling and Testing Center (VCT) in Bangalore (Chandrasekaran et al 2007), 42% of respondents reported domestic violence including physical abuse (29%), psychological abuse (69%) and sexual abuse

(1%). Older women and those with a low socio-economic status were the most likely to have experienced domestic violence. Other associations with domestic violence include spouse's education, HIV seropositivity, alcohol or tobacco use.

Rates of violence reported in the present study are much higher than those reported in other studies from India. The spouse/partner normally being identified as the perpetrator is a common thread across all studies. According to the present study, the rate of actual physical injury caused during violence, is also extremely high. Whereas, help seeking for all kinds of violence is extremely low.

A study of South Asians in the United States (Raj et al 2006) examined the association between intimate partner violence and emotional abuse from in-laws. There was a significant relationship between partner violence and in-law abuse (OR =5.7 95% CI =1.5-21.5). For NSUPs, according to the present study, while there is a greater likelihood of experiencing violence from in-laws, the latter can also be a source of support for them. The study evaluated, in detail, the sources of possible support that need to be strengthened within the community. These are discussed later.

Summary Points

Violence against women is a global phenomenon that cuts across all social and economic classes

Studies from India show high rates of violence against women, particularly from spouses

These studies show that an intimate association exists between alcohol use among males and sexual violence towards their spouses

The present study reports very high levels of all violence - both among NSUPs and FSUs.

While violence is overwhelmingly from spouses/partners, both groups also report violence, though to a much lesser extent, from parents, in-laws (NSUPs more than FSUs), friends, employers, police and pimps (FSUs more than NSUPs)

More than 75% of FSUs and two-thirds of NSUPs have sustained physical injuries because of violence

Common contexts of violence from spouse/partner include respondent's refusal to provide money for partner's substance use, asking him not to use substances and refusing to use substance with him

Sexual violence from partner is commonly associated with partner and respondent's use of substances

Condom use during any act of sexual violence, is low

Approximately 50% of the respondents in both groups, do not seek help for intimate partner violence

Nearly a third do not take help for any violence

NSUPs tend to turn to family for help and FSUs rely more on friends and neighbours

Aggression and violence by FSUs is not uncommon

The utilization of formal services within the community and of service providers for help, following violence, is low

8.1 Nobody's Child

Lakshmi, 38-year-old from Tuticorin, Tamil Nadu

I am a woman in prostitution who lives on the streets. I do not know who my mother, father or siblings are. I have never seen them as I was handed over to an orphanage where I lived till I was five years old. Then a male beggar adopted me to help him beg. When he died, I was left alone to beg and live on the pavement. I even stole money and was punished many times. I attained puberty at twelve. One day, a youngster from a well-to-do family forced me to have sex with him. Though, I was scared initially, later I liked it because he gave me Rs 100. After that many men called me for sex. I ensured that I got money first and then agreed. Life went on till one of my regular clients took me to a temple and married me. Very soon, I did not like having only one partner so I walked out of the house and went to live with another client who also insisted that I should not have sex with anyone except him. I could not agree. So, I was sent out of his house and came back to the street again.

When I was 20, one of my clients offered me alcohol, which I accepted. Then, I gradually began to take beedi and cannabis, regularly, while having sex. My clients meet most of my expenses for drugs, so why should I worry?

Most men who have sex with me inflict violence, as they are generally under the influence of alcohol, heroin, cannabis or other drugs available in the medical shops. They also share the drugs with me while having sex. For both money and drugs, I have learnt to tolerate violence; there is no other choice. I go to places like parks, benches and tourist spots with clients to have sex. I don't socialize with anybody. Being a woman in prostitution, I don't mingle with other women. All my needs are met with the money I earn. Some of my clients also give me drugs and food. I am never short of money and don't need to borrow. In fact, I have lent money to my poor clients. I solicit in front of the medical college and the court complex. I know several advocates, government officials and even some doctors. They would help me in times of difficulty, but I have never approached them.

Recently, some of my clients have started wearing condoms, which I resisted, because it was new for me. I know about HIV through the NGOs and hospitals. But condom wearing is my clients' choice, I never insist. I have been treated for STDs in the government hospital, and conceived many times. Each time I aborted with oral pills brought from the hospital or over the counter from a pharmacy. Having a child is a nuisance so I do not plan to have any children.

The only disadvantage of taking drugs is that I tend to fight and use abusive language, which some clients don't like.

Today I cannot think of a life without drugs. Why should I think of abstaining? You people are very moralistic. You are campaigning against alcohol and drugs but your views will never affect me.

I have faced conviction for soliciting clients and indulging in prostitution. As I am aware that I am indulging in an unlawful activity, I gracefully accept any legal action and will cooperate with the law enforcement agencies.

8.2 Middle Class Blues

Kemani Devi, 49-year-old partner from Manipur

Kemani Devi was born in a middle class family, in Imphal. She was married at 19 and initially lived happily, even though her spouse was unemployed. Some years later, he got a job as a driver earning a regular income of Rs 3500 per month.

After some time, she noticed several changes in his behavior. He started coming late smelling of alcohol and would find fault with her. He took less interest in the children's health and education. Then she noticed that he had started using other drugs as well.

With his use of multiple drugs, the family atmosphere deteriorated. He stopped contributing even a single paisa to the family. Instead, he sought money from her for drugs. She experienced open verbal and physical violence when he was intoxicated. He sometimes broke household articles and abused her badly.

She decided to earn some money by opening a petty shop. Her brother invested money for her to start an agarbathi (incense stick) business.

Kemani has already undergone one abortion and does not practice any family planning. She has had some problems in her external genitalia and also noticed that her spouse has pain during urination. He has lost interest in a sexual relationship. She suspects that he may be infected with HIV. With all these troubles, she is emotionally disturbed and her concentration, sleep and decision-making abilities are affected. Sometimes she wants to end her life, but keeps going for her children's sake.

9 Substance and Reproductive Health

An important but often neglected health right

Introduction

Available literature suggests that the global burden of disease with regard to substance use, particularly use of substances and unsafe sex, is considerable (Lopez and Murray 1998, Room et al 2002). A range of socio-cultural and economic factors influence substance use and sexual and reproductive health. These factors vary from country to country and in India, from one region to another.

The Substance, Women and High Risk Assessment Study

Family planning

170 FSUs (9.6%) and 368 NSUPs (8.6%) answered 'don't know' or 'no response' to the question whether they had ever used family planning. With respect to their choice of family planning, 545 (32.6%) FSUs and 1251 (29.3) NSUPs provided 'don't know' or 'no response'. Regarding their preferred choice of family planning methods (male, female, or both}745 (45.3%) FSUs and 1669 (40.3%) NSUPs either did not know or did not respond.

Overall, less than 50% had used any family planning method, and this was significantly lower among FSUs [OR 0.7 (95% CI= 0.7-0.9), $p < 0.001$). Both groups were likely to have mainly used female methods, which in India primarily include a tubectomy or contraceptive pills.

- About 40% of respondents are unable to indicate choice of family planning
- Only one in two respondents among both NSUPs and FSUs has ever used any form of family planning
- FSUs are even less likely to be using family planning methods

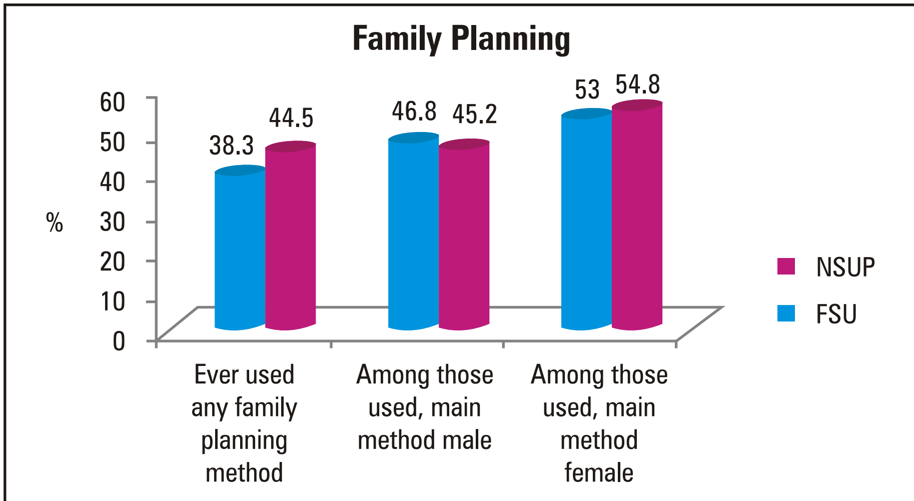


Figure 44: Methods of family planning

Among respondents who answered, more than one-third in both groups preferred a female method of contraception, or a combination of male and female methods. In the qualitative interviews, many indicated that their partners were unwilling to use condoms, as they diminished sexual pleasure.

There are negative expectancies regarding condom use among male partners, primarily that it diminishes sexual pleasure

	FSU		FSU	
	N	%	N	%
Miscarriages Nil	1347	75.9	3098	71.3
1-3	390	22.0	1055	24.5
More than 3	37	3.0	166	3.9
Induced abortions Nil	1328	75.1	3525	82.2
1-3	401	22.6	741	17.3
More than 3	40	2.3	20	0.5

Table 22: Miscarriages and abortions

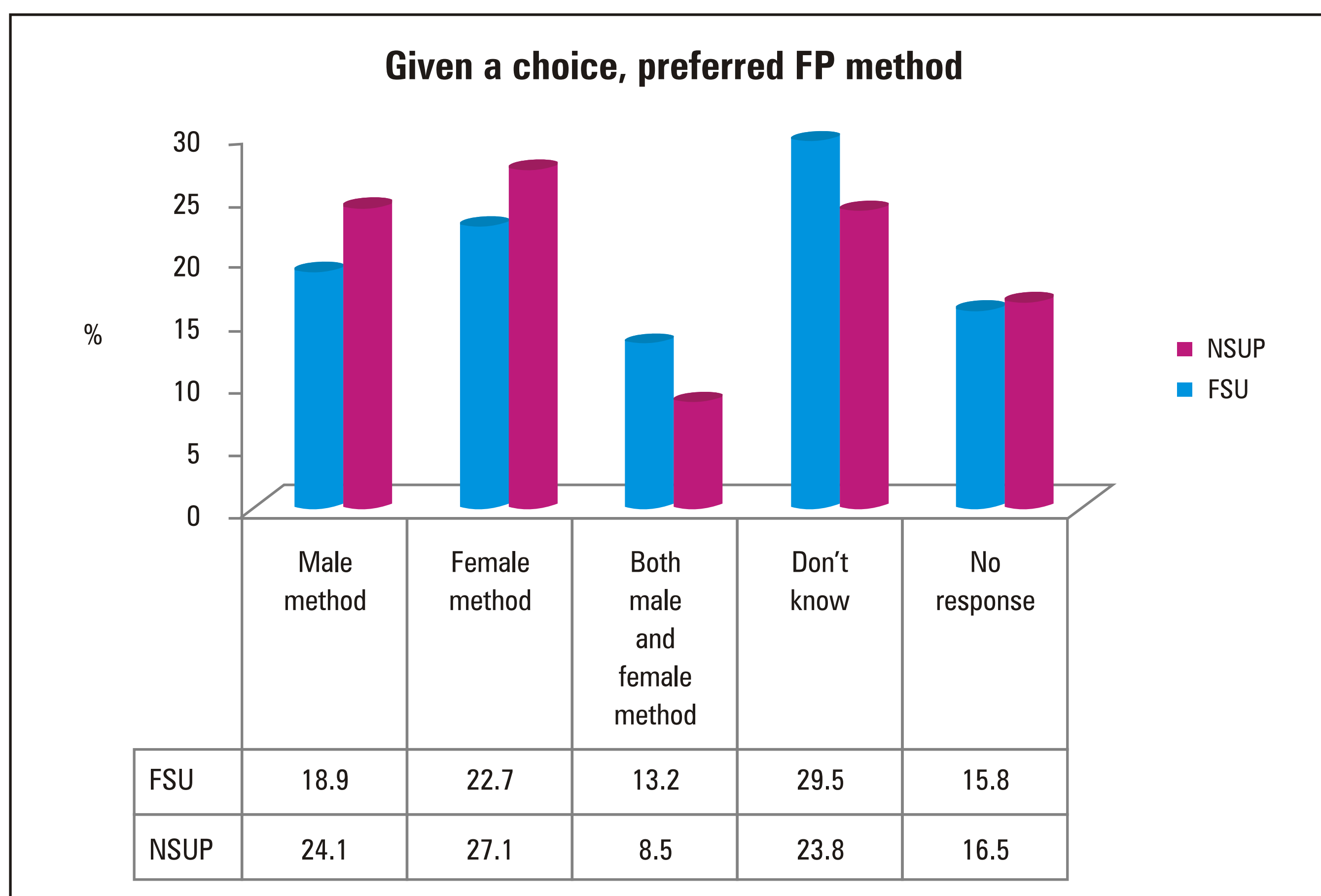


Figure 45: Preferred family planning method

Among NSUPs, nearly 30% report a history of miscarriages.

Most of my friends and partners are drug users. They don't like protective measures like condoms or others and refuse to use anything even after my advice. I conceived twice, again, but aborted medically, because of the poor condition of my family.

- Laxmi, 28-year-old drug user from Varanasi

We did not use condoms at all. My partner does not like them. I have undergone a family planning operation.

- 30-year-old IDU from Patna

Nearly one in five has had an induced abortion. Among FSUs, 24% have had miscarriages and nearly one in four has had induced abortions. Thus, FSUs are significantly, more likely to have ever had an induced abortion [OR 1.5(95% CI 1.3-1.7), $p<0.001$] compared to NSUPs. There is no significant difference with respect to miscarriages ever across the two groups.

One or more induced abortions is reported by

- Nearly one in five NSUPs
- One in four FSUs

	FSU		NSUP			
	N	%	N	%	95% CI	Odds ratio
Boils/warts around vulva	348	19.8	607	14.2	1.2-1.7	1.43***
Low backache	1091	61.6	2628	60.9	0.9-1.1	0.95
Pain during sexual intercourse	505	28.7	990	23.1	1.1-1.5	1.3***
Bleeding after intercourse	109	6.2	199	4.7	1.0-1.7	1.3***
Pain/burning during urination	502	28.5	1288	30.2	0.8-1.0	0.8
Frequent urination	468	26.7	1412	32.9	0.6-0.8	0.71***
Significant weight loss (greater than 15% of usual)	253	14.4	481	11.2	1.1-1.5	1.3***
Continuous diarrhea	138	7.8	347	8.1	0.8-1.1	0.93
Fever/cough > 1 month	239	13.5	583	13.6	0.8-1.1	0.96
Other gynecological problems	175	10.0	375	18.8	0.9-1.3	1.1

Table 23: Genito-urinary problems

Genito-urinary problems

The common problems reported by FSUs and NSUPs are low back pain (61.6% and 60.9% respectively), pain during sexual intercourse (28.7 and 23.1%), pain and burning during urination (28.5% and 30.2 %), and other problems (10.0% and 18.8%), which include a white discharge. A small percentage report fever and cough for more than a month and continuous diarrhea. Both groups do not differ significantly on these complaints. However, FSUs more commonly report boils/warts around the vulva, pain during sexual intercourse, bleeding after sexual intercourse, frequent urination, and significant weight loss. One of the expectancies from substance use (as mentioned in the previous chapter) is relief from pain.

FSUs more commonly report:

- Boils/warts around vulva
- Pain during sexual intercourse
- Bleeding after sexual intercourse
- Frequent urination
- Significant weight loss

Problems of Partners

Nearly one in four FSU's and one in five NSUPs report that their partners are disinterested in sex. Two factors, the disinterest in sex and difficulties in sexual activity (commonly erectile difficulties) are significantly more among FSU partners. Less than 5% of both FSUs and NSUPs report that their partners have wounds/sores/abscesses on their penis or a smelly discharge.

Common genito-urinary problems among substance using male partners include:

- Disinterest in sex
- Difficulties in sex, commonly erectile dysfunction
- Pain during urination

Partners: Genito-urinary problems

	Partner FSU		Partner NSUP			
	N	%	N	%	95% CI	Odds Ratio
Pain during urination	322	20.5	709	16.8	1.1-1.5	1.3**
Disinterest in sex	396	25.0	928	21.9	1.0-1.4	1.2*
Difficulties in sex	358	22.7	672	15.9	1.3-1.8	1.6***
Wounds/sores/abscesses penis	72	4.6	170	4.0	0.9-1.5	1.1
Smelly discharge from penis	49	3.1	124	2.9	0.8-1.5	1.1

Table 24: Genito-urinary problems among partners

Substance use and reproductive health in context

UNIFEM-SARO (2000) undertook community-based research on Gender and HIV/AIDS in four regions of India, representing both high and low prevalence regions. They found that most women respondents lacked elementary

knowledge of reproduction, health issues and safe sex practices. In the CHARCA Study (Singh et al 2004), a substantial number of young women reported at least one symptom of sexually transmitted infection (STI) (23% in Bellary to 85% in Kishanganj). The determinants of RTIs/STIs (reproductive tract/sexually transmitted infections) appeared to be poverty-driven sex, poor economic backgrounds, alcoholic spouses, domestic and sexual violence, pre-marital sex, repeated abortions, low age at first birth, short birth intervals, unhygienic practices during menstruation, poor ability to deny sex and lack of early diagnosis and treatment by trained medical practitioners. Treatment was obtained mainly from private providers (13-37%) and government facilities (7-21%) followed by chemists and medical shops (2-32%), AYUSH (1-4%). In the absence of adequate health services, medical professionals and available treatments, other providers such as quacks, faith healers and medical stores/chemists were the only sources available for advice on reproductive health problems. Similar themes emerge in the present study and are discussed later.

Summary Points

A range of socio-cultural and economic factors influence substance use and sexual and reproductive health

In the present study, nearly one in ten respondents are unable to provide information on whether or not they use family planning methods

A significant number of respondents are unable to indicate the family planning practice they use or their preferred choice of family planning

Overall, less than 50%of all respondents have used any form of family planning

FSUs are less likely than NSUPs to have used any family planning methods

Among those expressing a preferred choice of family planning, more than a third prefer either a female form of contraception or a combination of female and male methods

Qualitative interviews suggest that many male partners do not like using condoms because of their perception that sexual pleasure diminishes with condom use

FSUs report significantly more genito-urinary problems

9.1 Substances For Sex

Nazreen, 40-year-old from Kanpur

I was born in Kanpur. Since my grandmother died just before my birth, I was considered to be very lucky. I am the youngest of three siblings and even today, my family helps me emotionally and economically. I had a great time during my childhood and my parents loved me a lot. Father's economic condition was satisfactory so I did not have to work. My marriage was arranged at an early age and father gave a lot of dowry in the wedding. My spouse has a business so we are in a strong financial position. I have healthy relations with my in-laws. Though I am in the habit of taking drugs, I still manage to maintain a good relationship with them. I had my first child when I was 18 and then had three abortions which was my husband's decision. Now, I have three children, one daughter and two sons. My spouse is a responsible father and a sincere spouse. Sometimes he gets annoyed and abuses me.

My first sexual experience was with my spouse after marriage, when I was 17 years old. I am satisfied with him both physically and emotionally. Earlier my spouse used condoms but since he refuses now, I have started taking pills.

My drug habit started recently and my spouse was the culprit. I had a stomach pain one day, but he wanted to have sex with me. I refused, but he forced me and urged me to smoke a special cigarette. That gave me relief from the pain, so when we had sex it was full of pleasure. This is how my spouse and I got trapped into drugs. Once, when he was under great tension (after a loss in business), his servant introduced him to it. Though we tried to get treated, we failed. Sexual habits are also responsible for these relapses, because, without using drugs, we do not get so much pleasure. I admit that I am also fully involved because under the influence of drugs, we become quite experimental and use new ways and techniques.

10 Substance and HIV vulnerability

We are now witnessing the feminization of the HIV/AIDS epidemic

Introduction

Overall, HIV infection is increasing in the developing world (Ramasundaram 2002). The first case of AIDS, in India, was detected in 1986.

The Behavioural Surveillance Survey (BSS) conducted among general populations, bridge populations and risk populations showed that India presents a contrasting picture of sexual notions, attitudes and sexual behavior.

The 2006 NACO estimates suggest that HIV prevalence among adults, in India, was approximately 0.36%, between 2 and 3.1 million people. If an average is calculated, it means that 2.5 million people lived with HIV and AIDS (NACO 2006). HIV prevalence is high in the 15-49 age group (88.7% of all infections), indicating that AIDS still threatens those in the prime of their life. High-risk groups inevitably show higher numbers. It is as high as 8.71 % among Injecting Drug Users (IDUs), 5.69 % among Men who have Sex with Men (MSM) and 5.38 % among Female Sex Workers (FSWs).

Nearly 59% of the HIV infected population lives in rural areas. Despite being a low prevalence country, India accounts for nearly 69% of the HIV infections in the South and South-East Asian region (NACO 2006). HIV/AIDS has far-reaching consequences for the individual and family, and wide health, social and economic impacts for the community and country. In India, the impact is not very visible due to low prevalence and large population size (Olson 2006). The major transmission route is through unprotected heterosexual intercourse, which accounts for 86% of cases (NACO 2005).

A majority of both NSUPs (76%) and FSUs (83%) have heard of HIV/AIDS They obtain the information mostly from the media or from others

In India, there is a marked gender imbalance in literacy rates, access and availability of health related services for adolescent girls and women. This situation is aggravated by early marriage, low rates of employment and a general lack of awareness of risks and vulnerabilities.

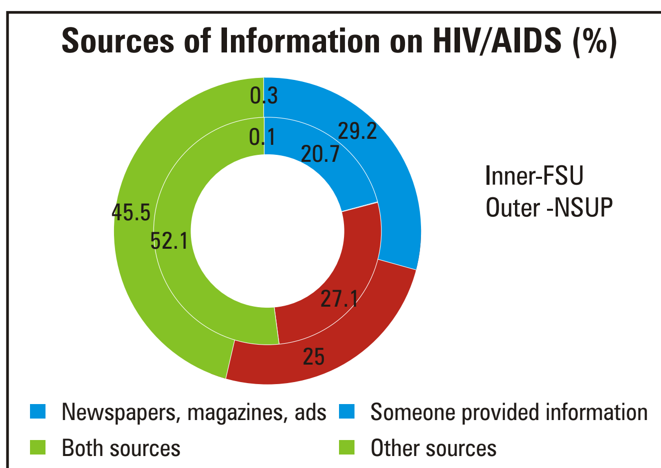


Figure 46: Sources of information on HIV/AIDS

The Substance, Women and High Risk Assessment Study

Knowledge of HIV/AIDS

More than three-fourths (3337, 76%) NSUPs have heard about HIV AIDS. This seems reassuring. Among FSUs, the knowledge of HIV/AIDS is even higher (1536, 83.3% - significantly more than among NSUPs (= 41.6, $p<0.001$).

Sources of knowledge of HIV

Both NSUPs and FSUs in the study, obtained information primarily from the media or heard it from someone.

Knowledge of the ways HIV spreads

While a majority of respondents have heard about HIV/AIDS, their knowledge of the routes of transmission and risky behaviours is far from satisfactory. NSUPs have significantly less knowledge than FSUs. Approximately 40% of NSUPs either do not know or have misconceptions about whether HIV transmission can occur from an infected mother to child, whether it can be transmited by sharing food and utensils, or the use of public toilets. Nearly a third are unsure of the risk involved in having sex with an infected partner. However, they are relatively better informed of the risks of transmission from contaminated blood and injection sharing.

Both groups are poorly informed about the risks/benefits of breast feeding.

Among women substance users, as with FSUPs, knowledge of risks related to contaminated blood, infected needles and syringes and the sexual route is relatively higher than the knowledge of other modes of transmission. About one-third of FSUs are unsure of the vertical transmission risk.

- NSUPs have significantly poorer knowledge about the modes of HIV transmission
- Knowledge is especially poor regarding vertical transmission of HIV
- Common misconceptions exist regard spread of HIV by sharing food and utensils and use of public toilets
- FSUs are relatively better informed about sexual modes of transmission and risk of IDU
- Among both NSUPs and FSUs, there is a poor knowledge of benefits/risks of breast feeding

HIV spreads through:	**FSU %**			**NSUP %**			**X^2**	**P**
	Yes	No	Don't know	Yes	No	Don't know		
Contaminated blood	79.3	1.5	19.2	72.7	1.4	25.9	30.9	<0.001
Contaminated needles and syringes	76.5	2.8	20.7	70.3	1.5	28.2	45.6	<0.001
An infected mother to her unborn child	65.2	4.8	30.0	60.9	3.3	35.8	23.4	<0.001
Breast feeding by an infected mother	53.1	14.5	32.4	51.3	8.8	39.9	57.2	<0.001
Mosquito bites	5.8	64.1	30.1	6.8	59.5	33.7	11.3	<0.01
Sharing food and utensils with an infected person	10.6	61.1	28.4	9.9	57.4	32.7	10.7	<0.01

Multiple sexual relationships	73.5	3.6	22.9	67.1	2.3	30.6	41.3	<0.001
Sex with an infected partner	78.3	2.2	9.5	69.7	2.8	27.5	46.3	<0.001
Having sex when intoxicated	34.1	24.7	41.3	35	15.8	49.2	68.9	<0.001
The use of public toilets	4.6	64.7	30.7	3.8	60.1	36.1	16.1	<0.001

Table 25: Knowledge of modes of HIV transmission

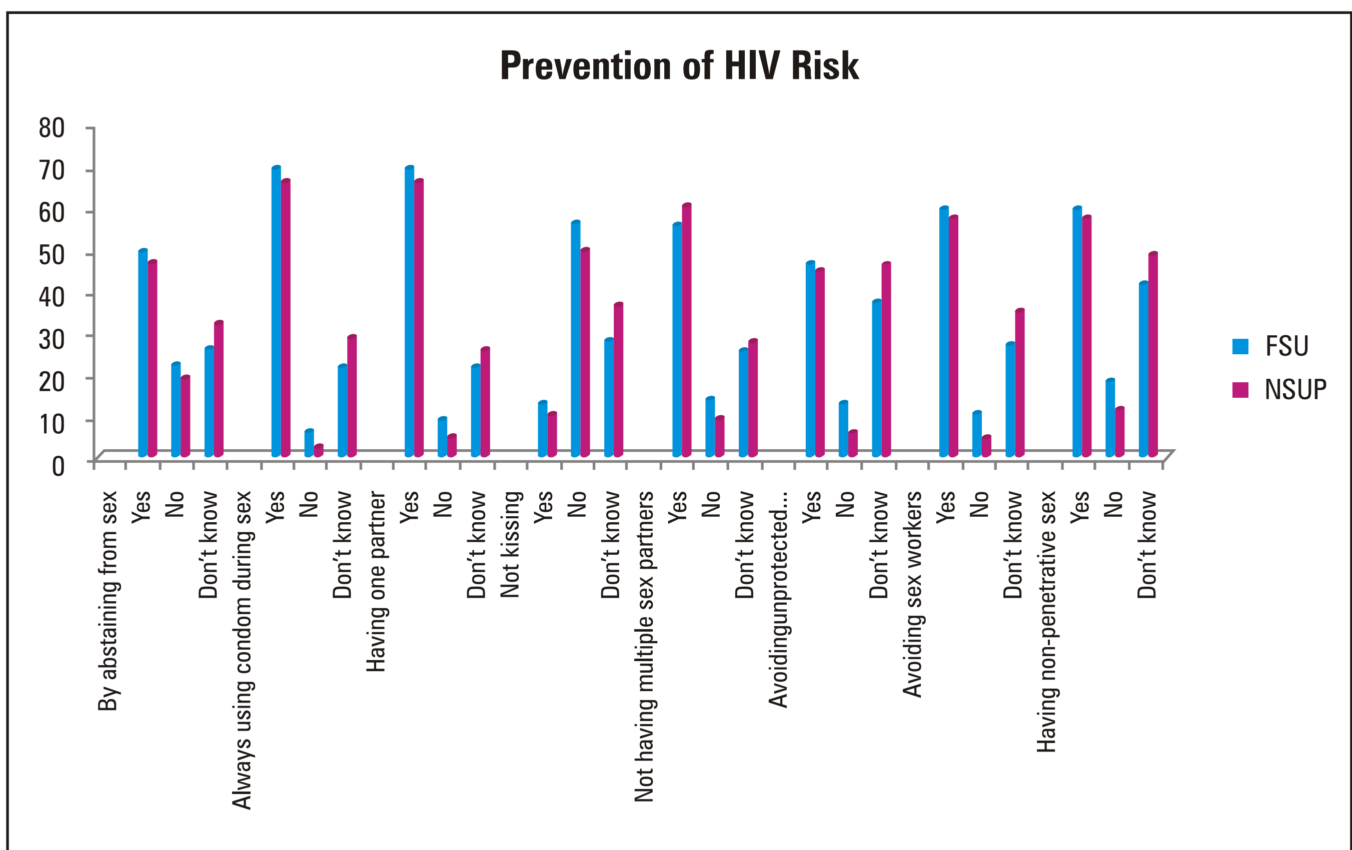


Figure 47: Knowledge of methods of preventing HIV

Similarly, the response, "don't know" for knowledge of methods of prevention, is particularly high. More than a third of NSUPs do not know whether sexual abstinence, not kissing, avoiding sex with sex workers reduce HIV risks. Nearly 50% NSUPs, and nearly one-third of FSUs are unaware whether non-penetrative sex and avoiding unprotected sex in homosexual relationships reduce risk of HIV infection. FSUs are significantly more likely than non-users to be aware of the methods of preventing HIV transmission. But even among them, one in five is unaware of how to reduce risks or prevent the infection.

Nearly one in five respondents in both groups, does not know whether it is possible to recognise someone who is HIV positive just by looking at him/her. Among those who know, nearly 95% of both groups opine that it is not possible.

Perception of HIV risk

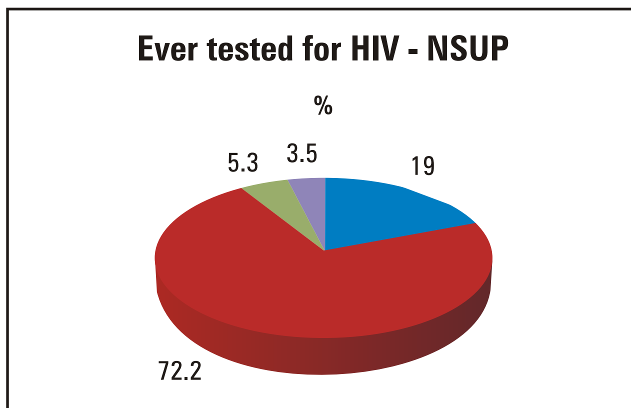
The risk perception to HIV/AIDS is the same for both groups, either with response to self or risk to partner. Despite a greater behavioral risk (multiple partners, unprotected sex for money, greater sexual violence) combined with better knowledge of transmission routes and ways of prevention, the fact that FSUs do not have a heightened perception of risk raises the important issue of the gap between knowledge and subjective risk perception.

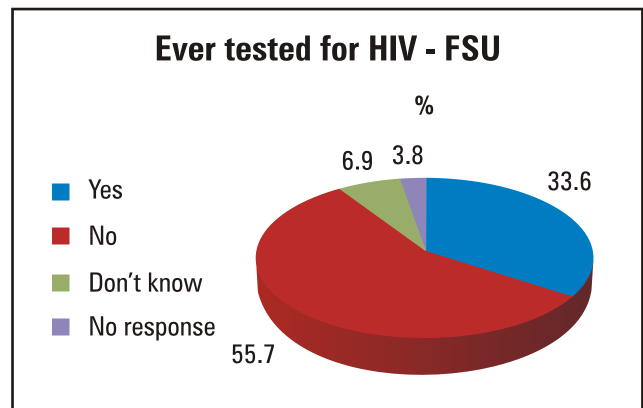
- More than one in two NSUPs and FSUs do not feel they are at risk for HIV
- Nearly 50% of respondents in both groups, do not perceive that their partners are at risk for HIV

	FSU		NSUP		OR
	N	%	N	%	
Respondent feels at risk for HIV/AIDS	572	46.5	1293	45.3	1.1
Feels partner is at risk for HIV/AIDS	541	53.0	1346	52.4	1.0

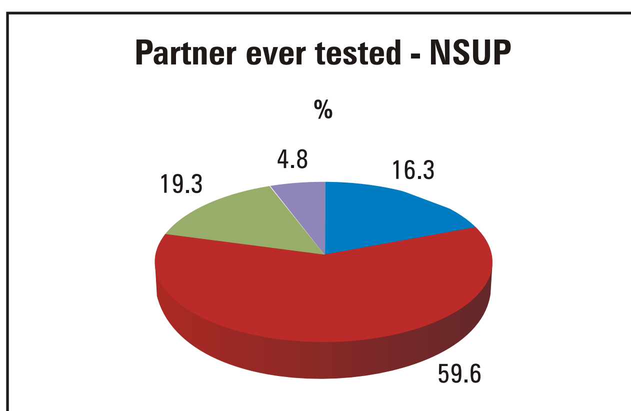
Table 26: Perception of HIV risk

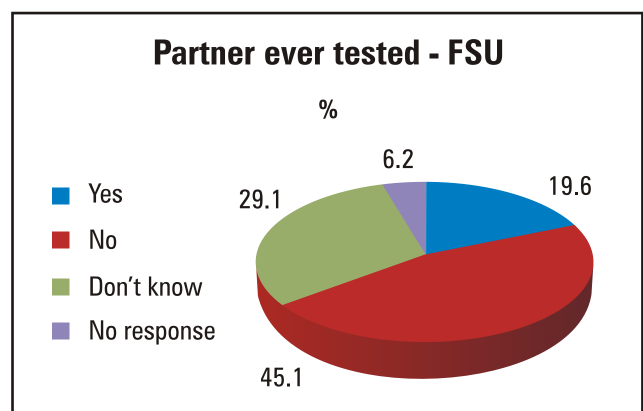
Testing for HIV





Figures 48 & 49: Tested for HIV- Respondents





Figures 50 & 51: Tested for HIV-partners

Less than one in five (19%) women partners report ever having been tested for HIV and only 16% of their substance using partners have ever been tested. Nearly one in five partners (19.3%) is unaware whether her partner has been tested.

Only one-third of FSUs report ever having been tested. Testing among their partners is significantly lower, with less than one in five never having been tested. Among FSU's, a larger number (29.1%) are not aware whether their partners have been tested.

Overall, FSUs are significantly more likely to have been tested for HIV compared to NSUPs (OR 2.29, $p<0.001$). Among partners, the numbers tested are small, and relatively more FSU partners are likely to have ever been tested (OR 1.59, $p<0.001$). Within FSUs, significantly more FSUs have been tested compared to their partners ($=78.1$, $p<0.001$). While the testing rates among both NSUPs and their partners is very low, more NSUPs report being tested compared to their partners ($=19.0$, $p<0.001$).

- Less than one in five NSUPs has ever been tested for HIV
- Nearly one in five NSUPs is unaware whether her partner has been tested
- Only 16% of NSUP partners have ever been tested
- Only one in three FSUs has ever been tested
- Nearly 30% of FSUs are unaware if their partner has been tested
- Less than one in five FSU partners has ever been tested

Willingness to share information on HIV status

FSU's are significantly more willing to share the results of their HIV testing ($=89.9$, $p<0.001$) compared to NSUPs.

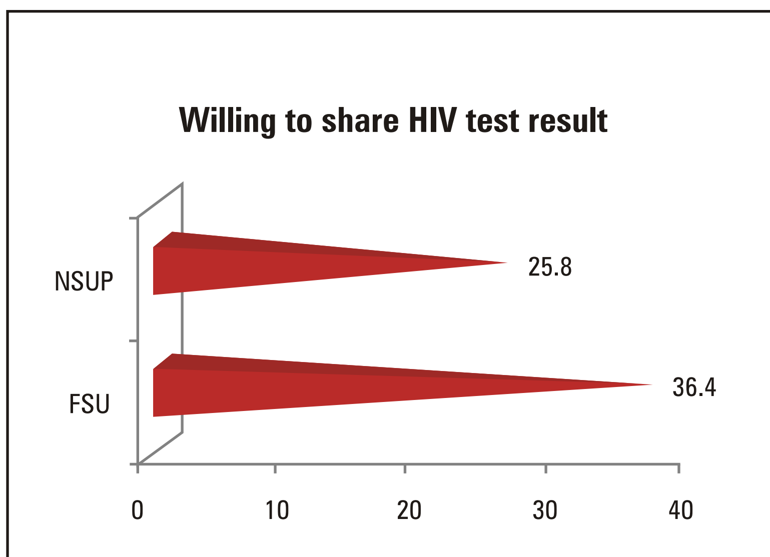


Figure 52: Willingness to share HIV test results

- FSUs are more willing to share their HIV status, than NSUPs
- Among those willing to share status, more NSUPs report being HIV positive
- Among those willing to share partner status, more NSUP partners are HIV positive

Among respondents who shared their own HIV status, more NSUPs report being HIV positive compared to FSUs. Similarly, among NSUPs willing to reveal partner status, nearly 50% of the partners are HIV positive, significantly higher than FSU partners.

	FSU		NSUP		OR
	N	%	N	%	
HIV + status among Respondents who shared status (FSU =200, NSUP = 223)	25	12.5	66	29.6	0.34***
HIV+ status among partners of respondents who shared status (FSU=562, NSUP=1855)	24	20.9	114	46.9	0.30***

Table 27: HIV sero positivity results

Stigma and discrimination

- One fourth had not disclosed HIV positive status in the community
- Higher percentage of women inform husbands immediately of HIV status than vice versa
- A higher percentage of women had gone for voluntary testing
- Majority do not disclose HIV status at workplace
- Reported discrimination of families after a member dies of AIDS; discrimination at hospital
- Discrimination during last rites and social boycott
- More women with PLWHA(5.5%) had been asked to leave home compared to men(1.9%)
- Supportive family for 42% of male PLWHA, 45% female PLWH
- High perception of good family support (74% males, 70% females)
- More women supportive of HIV positive husbands than men of their HIV positive wives (12.4% vs 8.5%)

Source: Pradhan and Sundar 2006

Married at the age of 23, I dreamt that life ahead would be pleasant with a peaceful and happy family. My son's birth was a turning point in my life, as I came to know that my spouse was a No IV (heroin) addict. I was subject to his torture just because I could not meet all his demands. When there was no money, household objects started to disappear. I just did not know what to do except blame my fate. When my spouse's health began to deteriorate, he remained bed-ridden, while I nursed him futilely.

The most dreadful disease, HIV/AIDS, had caught up with him as a result of his misdeeds. He died after two years. There was no one to grieve except my son and me. Then an unknown fear started troubling me, had I also been affected by this disease. What about our innocent son? These were big questions in my mind. Very soon, I went to the HIV center with my son, to get our blood tests. Just as I feared both were HIV positive. This was the day everything around me i.e., the moon, the sun and the earth seemed to stop functioning. I asked myself 'Are there any reasons to live now?' I was on the verge of committing suicide many times, with my own child. Just then a miracle happened. An organization dealing with counseling and rehabilitation of drug addicts came to my rescue. They gave me good counseling which motivated me to continue living. Now, I am living with my son as happily as ever, even though memories of my spouse have not totally faded from my mind.

- Papki, 34-year-old from Ukhrul, Manipur

Her first spouse, addicted to heroin, died of HIV/AIDS. She ran away with another man who befriended her, leaving two young children with her demanding in-laws. Then, she had another child. Her second spouse was also a heavy drug user. 'It was at this time I got into action, all three of us got our blood tested and unfortunately I was also HIV positive. I was in a dilemma what to do. Should I commit suicide or wait for the disease to slowly eat me away'.

- Jameela, partner of an IDU

I have tested positive after the birth of my second child. I can live with AIDS, but the social pressure of being the wife of a user and having no close person to support me and my two little daughters is more unbearable.

- Monica, 32-year-old partner of an IDU

Condom use- the KAP (Knowledge, Attitude and Practice) divide

From the qualitative interviews it is evident that condoms are used in a marriage primarily for family planning, and, as mentioned earlier, many partners are averse to using them. Despite their better knowledge of HIV and other STI risks, even substance users engaging in high-risk practices, are not adequately protected by consistent condom use as illustrated in this example.

I think I am at risk for these infections (STIs and HIV). I am taking some precautions, like using condoms. Though I generally accept only those clients who are hygienic, in unavoidable circumstances I sometimes have to entertain others. For sex with people I like, I don't insist on condoms. But, I always insist with people from outside. Some men are reluctant to use condoms so I oblige them.

Despite the precautions, I became pregnant twice and got aborted with a doctor's help. Since the last two years, I have regularly used pills to avoid pregnancy again. I always try to avoid anyone ejaculating into my vagina even with a condom.

I always have drugs before sex because without them I am unable to perform. Drugs help me to satisfy my visitor even in unnatural ways. They drive away my aversion towards some people. Most of the visitors want oral or anal sex and some never want vaginal sex. For that I always insist on a condom.

- Mercy, 24-year-old drug user from Kerala

On a positive note

Despite an overwhelming lack of a proper understanding of the routes of HIV spread and prevention, and the major gaps between knowledge, attitude and practice, it is evident that the publicity campaigns during the last decade have benefited some sections of the population. There can be no greater testimony than this respondent's account:

We had heard about HIV/AIDS when I was first admitted to a drug de-addiction centre. A lady told me about this sickness. I was so scared inside and wanted to get tested for HIV/AIDS, but I was afraid that if I tested positive who would take care of my children? After knowing all the facts, I realized how wrong I was, but one positive thing has happened after learning about HIV/AIDS. Now I use precautions and have also been able to get treated for my vaginal infection

- Salma Banu, injecting opiate user from Kanpur. Both she and her partner inject opiates

Substance use and HIV risk

'Revisiting "The Hidden Epidemic": a Situation Assessment of Drug Use in Asia in the Context of HIV/AIDS' (Reid and Costigan 2002) reports an increase in substance use among Asian women and an increased involvement in sex, of women injecting users in many Asian countries. The intersection of injecting drugs, sex work and unsafe sexual practices has become a significant factor in the increased risk of HIV among women, particularly in Asia, Eastern Europe and North America. Studies indicate that women who inject drugs may engage in more HIV risk behaviors and also have a higher mortality than men. Women more often than men have a sexual partner who injects drugs and is likely to be HIV positive (UNODC 2004).

The HIV/AIDS epidemic in India is categorized by its heterogeneity. It seems to be following the Type 4 pattern, where the epidemic shifts from the most vulnerable populations (such as commercial sex workers, intravenous drug users, and males having sex with males) to bridge populations (clients of sex workers, patients with sexually transmitted illnesses, partners of drug users) and then to the general population. This shift usually occurs when the prevalence in the first group exceeds 5%, with a two-three year time lag between shifts from one group to another (NACO 2005). The Sexual Behavior Surveillance (NACP II 2002) suggests that despite largely monogamous relationships reported by women, they remain vulnerable to HIV, mostly from infected spouses.

Women more susceptible to HIV infection

Aarti Dhar

NEW DELHI: Women account for 40 % of all HIV/AIDS infections in the country.

According to National AIDS Control Organization (NACO) figures, 40 % of the people living with the disease in India are women. Studies have shown that HIV is transmitted mainly through unprotected heterosexual sex. A significant proportion of new infections occurred in married women, mostly transmitted by their spouses who frequented sex workers. There has been an alarming rise in infection among young women and girls in the age group 15-24 (as high as 75 %).

Women are biologically more susceptible to HIV infection than men, from any single act of unprotected sex with an infected partner. In fact, male-to-female transmission of the virus is 2 to 4 times higher than female-to-male transmission among couples engaging in unprotected sex.

http://www.hinduonnet.com/thehindu/thscrip/

The patterns of HIV transmission make NSUPs, who are largely in monogamous relationships and FSUs - who have high

rates of alcohol use, high risk sexual behaviour, a greater likelihood of involvement in selling sex and risky injecting patterns - vulnerable to HIV/AIDS and other sexually transmitted diseases (STIs). This important dimension was addressed in the study.

Awareness of HIV/AIDS

The three important sources of information mentioned by female respondents in the CHARCA Study (Singh et al 2004) were other women (91%), peers/friends (80%) and media (60%). Information on sex and sexuality was obtained mainly from school/teachers and health service providers (doctors and paramedics). NGOs and CBOs were not cited as important sources of information. In the study, the media and hearing about it from someone around them are the commonest sources of information for respondents about HIV/AIDS.

A study by UNIFEM (2003) in partnership with the Ministry of Railways of Railway employees and their families found that boys are better informed about HIV/AIDS than girls. Almost a third of students have misconceptions about it. According to CHARCA (IIPS 2004), the most common misconceptions across five districts, were, that HIV could be transmitted by mosquito, flea or bedbug bites (22-48%), kissing (13-48%), stepping on urine or stool (11-30%) sharing clothes (7-29%) and sharing eating utensils (7-39%). Similar misconceptions were found in both HIV and non-HIV households (Pradhan and Sundar 2006). An attempt was made to gauge the knowledge and awareness of HIV and AIDS among a sample of 3299 men and 2925 women from non-HIV households. Although everyone had heard about it, only a little more than 50% could mention all the modes of HIV transmission. Beliefs that HIV could be spread by sharing razors or through mosquito bites were common and only about 25% of respondents were aware that the use of condoms could prevent HIV transmission. Women's knowledge of HIV transmission modes, prevention and facilities for testing was poorer than the men. They were more likely to have a negative attitude towards people living with HIV and AIDS.

While the respondents in the study appeared to be better informed than the population surveyed in the CHARCA study, specific awareness of risky modes of transmission and behaviours to prevent such risk was inadequate, particularly in NSUPs who are at high risk since their spouses use substances.

Even among those with a relatively higher knowledge of HIV transmission, the practices reported are a source of concern. In a study of 453 migrants from Rajasthan under the Hamara Project (Singh et al 2004), nearly 25% of the unmarried migrants had a sexual encounter in the last six months and 5% reported using a condom in the last sexual encounter. STIs were reported by 12% and 29% used local remedies as treatment.

Condom use

According to the Charca Study (Singh et al 2004), only two fifths of women across the five districts knew where male condoms were available. This knowledge varied from 11% women in Bellary to 81 % in Kanpur. A married, literate, urban dwelling woman who is a member of a CBO/NGO and has been exposed to mass media is more likely to be aware of the source for a male condom. Perception of condoms as protection from HIV/AIDS varied from 24% in Bellary and Guntur to 83% in Aizawl and 84% in Kanpur.

A study in Pune, which randomly sampled 707 women attending antenatal clinics, found that over 75% of women displayed knowledge of primary transmission routes of HIV, and over 70% had knowledge of maternal to child transmission. However, only 8% were aware of prevention methods. TV and written material were stronger sources of knowledge than access to radio messages or conversations with individuals. Women reporting alcohol or drug use in their partners were twice as likely to have adequate HIV/AIDS knowledge compared with those who did not report such abuse (Shrotri et al 2003).

The CHARCA Study (Singh et al 2004) revealed some startling facts about the use of condoms. Use for family planning, was less than 1% in Bellary, 7% in Guntur, 19% in Aizawl, 26% in Kishanganj, and 41% in Kanpur. For dual protection (family planning and protection against HIV/AIDS) the figures were even lower. Similar findings were even noticed among sex workers, where the awareness of HIV/AIDS is likely to be higher. Reza-Paul (2005) found that 26% of sex workers in Mysore were HIV-positive. While 14% used condoms consistently with clients, 91 % of them never used them with their regular partners. In the study, which predominantly addresses the urban young woman, the patterns of condom use are closer to those in Kishanganj and Kanpur. Low rate of condom use in HIV vulnerability reduction initiatives has been attributed to the initial association of nirodh (male condom) with the failed family planning program and the gradual shift in the onus of family planning from men to women, entirely negating any previous progress in habituating men to regular condom use (Sivaraman et al 2006).

There is evidence to suggest an association between alcohol use among men and high-risk behaviors in India with low condom usage (Rao et al 1994, Sharma and Chaubey 1996, Tripathi et al 2004).

In the present study, more than three-fourths of respondents in both groups [4873 (77.8%)] had heard of HIV/AIDS. However, 30.5% of FSUs and 32.2% of NSUPs were not able to assess their own perception of risk to HIV/AIDS. When it came to assessing their partner's risk for HIV/AIDS, 40.2% of FSUs and 38.7% of NSUPs were unable to comment on their perception of it. But, since the women in this study, by virtue of their partners, and their own substance use constitute a very high-risk category, the lack of knowledge, attitudes and behaviors of these women and their partners, need to be addressed. Similar themes emerge from the RSRA, where 25% of regular female sex partners of male substance users, in many South Asian countries, have not heard of HIV/AIDS, the likelihood of HIV testing is low and condom use with regular sex partners is also very low (Kumar et al 2008).

Injecting drug use and HIV risk

In a Chennai study of IDUs and their regular sexual partners, Panda et al (2007) found that women having their first sexual experience at age < or = 17 and those who had HIV-positive IDUs as their male sexual partner, had two times the odds of having any non-HIV STI. Women who were 38 years or older had seven times the odds of having any non-HIV STI.

Miller et al (2002), in a comparison of socio-demographic, drug related and sexual risk variables between young (13-25 years) and older (25 years or more) IDUs in Canada, found that younger injectors were more likely to be female, work in the sex trade, report condom use, inject heroin daily, smoke crack cocaine daily and need help in injecting. HIV prevalence in their sample was associated with female gender, history of sexual abuse, engaging in survival sex and having multiple sexual partners.

In a study of five cities in the European Union it was found that, in addition to injecting behavior, sexual behavior was the strongest determinant of HIV. This included having a partner who was HIV positive, commercial sex work and being co-infected with a sexually transmitted disease. Other determinants were related to age, educational levels, homelessness and previous imprisonment. In addition to the risk of HIV, once infected with HIV, women appear to progress to AIDS more quickly than men (NIDA 2000).

A study of female IDUs from Bangladesh is quite informative. Of the 130 female IDUs enrolled, 82 were sex workers and 48 non-sex workers. None had HIV, but more sex workers (60%) had lifetime syphilis than non-sex workers (37%). Fewer sex worker than non-sex worker IDUs lived with families (54.9% and 81.3% respectively), but more reported lending needles/syringes (29.3% and 14.6% respectively) and sharing other injection paraphernalia (74.4% and 56.3% respectively) in the past six months. Although more sex workers than non-sex workers used condoms during their last sex encounter (74.4% and 43.3% respectively), more reported anal sex (15.9% and 2.1% respectively) and serial sex with multiple partners (70.7% and 0% respectively). Lifetime sexual violence and being jailed in the last year, was more common in sex workers (Azim et al 2006).

Year	Nagaland	Mizoram	Karnataka	Delhi	Tamil Nadu	Mumbai	Megalaya	West Bengal
1998	13.2	1	-	-	-	-	-	-
1999	7.6	1.5	1.3	-	-	-	-	-
2000	7.03	9.61	4.23	5	26.7	23.68	1.41	-
2001	5.5	2	2	2.4	24.56	41.37	1.39	-
2002	10.28	1.6	2.26	7.4	33.8	39.42	0	1.5
2003	13.86	4	2.8	7.2	63.8	24.8	0.4	2.7
2004	4.49	-	0	17.6	39.9	28	0	5.5

Table 28: HIV Prevalence Among Injecting Drug Users, HSS 1998-2004

Source: NACO

One of the challenges the surveillance system in India is facing is the representativeness of the sites between most-at-risk population (FSW, MSM and IDU) and the other populations. The expert committee on estimation has identified this and action has been initiated to start more number of sites for most-at-risk population groups across the country.

Drug injectors report higher levels of regular and casual partnerships and as a rule, their use of condoms is even lower than commercial sex workers (MAP 2005, Kumar 2002). In Chennai, as many as 46% injectors are married/ or have live-in partners.

Harm reduction efforts (including needle and syringe exchange), as well as limited substitution programmes were introduced in some states. In such states the sero-prevalence is about 24%.

Throughout Asia drug injectors buy sex. Except for Thailand, most of it is unprotected.

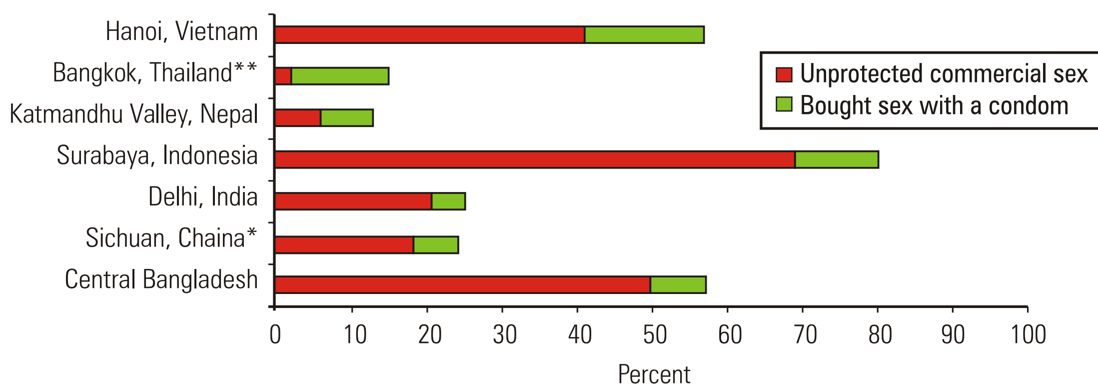


Figure 4 Percentage of male IDU buying sex in various cities, by consistent condom use in commercial sex

*Sichuan: condom use at last commercial sex **Bangkok: includes non-injecting drug users

Fig 53: Commercial sex in Asia Source: MAP 2005

HIV is just one of the problems faced by IDUs. Other serious and often more urgent problems include accidental overdose, abscesses, hepatitis and suicidal attempts (MAP 2005).

Since the major mode of HIV transmission is unprotected heterosexual intercourse (responsible for 80% of the total cases) with an infected partner, the focus must be on the prevention of sexual risk behaviors (Jha et al 2001, Lamptey 2002). Due to the large population size, high levels of illiteracy and unawareness, poverty, caste and gender based social inequalities, the problem gets further complicated.

Women engaging in sex work have a close association with compulsive and addictive behaviour involving drugs, alcohol and gambling (Harcourt and Donovan 2005)

Substances and sex: chicken or egg?

Some studies propose that the use of alcohol and illicit drugs is a contributing factor to sexual risk-taking, whereby substance use impairs individual judgment and decision-making and increases an adolescent's risk to unintended pregnancy or a sexually transmitted infection (Ozer 1997). Others caution that both behaviors could be caused by a possible third behavior, including an acceptance of deviant behaviors, a predisposition to risk-taking, sensation seeking, mental health problems and developmental factors (Halpern-Felsher 1996).

Substance use and HIV: Stigma compounded

The few studies that document the social reaction to AIDS highlight an overwhelmingly negative response to PLWHA in India (Bharat et al 2001). Of those who do disclose their status, a majority does so only to their immediate and - to a lesser extent - extended family (Chandra et al 2003).

There are continuing anecdotal examples of initial discrimination against young women accusing them of infecting their

spouse, expulsion from the family home after the spouse dies, compulsion to continue sexual relationships with the infected spouse, and forced separation from children. Community reactions range from ostracism, discrimination at school, denial of basic amenities in the community to discrimination at the time of death (Bharat et al 2001). Research consistently suggests that most individuals will eventually receive support.

UNIFEM-SARO (2000) undertook community based research on Gender and HIV/AIDS in four regions of India, representing both high and low prevalence regions. They found that most women respondents lacked elementary knowledge of reproduction, health issues and safe sex practices. Partners of infected men and women who were infected themselves, did not get the same kind of support/ care that positive men got. Most positive women were dependent on their spouses due to lack of education and insufficient skills. Their in-laws denied them a right to property. The pressures on the women were enormous, as they had to support the family while repaying debts resulting from high medical costs. Women were often blamed for the infection; lack of basic amenities like water was a problem as was the loss of job when the employer was informed of their sero-positive status. Other findings include refusal of treatment, medical care and counseling services, poor functioning of hospitals and absence of hospital staff.

In an attempt to understand hospital-based stigma and discrimination against PLWHAs, Population Council Horizons (2000) and Sharan studied three hospitals in Delhi. A random sample of 884 health sector representatives including doctors, nurses and ward staff, showed that discrimination ranged from a condescending attitude to delay and denial of treatment. Both individual and institutional factors contributed to HIV and AIDS related stigma and discrimination. Training and post-evaluation in this group resulted in a better understanding of HIV transmission though some misconceptions still persisted. Following intervention, health workers also showed a significant improvement in their attitudes and reported improved practices in caring for the PLWHA group.

A study from the Tata Institute of Social Sciences showed that testing for HIV/AIDS was almost routinely conducted without the informed consent of the person seeking medical care. This was particularly true of women whose spouses had tested HIV+. They were often forced to undergo the tests, regardless of their asymptomatic status and without any immediate benefits accruing to them. Informed consent for HIV testing is rarely considered important for members of vulnerable groups such as sex workers and eunuchs. Pregnant women face double discrimination when they are forced to undergo mandatory testing for HIV and, in the event of testing positive, are denied child delivery services or advised abortion without counseling for other options. The study also revealed that women and members of marginalized groups are more severely discriminated against than other groups. For women, the discrimination starts at home, within intimate relationships, and extends to several other spheres, including healthcare or the right to a share in property. For members of marginalized groups, such as sex workers, homosexuals or eunuchs, HIV/AIDS implies two stigmatized identities compounding the existing forms of discrimination already levelled against them. HIV+ sex workers lose their business and face complete destitution and death on the streets.

What is urgently needed is a government anti-discrimination policy on AIDS, supported by a law that will ensure protection of HIV+ people's rights. Women with substance use and HIV are likely to be stigmatized even more. Social stigma can be a very important barrier to seeking timely and effective care.

Summary Points

India presents a contrasting picture of sexual notions, attitudes and behaviors

The major transmission route for HIV in India is through unprotected sexual intercourse

Injecting drug users, women engaged in commercial sex, and men having sex with men have been recognized as being exposed to higher risk

Injecting drug using males and their partners have been shown to have high rates of HIV sero-positivity, particularly in the Northeastern regions

Studies in India have shown a close association between alcohol use in men and high-risk sexual behavior

Women, who do not have high-risk behaviours, by extension of being partners of men having such behaviors, are also at high-risk to HIV and other STIs

In the present study, while a majority of respondents knew/have heard about HIV/AIDS, many are not aware of specific modes of transmission, which have an association with high-risk

FSUs are generally better informed than NSUPs on modes of transmission and methods of reducing risk to HIV

Most of the respondents' information on HIV/AIDs has been obtained from the media or through others in the community

Despite engaging in high-risk activities (substance use, unsafe injecting, multiple sexual partners, sex for money and sex under intoxication), FSUs perception of own risk does not differ significantly from NSUPs perception

Only one third of FSUs and one-fifth of NSUPs have been tested for HIV

There is a greater reluctance among NSUPs to share their HIV status, perhaps on account of perceived stigma

Among respondents willing to share their status, more NSUPs have a HIV sero-positive status, and more of their partners are sero-positive compared to FSUs and their partners

Substance use and HIV dually impact the mental health of families

10.1 Double Trouble - Drugs & Sexually Transmitted Illnesses

Mareena, 26-year-old from Imphal

I was born in Laipham Khunou, Imphal district and brought up with a lot of do's and don'ts, as my mother was quite religious. My father was a contract worker so most of the time he was away from home, and I did not get the attention and affection I needed. My parents always quarrelled over petty matters since my father's income was very unstable. He would bring his friends over and have parties with alcohol and order my mother to prepare all kinds of dishes. Whenever he drank, he always beat up my mother and this really affected my siblings and me. I ran away from home and have been staying with friends for the last four years. I studied in a convent school where I was very naughty and always got punished. I was always rebellious in my childhood.

I started drinking alcohol and smoking when I was 14, and lost my virginity at the same age. That day I went for a picnic and drank alcohol for the first time. One guy who was attracted to me was heavily drunk. He took me to the bushes and since I was also drunk I was not aware of what was happening. I enjoyed it when he started fondling me and then we had sex. After this, sex became my defense tool to please the boys. I got married when I was 20 and for a month it was fine. But very soon the truth showed up. My spouse was a most abusive person and abused me sexually, physically and verbally. Since he never took care of my daily maintenance, I had to borrow from the neighbors. One particular male neighbor helped me a lot so I automatically became close to him. We would sometimes laugh and chat. One day my spouse returned when I was chatting with him and became aggressive and very angry. He screamed at me and accused me of being immoral. When the neighbor left my house he tore my clothes and brutally beat me up. One day, he brought a local girl home and started getting physical with her in front of my eyes. That was when I said 'enough is enough' and returned to my maternal home.

After separating from my spouse I used to work as a casual laborer and earn around Rs 80 per day. I changed my work because I was becoming physically weak and the money was not sufficient to cover my drug expense. When I was a casual laborer the male laborers used me for their sexual satisfaction and I couldn't stop them as I needed the work for my drug expenses and survival, and had no one to ask for help. If I satisfy them sexually they do my work. Now I am a professional sex worker, and on an average I earn around Rs 300/day. Even in sex work, the police personnel sexually abuse us.

I have only one daughter but I don't know who the father is since I entertain so many customers a day. She is now in an orphanage because the place where I live is not a healthy environment for her. I want to be a good mother but I can't.

I know that one gets HIV/AIDS through sharing needles and syringes and gets STDs (sexually transmitted diseases) through many sexual partners. I have suffered from STDs and been treated, recently. I have a heavy white discharge, which smells a lot. Even my spouse used to have some sort of ulcer on his penis, but it vanished without treatment so we were not very concerned. I know that condoms can protect me from HIV/AIDS and STDs but sometimes the clients refuse to use them

11 Substance and Children

Children must be ensured many rights...including a right to grow up in a substance-free environment

Introduction

International surveys and other population estimates suggest that approximately 10% of children live in households where there is parental alcohol abuse or dependence and drug abuse or dependence (ANCD 2006). Children whose parents have substance abuse are at a greater risk of suffering various adverse outcomes during their childhood, and later in life. The impact of substance use on children must be understood against the ground realities that children face in India.

The Substance, Women and High Risk Assessment Study

Children who have an addict parent suffer even more than adults do. Constant bickering at home is hardly a prescription for a happy childhood

A majority of NSUPs had children (86.9%), compared to 69.4% of FSUs. 163 FSUs (10.7%) and 440 NSUPs (11%) reported the death of one or more of their children. Respondents were asked to provide information about all their children. The ratio of female to male children among FSUs was 760:1000 and 803:1000 among NSUPs. This is startling. Although the respondents were asked to provide information about all their living children, there has clearly been some underreporting of female children who are married and have moved away. This is supported by the fact that when only children below 16 years are considered, the ratio improves to 914:1000 among FSUs and 919:1000 among NSUPs. The lower ratio of daughters to sons however, persists, even in the younger age groups and cannot be explained entirely by underreporting of offspring who have married and are living away from home.

Present education levels of children

As the majority of children have not yet reached their teenage years, it is difficult to comment on their ultimate educational achievement. But, it is a matter of concern that nearly 25% of daughters and sons, in both groups, are facing academic difficulties. However, when children above the age of 25 are considered separately, it is evident that those in families where both parents use substances have higher levels of illiteracy and dropout rates at the primary school level. In families where the mother is not using substances, more children are likely to have gone to college.

- Respondents do not seem to count daughters who may be married and staying away as children
- Both among NSUPs and FSUs there are far fewer daughters than sons reflecting gender disparities

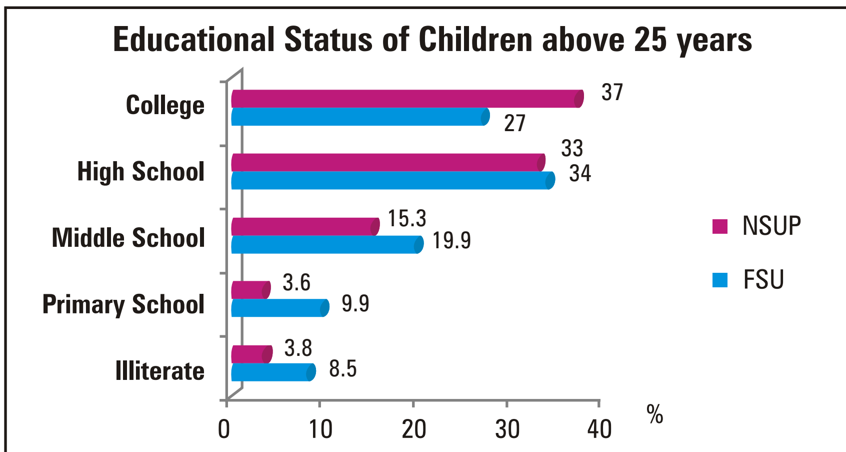


Figure 54: Education status of children of respondents

Effects of parental substance use upon children

More than three fifths of NSUPs feel that their partner's substance use affects their children. More than half (54%) of the FSU's feel that theirs and their partner's substance use, adversely impacts the children. FSUs perceive there is less of an adverse impact of substance use on their children than NSUPs ($OR = 0.37$, $p < 0.001$).

- FSUs feel there is less of an adverse impact from their own/partner's substance use on their children
- Where both partners use substances, the responsibility of parenting falls on the grandparents

Absent for parenting

From the qualitative interviews it is evident that some FSUs, especially those in dual substance using households, are unable to look after their children, so the responsibility falls on the grandparents.

> After my spouse died of an illness, I moved out from my in-laws to my maternal home with my children. As a widow with three children, I was left with a life not worth mentioning. I began to move out from home frequently, and had my first taste of alcohol. My family, especially my mother, took over my responsibilities so I didn't worry about anything, my children, money, or the future.
>
> Phamila, 41-year-old from Ukhrul

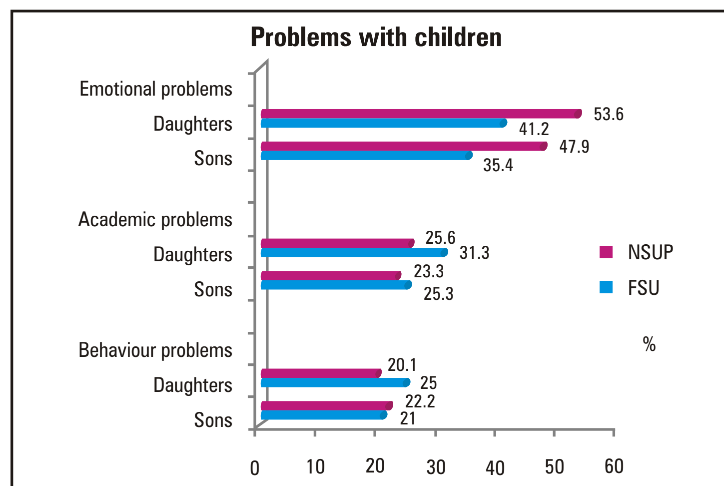


Figure 55: Problems among children

Current problems among children

Variables	Gender	FSU		NSUP		Chi-square	Level of Sig.
		Yes	No	Yes	No		
Physical illness	Male	108	1232	351	4640	1.66	NS
	Female	78	1134	257	3938	0.15	NS
Behavioral	Male	282	1055	1111	3887	0.79	NS
	Female	255	958	698	3504	12.63	<0.001
Academic	Male	340	1000	1171	3827	2.20	NS
	Female	319	894	891	3311	14.08	<0.001
Emotional	Male	474	866	2391	2605	66.49	<0.001
	Female	420	791	1863	2322	37.21	<0.001
Tobacco	Male	227	1113	507	4491	47.66	<0.001
	Female	34	1179	34	4168	30.18	<0.001
Alcohol	Male	147	1192	245	4741	66.78	<0.001
	Female	26	1187	19	4183	32.67	<0.001

Table 29: Comparion of problems among children

Emotional difficulties (depression and anxiety, being withdrawn, self injurious behavior) were the commonest problems among children in both groups. NSUPs reported significantly greater emotional difficulties among both sons and daughters compared to FSUs. FSUs reported greater academic problems among both genders. Behavioral problems (like truancy, running away from home, lying, stealing, aggressive behavior and involvement in petty crime) were significantly more common among daughters of FSUs. Rates of physical illness did not differ significantly, across the two groups.

Emotional Problems

- More than 50% NSUPs and over 40% FSUs reported emotional problems among daughters
- Nearly 50% NSUPs and more than one-third FSUs reported emotional problems among sons

Academic Problems

- About one in four NSUPs and one in three FSUs reported academic problems among daughters
- About one in four NSUPs and FSUs reported academic problems in their sons

Behavioral problems

- One in five NSUPs and one in four FSUs reported behavioral problems among daughters
- About one in five NSUPs and FSUs reported behavioral problems among sons

Substance use among children

Rates of tobacco, alcohol and other drug use are likely to be doubled among children staying with mothers who use substances. These are often likely to be dual substance use households, as many of the partners of women substance users also use substances. From information obtained on all children, boys across both groups have significantly higher use of all substances compared to girls, and boys in dual substance use households have significantly higher levels of tobacco, alcohol and other drug use.

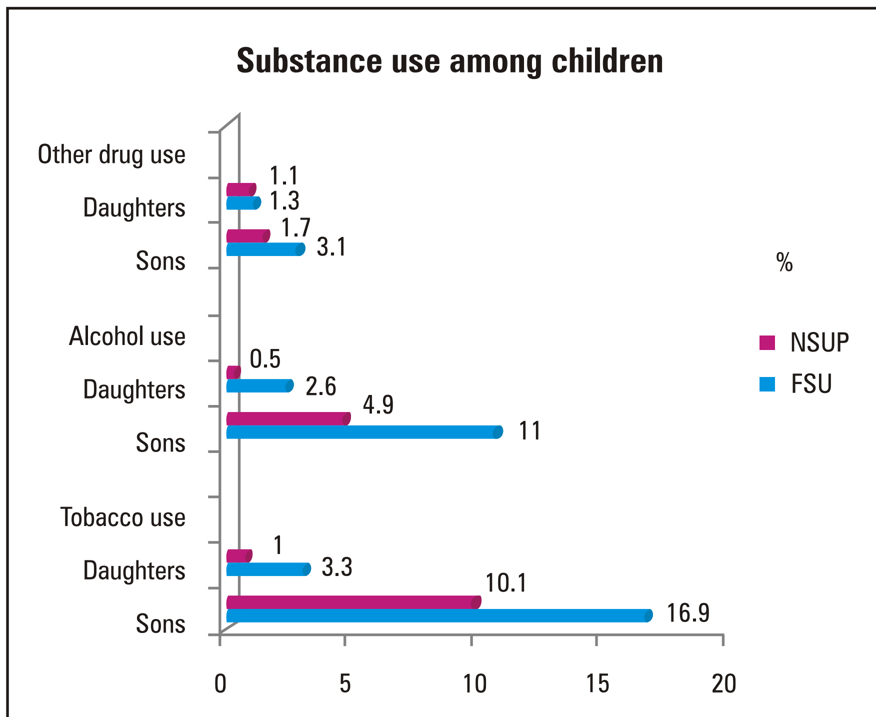


Figure 56: Substance use among children

- Sons of FSUs have significantly higher rates of tobacco, alcohol and other drug use compared to sons of NSUPs
- Daughters of FSUs have relatively higher rates of tobacco and alcohol use than daughters of NSUPs
- Rates of substance use among children, especially sons, is higher in dual substance using households

Children and violence

Non-substance using mothers more significantly reported that their children have witnessed and experienced physical and/or verbal violence at home. They were significantly more likely to worry about all children's issues like parenting, neglect, financial security, safety, education, future, behavior, health, food and nutrition, current or potential substance use, and social acceptability. While many respondents in both groups were concerned about their children witnessing violence, this concern was also significantly more among women not using substances.

- Nearly two-third of NSUPs worry about children experiencing verbal violence at home and more than 50% about physical violence
- A majority worry about parenting, finances, education, health, behavior and substance use among their children
- Compared to NSUPs, less FSUs expressed concern regarding the above issues.

	FSU		NSUP		OR
Children ever experienced:	**N**	**%**	**N**	**%**	
Physical violence at home	740	39.7	2420	55.0	0.54***
Verbal violence at home	830	44.5	2848	64.7	0.44***
Children witnessed violence at home	785	42.1	2559	58.1	0.5***
Respondent worried about children's:					
Parenting	968	51.9	3339	75.9	0.34***
Neglect	893	47.9	2925	66.5	0.46***
Finances	962	51.6	3055	69.4	0.48***
Future	1036	55.5	3451	78.4	0.34***
Education	994	53.3	3352	76.2	0.36***
Safety	977	52.4	3329	75.6	0.35***
Behavior	967	51.8	3321	75.5	0.35***
Health	959	51.4	3319	75.4	0.35***
Food and nutrition	873	46.8	3004	68.3	0.41***
Current/potential substance use	794	42.6	2799	63.6	0.42***
Social acceptability	837	44.9	2876	65.3	0.43***
Witnessing violence at home	820	44.0	2765	62.8	0.46***

Table 30: Violence and parental concerns

Significant at *$p<0.05$, ** $p<0.01$, *** $p<0.001$

Children as motivating factors for change

In the qualitative interviews, many FSUs wished to change mainly for the sake of their children.

I tried to give up once 10 years back, for six months, but I relapsed. Again I tried three and five years later. The reason I wanted to stop was that I was very tired of the street life. This time I feel I should stop for the sake of my child.

Zuali, 34-year-old from Manipur

Today, when I look at the future, I can only see my daughter who is growing up and is now four years old. At least in front of my daughter I should be a good mother.

Marina, 26-year-old from Imphal

The disadvantaged girl child

While the specific cause of the low female: male ratio in the study cannot be pinpointed, it is a reflection of the social disadvantages that the girl child faces in large parts of the Asian subcontinent. Amartya Sen, in a recent editorial, refers to the terrible deficit of women in substantial parts of Asia and North Africa, which arises from sex bias in relative care. Reduction in female mortality in many countries has been counterbalanced by sex selective abortions (Sen 2003).

Children in India and the impact of substance

India has made some significant commitments in ensuring the basic rights of children and there has been progress in overall indicators: infant mortality rates are down, child survival is up, literacy rates have improved and school dropout rates have fallen. There are several constitutional provisions that protect children - prohibition of child labor, right to opportunities to develop in a healthy manner and in conditions of freedom and dignity, protection against exploitation and moral and material abandonment, and free, compulsory education till 14 years of age (Articles 15, 24, 39, 45). But the issue of child rights is still caught between legal and policy commitments to children on the one hand, and the fallout of the process of globalization on the other (Info Change Agenda 2007).

Sudharak Olwe

(downloaded from www.infochangeindia.org)

It is in this context that the impact of paternal and maternal substance use needs to be evaluated. Whether substance abuse among parents is a consequence of poverty, illiteracy and other social adversities or whether

Children in India: Ground Realities

- With more than one-third of its population below 18 years, India has the largest young population in the world.
- Only 35% of births are registered
- One out of 16 children die before they attain the age of 1, and one out of 11 die before they are 5 years old.
- 35% of the developing world's low-birth-weight babies are born in India.
- 40% of child malnutrition in the developing world is in India.
- The declining number of girls in the 0-6 age group is cause for alarm. For every 1,000 boys there are only 927 females -- even less in some places.
- Out of every 100 children, 19 continue to be out of school.

substance abuse leads to impoverishment and adverse psychosocial consequences is a tautological issue. It would be fallacious to suggest simple linear models for understanding these dynamics. There are a host of interactive factors influencing each other. Nevertheless, given the ground realities of children in India, the added dimension of maternal substance use, and more often than not, substance use among both parents, is exponentially likely to increase the problems that children face. Experiences from the UK and Australia are enlightening. A qualitative study of 38 youngsters aged between 15 and 27 in the UK whose parents' have/had a drug/and or alcohol problem reveals that:

- Of every 100 children who enroll, 70 drop out by the time they reach the secondary level.
- Of every 100 children who drop out of school, 66 are girls.
- 65% of girls in India are married by the age of 18 and become mothers soon after.
- India is home to the highest number of child labourers in the world.
- India has the world's largest number of sexually abused children, with a child below 16 raped every 155th minute, a child below 10 every 13th hour, and at least one in every 10 children sexually abused at any point in time.

- Summary of a Perspective paper on child rights by Enakshi Ganguly-Thukral et al and Status of Children in India Inc, 2005 published by HAQ: Centre for Child Rights, New Delhi. Accessed at www.infochangeindia.org

- Children perceive a lack of consistent, practical and emotional care.
- There are higher levels of anxiety and social stigma
- There is resilience associated with finding adaptive ways to deal with difficulties, developing informal relationships with extended family members, neighbors, friends and friends' families (but such support was seldom reliable or unconditional)
- Where experienced, a strong personal relationship with a service worker was highly valued
- Young people shared similar goals and dreams - of jobs, houses and families - but not all were on the way to achieving them. Education and work were key factors in putting them in a position to achieve their goals (Bancroft et al 2004)

International household surveys and other population estimates suggest that approximately 10% of children live in households where there is parental alcohol abuse or dependence, or other drug abuse or dependence. While parental substance abuse can affect many aspects of a child's life, it is generally difficult to disentangle its effects from broader social and economic factors that contribute to and maintain the misuse of either drugs or alcohol. A study from Australia found that grandparents are taking increased, full time caring responsibilities of their grandchildren in such circumstances (ANCD 2006).

Children and substance use

The common drugs that children abuse in India are tobacco and alcohol, but use of cannabis and heroin has also been reported. (Tripathi and Lal 1999, Pagare et al 2004). A study of the prevalence, consumption patterns and correlates of tobacco use among 3422 adolescent children from Government schools in Delhi, found that 9.8% had a lifetime history of tobacco use, and 5.4% were current users (Singh et al 2007). The use of dendrite, paint thinners, Iodex, a muscle stress relieving balm and Erasex, a correction fluid containing toluene, have been described by street and working children in

India (Murthy et al 2003, Seth et al 2005). The rates of tobacco use, particularly among the sons of FSU's, seem higher. Following the argument that early tobacco use may be a harbinger of later drug use, this group seems particularly vulnerable unless remedial measures are considered.

Children, in spite of being at risk, can become resilient to substance use and other problems, later in life. Some of the risk and protective factors are outlined in the accompanying table.

Risk Factors	Domain	Protective Factors
Early aggressive behavior	Individual	Self-control
Lack of parental supervision	Family	Parental monitoring
substance abuse	Peer	Academic competence
Drug availability	School	Anti-drug use policies
Poverty	Community	

Table 31: Risk and protective factors for substance use Source: NIDA 1997

From the present study it is evident that children growing up in environments where fathers use substances, and more so in dual substance using households, are vulnerable or already experiencing problems and are at greater risk of developing problems later in life, including substance use.

Summary Points

International surveys indicate that one in ten children live in households where there is parental substance use

Children of substance using parents are at a greater risk of adverse outcomes, both during their childhood and later in life

The impact of substance use upon children must be understood against the ground realities that children face in India

The present study found very low female: male gender ratios among the children - a grim reflection of persisting gender inequality in India

Children of FSUs have greater levels of illiteracy and school drop out at the primary level

In some homes where the mother uses substances, other family members like grandparents assume parental responsibilities

Where mothers do not use substances, despite paternal substance misuse, more children are able to go to college

Children in substance using families commonly experience emotional, academic and behavioral problems

These problems are significantly greater in homes where the mother also uses substances (most likely dual substance using households)

Children in both households show high rates of tobacco and alcohol use, and some also use other drugs

Substance use is higher among sons than daughters, in both groups

Non-substance using mothers have significantly greater concerns regarding all aspects of their children's health and functioning compared to mothers using substances

However, concern about their children is a main motivating factor for change among mothers using substances

11.1 I Must Recover....for My Child

Jyoti, 30-year-old from Rajasthan

Jyoti's family comprised of her parents and three elder brothers of whom one had not survived. Her father had just died. One of her brothers was chronically addicted to alcohol and the other suffered from epilepsy. Both had only studied up to primary school. She was the only member in her family who had studied up to middle school, but had to discontinue her studies due to the poor socioeconomic state of the family. She worked with her brother in a tea stall in the heart of the city.

"One day we saw a person selling packets at our tea stall and earning a very high amount of money. Soon, my brother started working with this strange person and we also began earning a lot. Ultimately, my brother got addicted to the opium we were selling. My spouse is a farmer, five years older to me and I have affectionate in-laws. My spouse is supportive. One day my brother offered him the opium, so now he is also addicted. We have only one male child. During the early period of our married life, we enjoyed sex, but after he got addicted to opium he became impotent and his sperm count is very low. I started using opium pills for sexual satisfaction and have been taking them regularly, for three years. My family is very poor, and our economic condition is the major cause for family violence. My spouse always beats me when he is off the drug. We feel very guilty that we are not responsible and good parents to our son. who is now working in a glass factory, day and night. I feel his career has been affected and we are responsible. All our families and relatives avoid us because of our addiction.

My first experience of sex was when I was 15 years old and a shopkeeper had oral sex with me. He gave me money for this guilty act, but as my experience grew, I became habituated to it. The same person gave me opium tea when he performed the act. I became a regular addict of opium using 8 to 10 grams daily. When my spouse started becoming impotent, my landlady, a very rich and famous 'aunty' in the area, got me addicted to various kinds of drugs like opium, alcohol, cannabis etc. Whenever I refused, she forcefully injected me with buprenorphine. Now I use 5 to 8 injections per day, my spouse also uses these injections. Sometimes my spouse uses my syringe. My landlady used me (controlled me) through the drugs. After I listened on the radio about how AIDS and syphilis spread, I started using precautions, but my partners don't like them. They think that a condom reduces their pleasure.

We have realized that drugs are harmful to our health. My spouse and I tried to go for de-addiction two - three times but our socio-economic state prevented us. Last year, I visited the civil hospital because my arms were destroyed from taking so many injections.

I think my life is finished and darkness follows me. When I remember my childhood days I cannot stop crying. Today, there is no one to help my family and me but I realize I have to be strong for the future of my child".

12 Substance and Emotional States

Mental health is so precious... but precious little is being done to protect it

Introduction

Gender is a critical determinant of mental health and mental illness. Common mental disorders like depression, anxiety and somatic complaints are more predominant among women. These are significantly interconnected with risk factors such as gender-based roles, stressors, negative life experiences and events. Gender specific risk factors include gender-based violence, socioeconomic disadvantage, low income and income inequality, low/ subordinate social status and the unremitting responsibility to care for others (WHO 2007). Substance misuse among men results in significant emotional distress for their women partners (Murthy 2002). NSUPs in the study of the burden on women due to drug abuse by family members (Shankardass 2002) tend to report depression, anxiety and suicidal thoughts.

The Substance, Women and High Risk Assessment study

In the study, the General Health Questionnaire (GHQ) was used to assess the respondents' mental health problems. The GHQ was designed by Goldberg to identify mental illness in patients in general practice, in the 1970s. Various versions of the questionnaire have been validated in different medical settings. The GHQ -12 has similar psychometric properties as the longer versions and is quick to administer. The Likert method of scoring was used in the present study (0-1-2-3)

Emotional problems

The most commonly reported symptoms of emotional distress are not being able to enjoy day-to-day activities, feeling constantly under strain, not feeling confident about overcoming difficulties and feeling unhappy or depressed. Almost half the respondents' felt less happy than usual, 'all things considered'.

	FSU		NSUP	
In the last few weeks, has respondent:	N	%	N	%
Been able to concentrate				
Better than usual	108	5.9	223	5.1
Same as usual	965	52.4	2638	60.6
Less than usual	633	34.4	1234	28.4
Much less than usual	135	7.3	256	5.9
Lost sleep over worry				
Not at all	280	15.3	642	14.8
No more than usual	752	41.0	1952	44.9
Rather more than usual	613	33.4	1406	32.4
Much more than usual	189	10.3	344	7.9

Felt she is playing a useful part in things				
More so than usual	117	6.5	381	8.8
Same as usual	917	50.7	2406	55.6
Less so than usual	648	35.8	1295	29.9
Much less than usual	126	7.0	244	5.6
Felt capable of making decisions				
More so than usual	131	7.1	325	7.5
Same as usual	903	49.5	2526	58.2
Less so than usual	605	33.0	1199	27.6
Much less than usual	194	10.6	293	6.7
Felt constantly under strain				
Not at all	235	12.8	573	13.2
No more than usual	750	40.8	1786	41.0
Rather more than usual	647	35.2	1535	35.3
Much more than usual	206	11.2	459	10.5
Felt she could not overcome difficulties				
Not at all	343	18.7	750	17.3
No more than usual	709	38.7	1804	41.5
Rather more than usual	574	31.4	1317	30.3
Much more than usual	204	11.1	472	10.9
Been able to enjoy day to day activities				
More so than usual	95	5.2	174	4.0
Same as usual	904	49.4	2054	47.5
Less so than usual	672	36.7	1702	39.4
Much less than usual	160	8.7	395	9.1
Been able to face up to problems				
More so than usual	137	7.5	471	10.9
Same as usual	919	50.2	2076	48.0
Less so than usual	575	31.4	1458	33.7
Much less than usual	199	10.9	324	7.5
Been feeling unhappy or depressed				
Not at all	281	15.3	632	14.6
No more than usual	703	38.3	1752	40.4
Rather more than usual	592	32.3	1530	35.3
Much more than usual	258	14.1	420	9.7
Been losing confidence in herself				
Not at all	475	25.8	1552	35.8
No more than usual	636	34.6	1236	28.5
Rather more than usual	567	30.8	1261	29.1
Much more than usual	160	8.7	290	6.7
Been thinking of herself as a worthless person				
Not at all	683	37.7	2368	55.6
No more than usual	513	28.3	942	22.1
Rather more than usual	467	25.8	777	18.2
Much more than usual	149	8.2	173	4.1

Been feeling reasonably happy, all things considered				
More so than usual	95	5.3	168	3.9
Same as usual	828	45.9	1990	46.4
Less so than usual	640	35.5	1582	36.9
Much less than usual	240	13.3	549	12.8

Table 32: GHQ symptoms last month

The GHQ cut-off for psychiatric caseness based on the Likert method of scoring is set at 11/12. Based on this, 75.2% of FSU's and 74.1% of NSUPs had scores of 11 or above, indicating diagnosable psychiatric disorders. Mean GHQ scores among FSUs [16.8 (7.1)] were significantly higher than NSUPs [15.8 (6.3)], $p<0.001$.

During the last year, 66.6% of FSUs and 54.3 % of NSUPs felt that life was not worth living. Among FSUs, one-third reported suicide attempts, sometimes (once or twice during the previous year), while 6.3% reported such attempts more than twice (often). Feeling that life was not worth living and attempts to take their own life were significantly more among FSU's.

- About three out of four FSUs and NSUPs scored above the cut-off for caseness on the General Health Questionnaire
- During the last year more than two-thirds of FSUs and more than 50% of the NSUPs felt life was not worth living
- During the last year, nearly 40% FSUs and 30% NSUPs had attempted to end their life

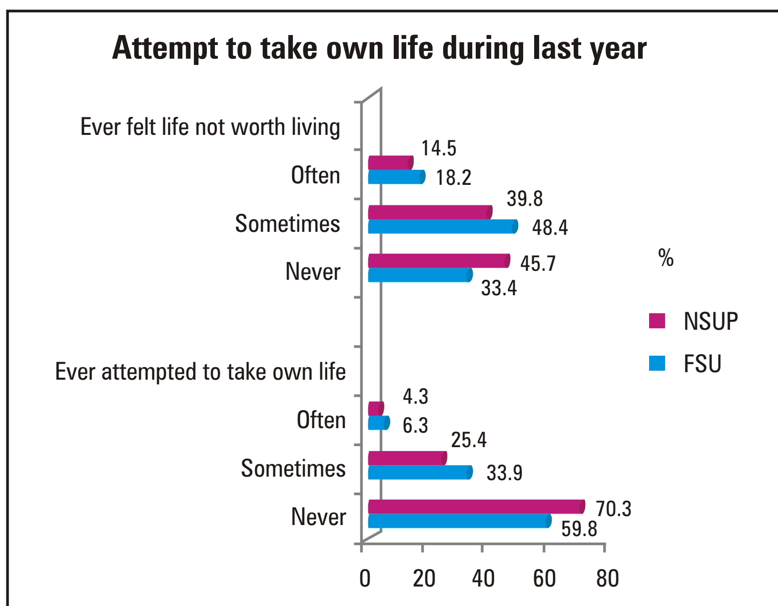
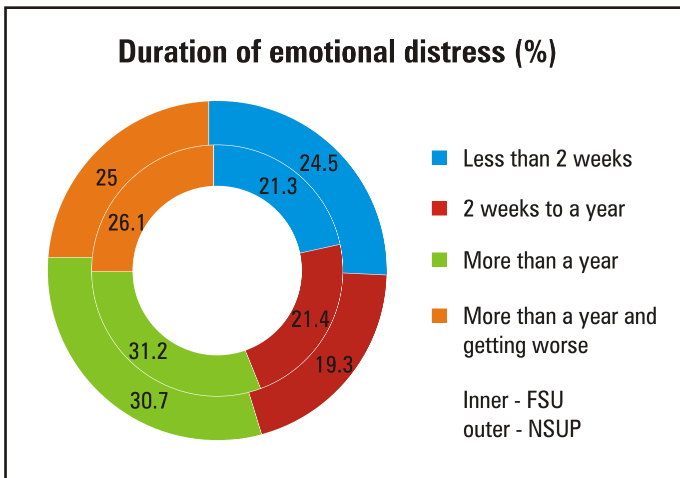


Figure 57: Suicidal attempts

	FSU		NSUP		OR
	N	%	N	%	
Felt life was not worth living during the last year	1218	66.6	2360	54.3	1.63***
Attempted to take own life during last year	726	40.2	1286	29.7	1.54***

Table 33: Feelings of worthlessness and suicidal attempts

*** significant at $p<0.001$



In more than half to two-thirds of respondents in both groups, symptoms of emotional distress have been present for more than one year

Figure 58: Emotional distress duration

In more than half to two-thirds of respondents, symptoms of emotional distress have been present for more than one year.

Sometimes, I feel so shameful that the thought of committing suicide comes to my mind, but once I take the drug I forget the rest of the world. I don't remember my thoughts, guilt, frustration or anxiety.

- Salma Akthar, drug user from Kanpur

Rajitha Ray's story (From Riches to Rags) at the end of this chapter, illustrates how substances are used to cope with emotional distress:

I was not happy with my loneliness, frustrated at the way I had ruined my life and guilty about my first child. My progression was rapid, from a single, nightly quota of drinking in the evening, to another in the afternoon and very soon my morning quota also started.

A Sense of Futility

I know about HIV/STD and we both consider ourselves at risk for HIV infection. We have not been clinically tested yet, but I heard my partner is Hepatitis C positive (tested while he was in rehab recently). To us HIV positive or negative is not going to make any big difference.

- Phamila, IDU from Ukhrul

I have tried giving up drugs many times and failed. For a drug user like me, life is not worth living. People always insult us, look down on us and discriminate against us. We are voiceless even for our own rights. I have also tried to commit suicide thinking that life is not worth living for a drug user like me. But I have concerns for my child and want him to have a bright future. I think all drug users will have the same problem of thinking clearly. I tend to forget things quickly. When I'm high, I can't recall things, can't open my eyes wide, my speech is not clear and I talk about irrelevant things. I was caught by the police and underground personnel, beaten up and fined more than 10 times but have, so far, never landed in jail.

- IDU from Hojai, Assam

Substance and mental health

In addition to physical and social problems, persons using substances have significant mental health problems influenced by the environment, and biological vulnerability. However - especially from the Asian region - there is a paucity of studies examining the psychological impact on women of partner's substance use and their own use.

The National Epidemiologic Survey on Alcohol and Related Conditions in the United States (NESARC) examined the association between partner alcohol problems and selected physical and mental health outcomes among married or cohabiting women, before and after adjusting for potential confounders (Dawson et al 2007). Physical health measures included criminal victimization of any type, injury, emergency-department and hospital visits, self-reported fair or poor health, and Short Form-12 Health Survey Questionnaire, Version 2 (SF-12v2), -based physical quality of life. Mental health measures included DSM-IV mood and anxiety disorders, number of past-year stressors, and SF-12v2-based mental/psychological quality of life. At the bivariate level, women whose partners had alcohol problems were more likely to experience victimization, injury, mood disorders, anxiety disorders, and being in fair or poor health than women whose partners did not have alcohol problems (odds ratio [OR]: 1.7-4.5). They also experienced more life stressors and had lower mental/psychological quality-of-life scores. All but one of these differences remained significant after adjusting for potential confounders, which included the significantly greater rates of substance use and AUDs among women whose partners had alcohol problems. Although the magnitudes of the ORs decreased after adjustment (adjusted OR [AOR]: 2.1-3.4), they generally exceeded the AORs associated with the women's own AUDs. While the study found high rates of mental morbidity among NSUPs, mean GHQ scores, feelings of worthlessness and the likelihood of attempting suicide was much higher among FSUs.

The frequency of attempted suicides, in the last year, is shockingly high. Several recent studies of completed suicides in this country show five times the rates in the Western countries and thrice that of China (Eddleston and Kondradsen 2007). In a study of 38,836 deaths in the Villupuram district of South India, Gajalakshmi et al (2006) found that 7167 were due to injury. Of these, intentional self-harm was responsible for 3429 (47.8%) deaths, an incidence of 62/100,000 per year for males and 53/100,000 for females. In Bangladesh, 50% of the women's unnatural deaths were suicide, mostly by poisoning; the largest number was in married women under 30 years (Ahmed et al 2004). Economic adversity and family discord are cited as the commonest causes for suicide. Research into reasons of attempted suicide by women reveals that quarrels with in-laws, interpersonal problems and alcoholism are the most common causes in India (Gururaj and Isaac 2001, Bhugra and Desai 2002, Gururaj et al 2006, Manoranjitham et al 2007). The study shows inordinately high rates of suicide attempts, especially among FSUs. Clearly, the combined stress of the partner's substance misuse and consequences along with their own substance misuse is a powerful cocktail for severe mental distress.

Research shows that there are three main factors powerful enough to prevent these mental problems, especially depression. These include sufficient autonomy to exercise some control in response to 'severe' events, access to some material resources that allow the possiblity of making choices in the face of severe events and psychological support from familly, friends or health providers (WHO 2007).

Persons with severe mental illness in western settings, have high rates of substance use, which is often correlated with

poor course and outcome of mental illness. In India, one of the factors attributed to a better course and outcome has been the relatively low rate of co-morbid substance use in patients with severe forms of mental illness (Isaac et al 2007). Given the changing patterns of substance use, it is likely that we will begin to see increasing associations between mental illness and substance use among both women and men, in the future, unless the trend of substance use changes.

Summary Points

Gender is a critical determinant of mental health and mental illness

Substance misuse among male partners results in significant emotional distress among women

In the study, nearly half the FSUs and NSUPs report feeling less happy recently, all things considered

A majority of both FSUs (75.2%) and NSUPs (74.1%) have GHQ scores above the cut-off for diagnosable psychiatric illness

Mean GHQ scores are significantly higher among FSUs than NSUPs

FSUs report significantly higher suicidal attempts during the last year compared to NSUPs

Symptoms of mental distress have been present for more than a year in half to two-thirds of respondents

12.1 Drowning Her Sorrows: A Riches To Rags Situation

Rajita Ray, 42-year-old from Darjeeling

I was born in the queen of hill stations, Darjeeling, and was the apple of my family's eyes. My father was a graduate and mother was also well educated. Though my father was an alcoholic, he hardly created any trouble because he feared his elder brother. The death of my father, as I now understand it, was due to alcohol. My childhood was wonderful. I studied in a convent, learnt Indian classical dance and the sitar and completed my graduation. I was not allowed to mix in the locality and by nature I had been a loner. My friends were my books, my brothers, sitar and dancing. My father hardly had time for my brothers or me when we were children.

I had an affair when I was in Class 10. We kept in touch through letters and after his graduation he asked for my hand in marriage. The proposal was refused as he was from a different caste. I tried to persuade him to have a registered marriage but he refused because I was still underage. He got a job abroad and left India. I continued with my studies and joined the post graduation course.

My boyfriend was back after two years, so I asked him over to my flat for dinner. One month later, I found myself pregnant. I was at a loss. I had to inform him when he returned in seven days. There must have been a ray of hope in my mind that he would marry me, but nothing of that sort happened. He asked me to have the child. We were to travel for a year, throughout India, and return after a year. I came back to get my family's permission and there was a hue and cry. Ultimately they agreed. I left with him and we stayed with friends. Many times I thought of talking to him about marriage, but I could not. Basically, I am a person who suppresses any kind of feelings. I could never express my emotions. After the baby was born, he left and I had to return home. For the first time I broke down and showed my emotion, but it was brutally rejected. I came home totally shattered and full of guilt. I had lost interest in life and everything around me.

After three months I came out of my self afflicted punishment and decided to move forward. I completed my post graduation and got a senior teaching job. While my family was getting ready to get me married though I was unwilling, I met another person. I confessed my problem about not wanting to get married. On the day of my engagement, I rang him, and he asked me to elope so I married him. I had no idea that he was a person with a dual personality. He used to be very loving and caring during the day but in the evening the other side of his personality would emerge after alcohol. Never in my life had I been physically and verbally abused till this time. I was stunned and horrified and soon realized I was pregnant; I could not go anywhere, as my family refused to have anything to do with me. My eldest uncle could not bear the humiliation and had had a severe heart attack, which took his life. So I was boycotted.

I gave birth to the child in the playground of the school I worked in. My spouse was so drunk that he could not even stand up. The servants helped me. My son was all I could live for. I had lost all feelings for my spouse. He

would go away for seven to ten days at the beginning of each month. He never contributed any money for the household or the baby. I was informed by one of his friends that he had a wife and two children. I thought of myself as a 'kept woman'. One day I left early for school, leaving the child in the care of his father and a servant. On my return I found the dead body of my child on the floor, bleeding from the nose and ears. The servant had called in the doctor who said it was an internal hemorrhage.

My son had got hit on his head by the VCP, which had fallen off the table when he pulled the tablecloth. My spouse was drinking. I stayed with him for six months but used to lock my room from inside. I hated him. The thought of alcohol used to drive me crazy. I hated the substance because of my father and then my spouse. I left him six years after the so-called marriage.

My family was happy when I returned home. I started teaching again. It was becoming very difficult to adjust there. My past used to haunt me. I never interacted with anyone. When I was with my family, I once again met my first boyfriend, this time with my first child. He was not married and his life revolved around the boy. I did not question him or introduce myself to the child as his biological mother. At around 28 years, I was introduced to alcohol at a party. After my first drink, I was in an elated mood. I found I could come out of my shell and it made me feel like a new person. All personal thoughts about my guilt disappeared. After that day I found I could lose all my inhibitions after a peg or two. Usually, I used to drink alone. But, I was not happy with my loneliness, frustrated at the way I had spoiled my life and guilty about my first child. My progression was rapid, from a nightly quota of drinking in the evening to regular quotas for the rest of the day. Though I used to chew pan (betel leaf) the smell could not be hidden.

As soon as school got over I would rush to the alcohol shop, come back and go straight up to my room. I started skipping breakfast, have my morning drink first and then on to school. Eventually, I was given two options: resign or stop drinks. I opted for the former. I had all the time on hand now. Gradually my savings diminished and I had no job. I had no hesitation to cash my fixed deposits because by hook or crook I had to drink. I found myself in a pathetic condition, thrown on the road by the family. I started staying with a beggar woman; addiction had made me homeless and helpless.

13 Family Responses, Treatment Seeking and Support

Parents are the most misunderstood and underutilized resources to prevent substance use among youth

Introduction

The study on 'Women and Substance Use in India' highlights the financial and emotional burden of caring for a drug-abusing member in the family (Murthy 2002). It is now recognized that women, as partners of men using substances suffer substantially, from the onslaught of physical and psychological abuse by close male relatives (usually spouses, partners and sons) and increasingly have to take on the responsibility of family breadwinner following the illness and death of HIV/AIDS-infected drug using partners.

The Substance, Women and High Risk Assessment Study

FSUs were asked about their families' main reaction to substance use. Of the 1364 that answered, 944 (69.2%) said their family members were aware of their substance use. While family reactions were mainly hostile (43.5%) or indicated a lack of concern (43.5%), a small percentage of respondents (13.3%) reported that their families were supportive.

Treatment

A majority of FSUs (81.5%) had not received any treatment for substance misuse. Among the few that had, the mean age at which treatment was first received was 25 years (7.8%). Among all respondents, NGOs are accessed as service providers by about 15.6%, with government institutions forming half that number. This may reflect a selection bias, as some of the respondents identified for the interview - though small in number - had been admitted to the NGO treatment centre or were in touch with the NGO. What is striking is that both FSUs and their partners are consistently less likely than partners of non-substance using women, to utilize any health services in the community.

- More than 80% of FSUs have not received any treatment for substance use
- For the few that have accessed treatment, NGOs have been the primary service providers

	FSU	Partner of FSU	Partner of NSUP
	% accessed	**% accessed**	**% accessed**
Traditional Healer	2.7	2.5	2.6
Government health care setting	7.2	11.4	11.2
Private health care setting	5.4	7.9	8.6
Non governmental organization	15.6	12.9	24.1
Home based detoxification	7.2	5.5	10.6

Table 34: Sources accessed for help

	FSU	Partner of FSU	Partner of NSUP
	% accessed	% accessed	% accessed
Counseling	19.5	17.4	20.2
Self Help Groups	16.7	3.3	5.6
Residential Rehabilitation	3.1	6.1	7.1
Treatment for physical problems including abscesses	6.1	5.3	4.8
Health education	7.4	5.1	8.2
Detoxification	10.7	13.3	24.4
Drug substitution	5.7	5.5	10.4

Table 35: Type of service accessed

FSU's perceived supports in rank order	NSUPs perceived supports in rank order
NGOs	Spouse/Partner
Friends	NGOs
Brothers	In laws
Spouse/partner	Friends
Neighbors	Neighbors
Sisters	Brothers
In laws	Sisters
Parents	Parents
Colleagues at work	Colleagues at work
Others	Children
Children	Others
Government facilities	Government facilities

Table 36: Support systems

Respondents were asked whom they would access for support for various requirements like material needs (food, clothing, shelter), emotional support, proper information and advice. FSUs placed NGOs at the top of their order, primarily for information/advice, followed by emotional and material support. NSUPs primarily perceived maximum support from spouses and partners (on whom they are financially reliant), with NGOs following a close second. While this may, in part, be a desired response (as the study was carried out by NGO

- In rank order, FSUs regard NGOs, friends, male siblings, spouse/partner as main sources of support
- In rank order, NSUPs regard spouses/partners, NGOs, in laws, friends, neighbors and male siblings as main sources of support

representatives), it nevertheless, places NGOs in a very important position as service providers in the community. FSU's put friends before family members as sources of support, whereas, NSUPs placed in-laws ahead of their family of origin. Parents and children figured much lower in the order for both groups andgovernment facilities seemed to offer the least support.

Knowledge of available community services

Services available	Yes %	No %	Don't know %
Community outreach workers			
FSU	44.6	20.6	34.8
NSUP	33.3	18.3	48.4
Gender sensitive HIV/AIDS prevention and care material			
FSU	41.1	25.1	33.8
NSUP	31.4	24.6	44.0
Substitution treatment (buprenorphine etc)			
FSU	20.5	39.7	39.8
NSUP	16.1	32.3	51.6
Access to male condoms			
FSU	67.3	11.3	21.4
NSUP	37.3	7.8	24.9
Access to female condoms			
FSU	13.5	51.9	34.5
NSUP	10.9	46.5	42.6
Access to sterile needles and syringes			
FSU	51.0	22.8	26.2
NSUP	49.0	18.7	32.3
Voluntary HIV testing and counseling			
FSU	46.2	23.2	30.7
NSUP	34.9	20.4	44.7
Facilities for diagnosis and treatment of STIs			
FSU	35.4	27.1	37.5
NSUP	32.9	20.3	46.9
Anti-retroviral treatment			
FSU	17.9	33.8	48.3
NSUP	15.1	25.4	59.5
Services for prevention of mother to child HIV transmission			
FSU	29.1	30.9	40.0
NSUP	25.5	21.9	52.5
Deaddiction and drug treatment services for women			
FSU	27.7	34.2	38.1
NSUP	19.7	24.3	77.6

Vocational training and employment services for women			
FSU	18.4	41.3	40.3
NSUP	19.2	25.6	55.2
Microfinancing programmes			
FSU	14.3	42.3	43.3
NSUP	13.6	28.8	57.3
Legal services and advocacy services			
FSU	15.9	41.4	42.7
NSUP	16.1	31.5	52.4
Safe housing/shelter			
FSU	19.6	41.4	39.0
NSUP	26.4	27.1	46.5
Mental health services			
FSU	20.0	43.1	36.9
NSUP	25.5	31.5	43.0
Nutrition supplementation program for children			
FSU	30.0	38.4	31.6
NSUP	42.1	24.6	33.3
Other services for children			
FSU	39.4	33.7	26.9
NSUP	49.5	20.2	30.1

Table 37: Knowledge of community services

The highest knowledge in both groups is about the availability of male condoms. Nearly half the NSUPs and more than half of FSUs were aware that female condoms were not available in the community. NSUPs were better informed than FSUs about community services available for children. However, more than half felt these services were not present in the community or they were unaware about them. Substance users were relatively better informed about community peer outreach, HIV related information, and needle/syringe exchange. However, even among them, knowledge about drug substitution programs, anti-retroviral treatment and services to prevent mother to child HIV transmission was low.

Only 20-25% of women in both groups were aware of mental health services in the community. Knowledge of social welfare programmes like vocational training for women, micro-financing programmes, legal and advocacy services that could be accessed was also very low.

	NSUPs	FSUs
No knowledge about:		
Female condoms	89%	86%
Microfinance schemes	86%	86%
Substitution treatments	84%	79%
Legal & advocacy services	84%	84%
De-addiction services for women	80%	72%
Mental health services	74%	80%
Nutritional supplementation programmes for children	68%	70%
Gender sensitive HIV/AIDS prevention and care	69%	59%
Services for treatment of STIs	67%	65%
Voluntary HIV testing & counseling	65%	54%

Table 38: Knowledge regarding services

Utilization patterns and desire to utilize community services

In actually utilizing the services described earlier, approximately half the respondents from each group had access to male condoms. Nearly 50% of the NSUPs and more than 50% FSUs would like access to female condoms. As expected, more FSUs had access to community outreach services from NGOs and HIV counseling. However, less than 20% NSUPs, who also have a heightened vulnerability to HIV/AIDS, had accessed HIV counseling. Both groups had very low access to STD services, and NSUPs were less likely than FSUs to have used them. Access to de-addiction services for women was negligible. There was very low utilization of mental health services by both groups, despite high rates of mental morbidity. Very few had accessed vocational training services, microcredit groups or legal aid.

Services	Have accessed %	Not accessed, would like to %	Not accessed, don't want to %	Don't know %
Community outreach workers				
FSU	41.7	35.4	5.9	17.0
NSUP	31.1	34.0	10.1	24.8
Gender sensitive HIV/AIDS prevention and care material				
FSU	27.7	47.2	11.7	13.4
NSUP	16.4	46.2	19.4	18.0
Substitution treatment (buprenorphine etc)				
FSU	10.6	53.5	15.6	20.3
NSUP	4.1	36.6	33.7	25.6
Access to male condoms				
FSU	49.8	23.7	14.6	11.9
NSUP	50.8	20.3	16.4	12.5
Access to female condoms				
FSU	8.5	54.7	20.1	16.7
NSUP	4.0	49.2	26.4	20.4
Access to sterile needles and syringes				
FSU	37.4	35.4	13.5	13.7
NSUP	35.9	27.2	18.9	17.9
Voluntary HIV testing and counseling				
FSU	30.9	42.9	13.8	12.4
NSUP	19.1	42.0	20.6	18.3
Facilities for diagnosis and treatment of STIs				
FSU	18.2	48.5	17.8	15.5
NSUP	10.2	41.3	24.3	24.2

Anti-retroviral treatment				
FSU	9.3	45.8	17.4	27.5
NSUP	6.8	30.8	25.8	36.5
Services for prevention of mother to child HIV transmission				
FSU	12.5	41.5	24.1	24.5
NSUP	8.0	38.3	18.6	29.3
Deaddiction and drug treatment services for women				
FSU	14.6	51.9	16.0	17.4
NSUP	5.4	35.0	31.1	28.6
Vocational training and employment services for women				
FSU	11.3	63.6	9.4	15.7
NSUP	9.0	54.9	12.7	23.4
Microfinancing programmes				
FSU	8.9	61.2	9.0	20.9
NSUP	6.7	51.0	12.9	29.4
Legal services and advocacy services				
FSU	7.5	61.2	14.9	16.4
NSUP	5.0	63.8	22.3	18.9
Safe housing/shelter				
FSU	14.7	63.3	9.7	12.3
NSUP	21.4	52.7	13.6	12.4
Mental health services				
FSU	11.1	65.7	11.1	12.0
NSUP	12.4	56.1	17.7	13.8
Nutrition supplementation program for children				
FSU	21.7	61.2	7.6	9.5
NSUP	31.8	52.0	7.1	9.1
Other services for children				
FSU	28.4	54.2	7.5	9.9
NSUP	41.8	42.7	6.7	8.9

Table 39: Access to/desire to access community services

Knowledge of services and utilization across regions

Among respondents who knew about community peer support, nearly a third were from the Northeast, a quarter from the North and a little over one-fifth from the East. The patterns for drug related services were similar.

Top 10 services, in rank order, that NSUPs have not but would like to access:

Legal and advocacy services	64%
Mental health services	56%
Vocational training	55%

Needs of women affected by substance

There is little data on the characteristics and needs of women substance users in treatment. Women represent 1 to 10% of all admissions to treatment centers throughout India. A retrospective characterization of 35 women seeking help at a de-addiction centre in North India (Grover et al 2005) revealed that the typical subject was urban, married, with opioids being the commonest drug of abuse. Common reasons cited for use were medical. Co-morbidity and impairment in functioning, especially social functioning were common symptoms.

It is common clinical experience that when a man requires treatment for substance misuse or dependence, it is the wife who normally brings him for admission and follow-up. Sadly, when the woman herself is affected, whether or not her spouse has a substance problem, she does not present herself for treatment unless there are serious physical complications, and almost never comes for follow-up in an institutional setting (Prasad et al 1998). In the present study, hostility and lack of concern from the family were the commonest responses perceived by FSUs.

Housing/shelter	53%
Nutritional programmes for children	52%
Microfinance	51%
Female condoms	49%
Gender sensitive HIV/AIDS material	46%
Other services for children	43%
Voluntary HIV testing and counseling	42%

Top 10 services, in rank order, that FSUs have not but would like to access:

Mental health services	66%
Vocational training	64%
Housing/shelter	63%
Legal/advocacy services	62%
Nutritional programmes or children	61%
Microfinance	61%
Female condoms	55%
Substitution treatment	54%
Deaddiction services for women	52%
Diagnosis and treatment of STIs	49%

Treatment services, even those that are comprehensive, rarely focus on women partners' gender specific issues like violence, HIV vulnerability, mental health and children's concerns. Considering children's extreme vulnerability to various emotional and behavioral problems, academic difficulties, and proneness to substance misuse, it becomes very important to integrate these issues into a comprehensive care programme. Facilities for women substance users are nearly non-existent in the country and urgently need to be developed. Despite such high rates of mental morbidity and suicidal attempts, the lack of awareness and access to mental health care is striking. Community based mental health services need to be strengthened, particularly for women enmeshed in substance use as partners or as users themselves.

Self-Help groups and micro-finance

In recent years, a significant development has been the growth of community based organizations and initiatives for women at the local level. Self help programmes combined with micro-credit have transformed many women's lives, enhancing their incomes, improving their quality of life and self esteem. The experiences of the Grameen Bank in Bangladesh, the Amul Co-operative in India and the Andhra Pradesh Tribal Development Project are some examples (UNESCAP 2002). There are several micro-finance implementing governmental and non-governmental agencies in India (SIDBI, NABARD, RMK etc). Vocational training for women has largely occurred in the context of funded projects, demonstrated success, but never been integrated as a community service that can be accessed and utilized by women.

Legal aid

Under Article 39 A, the Constitution of India provides that the State shall secure the operation of the legal system to promote justice on the basis of equal opportunity, and shall in particular, provide free legal aid, by suitable legislation or schemes, or in any other way ensure that opportunities for securing justice are not denied to any citizen by reason of economic or other disability. In 1980, a National Committee was constituted to oversee and supervise legal aid programmes throughout the country. The National Legal Services Authority was established in 1995, following the enactment of the Legal Services Authorities Act. On the ground, however, awareness of the general public about free legal aid is extremely poor. As always, the poor, disenfranchised, uneducated, poorly empowered women are the last to know. The findings in the study confirm this.

Summary Points

NSUPs have significant financial difficulties and emotional distress

In the present study, FSUs report that more than 60% of family members are aware of their substance use and their most common responses are hostility and lack of concern

A majority of FSUs have never received any treatment

NGOs are the most commonly accessed service providers

Government facilities are accessed half as often

FSUs and their partners are consistently less likely than partners of NSUPs to utilize any health services

FSUs place NGOs first in their list of potential support in the community

NSUPs rely the most on their spouses/partners, and also identify NGOs as important sources of support

NSUPs perceive greater support from their in-laws than their families of origin

FSUs place friends before family members as sources of support

Knowledge of availability of male condoms is fairly high compared to knowledge of other facilities

FSUs are more likely to be aware of peer community outreach, HIV related information and needle/syringe exchange

NSUPs are relatively better informed about services available for children

Only 20% - 25% of both groups are aware of mental health services available in the community

Patterns of service utilization mirror the knowledge about these services

Despite high rates of mental morbidity, knowledge of and access to mental health services is very low

Knowledge of, and utilization of social services in the community, like vocational training, micro-credit programmes and legal aid is very low

13.1 A Long Road To Recovery

Rita Singh, 28-year-old from Sikkim

I am the eldest of four children. My mother worked in a hospital and my father in a government department. My parents got divorced after my brother died of cancer and then my mother married another man. I have a stepbrother and a stepfather who treated me like a servant. One day, when I was 13, and mom had gone to Gangtok for work, he tried to rape me. The next day I told my mother everything but she did not trust me. I started resenting my stepfather and really hated my mom too. One day, my friend brought some pills to school. I used one and liked my first high very much. Then my addiction started. I used to take money to shop but share it with friends for drugs. I started injecting morphine and fortwin which was very expensive, but I had to manage it at any cost. Sometimes I stole money from home, or begged for it from my fellow addicts.

Due to my addiction, I failed my 11th class and returned to my hometown. One day, when my cousin and I were injecting he blacked out for a few minutes. I was really worried because he is the only son in his family. I tried my best to give him respiration and he woke up after 10 to 15 minutes. He told me I meant everything to him and we fell in love with each other. I lost my virginity at the age of19 when I was working in a private school, in the village. By this time, my veins had all collapsed, and I started injecting into an artery in the groin. It became very difficult to walk. Then I started to inject spasmoproxyvon. After six months, I left my job due to my addiction. At that time I was living with my family and though my mom would catch me with pills she excused me because she loves me very much. Our parents knew about our relationship, but my cousin's family wanted him to marry another girl and my mother wanted me to marry someone else. We surrendered to our parents' wishes, as we were real cousins. My life got worse. After six months, I got married to my best friend who is handicapped. After our marriage, I stopped using drugs. He is also an addict. He asked me for six months time to stop his pills. After he stopped I started using them again. My withdrawals were very painful. He used to give me two pills during the day and two at night. He didn't want to see me in the jitters (cold turkey). Then my family sent me to visit the psychiatrist in Gangtok. The doctor gave me some pills for six months, but I didn't take them. When I had an attack of hallucinations I visited the doctor again but it did not work, maybe because of my chronic addiction. My mother-in-law did not like me because I was from another caste and an addict. Many times she tried to torture me physically and mentally. So we left and started living in a rented room. After our second anniversary, my spouse became ill with tuberculosis. We both took the DOTS treatment but he died in 2004.

After his death, my in- laws threw me out and I started living with my mom. I used drugs more than before and soon found myself in a psychiatric hospital. During my bad days, my own drug using friends brought me drugs. My mother discovered this and sent me to a de-addiction centre. But I ran away four times because I was unwilling to stop the drugs. The center in charge referred me to a rehab in Sikkim but I ran away from there thrice. After seven days they found me. I was locked up in a black room for two days and kept in the

toilet for two to three hours. Then I was powerless. I have been working in the female unit of the rehab for 18 months . After my first sober birthday I met a guy who was also a recovering addict. We had a good relationship. Within seven months, I heard he was married with a kid. He had lied to me and told me he was a divorcee. We had both started using brown sugar after he spent all my money, and sold my jewellery, clothes, and shoes. Now, only I was left. I started going to NA meeting where my ex-addict friends told me to leave him. I detoxed myself in my friend's house but the illness was still active in me. I called my family to take me back. Though I was clean both my stepfather and stepbrother tortured me. I continued going to NA meetings and stayed clean for seven months but relapsed again. After one month my mom again sent me to the rehab. Now, I see myself working in the NGO for a few years and plan to become a counselor. I don't know. It all depends on God.

14 Women and Substance in Perspective

It is not alcohol, heroin or cocaine...it is an escape from harsh realities, temporary pleasure or relief from pain.

Introduction

In the previous chapters, individual areas have been addressed separately. This chapter attempts to integrate and correlate the information from the interviews and life narratives into a single picture to understand the problem from more than one perspective.

From earlier studies (Shankardass 2002, Murthy 2002), it is clear that NSUPs undergo tremendous difficulties. While the study provides a detailed insight into these problems, it highlights that FSUs are trapped in a worse spiral of adversity.

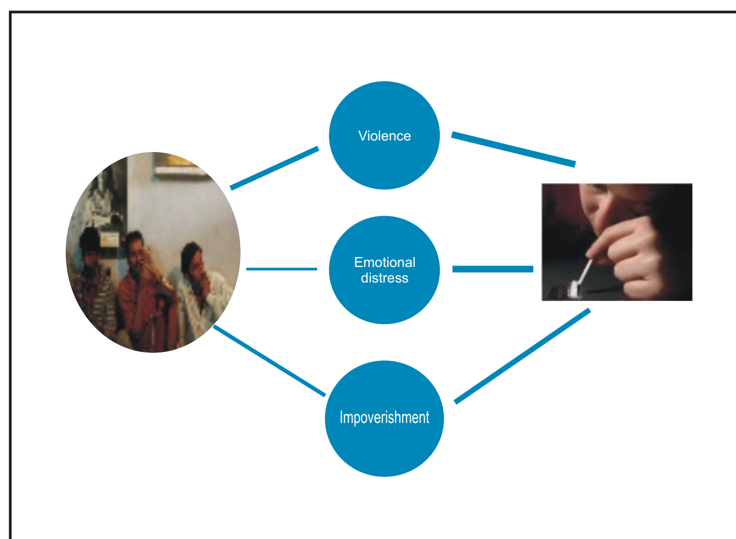


Figure 59: Substance use by self and partner and major adverse consequences

Whatever affects women partners equally affects women substance users. In addition, they have to face the consequences of their own addiction. So in every way, emotionally, socially, financially and in terms of vulnerability they are faced with a worse scenario. Thus, when we examine substance use among women, we are mostly examining the issues from a dual perspective: the impact of partner substance use coupled with their own substance use. NSUPs, however, more closely resemble women in the general population before exposure to a substance-using partner. These issues are further examined here.

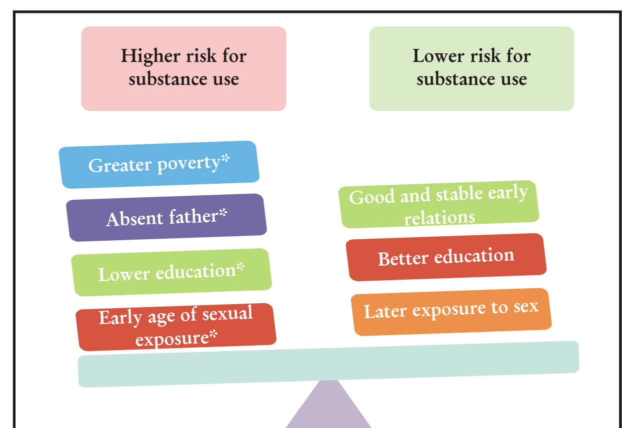


Figure 60: Early antecedents of substance use for women

The Substance, Women and High Risk Assessment findings: interpretation

Childhood antecedents

From the qualitative interviews, the significant themes that emerged among FSUs were childhood poverty, loss of father early in life, lower educational achievement, and early age of sexual exposure. The last two were also evaluated in the questionnaire.

Later life relationships

FSUs are likely to have more significant problems related to sexuality, such as a greater likelihood of being coerced into first sex, multiple sexual partners, and greater sexual violence. They are also more likely to have positive expectations from drugs with respect to sexual enjoyment and relief from pain. Some NSUPs also share these expectancies in relation to their partners' substance use. Despite more frequently being at higher risk to violence and HIV,

FSUs have a lower risk perception of themselves and their partners. They also tend to be less worried about children's issues. NSUPs have a better risk perception, are more likely to be in monogamous relationships and are, relatively, less likely to make suicidal attempts during the last year compared to FSUs, despite their high degree of mental distress.

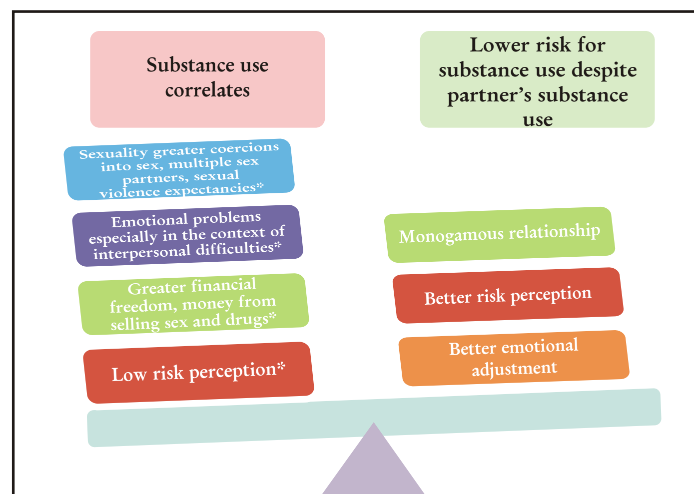


Figure 61: Later correlates of substance use

Stable childhoods inoculate, but don't entirely protect against substance use

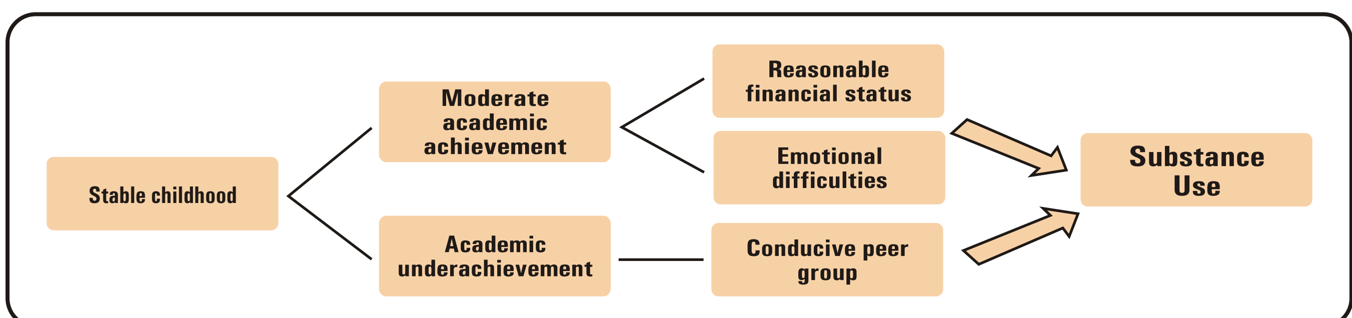


Figure 62: Other risk factors for substance use

The availability of substances in the community, substance using peer groups, heterosexual involvement with such peers and remunerative incomes when combined with emotional difficulties create another pathway to substance use among women.

Women partners: a high-risk group

There are several factors that put non-substance using women at risk. Proximity to partners using substances and commonly shared expectancies that substances can relieve physical/ emotional pain combined with poverty, low levels of autonomy including financial autonomy, poor access to health care and social services, and the stigma associated with substance use and related problems like HIV all place non-substance using women at an inordinately high risk to develop substance use, contract reproductive and sexually transmitted infections, suffer greater emotional distress and greater stigmatization.

Predictor	B	Wald	Sig.	95.0% C.I. for EXP(B)	
				Lower	Upper
Family size	.388	24.406	.000	1.263	1.719
Attempted self harm last year	.576	4.879	.027	1.067	2.965
Ever used alcohol	5.119	196.976	.000	81.784	341.655
Main income from drug peddling	2.521	19.728	.000	4.090	37.840
Using family planning method	-.659	6.782	.009	.315	.850
Asks permission to buy grocery	-.643	6.046	.014	.315	.878
Relies on friends for help	-.620	3.908	.048	.291	.995
Ever experienced sexual violence	1.053	16.161	.000	1.715	4.790
Ever experienced any violence	1.487	2.834	.092	.783	24.986
Partner likely to demand other forms of sex	-.627	5.000	.025	.309	.926
Sex less painful (under influence)	1.145	13.015	.000	1.687	5.856
Ever used tobacco	2.510	88.396	.000	7.290	20.754

Table 40: Predictors of substance use among women

Among those predictors based on the bivariate analysis, 38 were subjected to binary logistic regression. This identified 11 predictors as significantly contributing to classification as substance user or non-user. Ever use of alcohol and tobacco are highly significant and possibly eliminate many of the other psychosocial predictors with which they are highly inter-correlated. Family size, empowerment, sexual violence, sexual expectancies from substance use and emotional distress

are other important predictors that emerge as significant on logistic regression. Some of the factors significant in qualitative interviews (absent father, poverty) could not been included in the logistic analysis. These will need to be examined in larger samples, for their contributory role.

The antecedents of substance use among adolescents in the South Asian region were examined in study data from large-scale youth surveys conducted in Indonesia, Nepal, the Philippines and Thailand (Choe et al 2004). This study examined levels of substance use (drinking or smoking) and premarital sex among adolescents, including the factors associated with the initiation of these behaviors. Adolescent risk-taking behavior was more common in communities that have more permissive norms than others. At the family level, adolescents who spent their childhood in two-parent families and who have close relationships with their parents are more likely than others to avoid risk-taking behavior. A high level of parents' education is often found to be associated with the low likelihood of risk-taking behavior. It is likely that parents with high levels of education are better able to provide appropriate guidance for their children's behavior resulting in lower levels of risk-taking among their children. In developing countries, however, a higher level of parents' education, through better economic conditions, may be associated with easy access to substances and opportunities for premarital sex, and therefore, a higher prevalence of substance use and premarital sex during adolescence among their children (Choe et al 2004).

Summary Points

Women using substances are caught in a complex spiral of adversity

Looking at issues among FSUs most often involves examination of partner substance use and consequences

NSUPs resemble other women in the community with respect to factors preceding their involvement with a substance using spouse/partner

Childhood vulnerabilities (poverty, absent father, lower education, and early sexual exposure) emerge as significant predictors of substance use among women

Significant later life issues for substance use include sexual expectancies, sexual violence, coercive sexual experiences and sex with multiple partners

Despite their high-risk behavior and heightened vulnerability, FSUs, have relatively lower risk perceptions in relation to self, partner and children

NSUPs are a high-risk group who on account of social adversity, partner substance use, shared expectancies regarding the benefits of use and stigma can become substance users, and suffer more physical and emotional problems than they already face.

15 Developing Gender Sensitive Services

A substance free society...working towards that distant dream

The woman in India is presently in a complex psychosocial and economic-political spiral, which brings her many disadvantages. Add to this the complex matrix of drug use and HIV, and the ramifications become even more complex. A solution to any of these problems requires a recognition of the intertwining and often compounding nature of the issues involved.

Situation of women and girls in India

The National Institute of Public Cooperation and Child Development (NIPPCD) released a document on the statistics of women in India, in 2007. There has been affirmative action to involve women into the mainstream of development, with an increase in female literacy from 8.86% in 1951 to 54.16% in 2001; an increase in women's workforce participation from 19.7% in 1981 to 25.7% in 2001. However, there are important areas where progress is slow if not retrograde. Examples include reducing sex ratios of girls aged 0-6 years from 945 in 1991 to 927 in 2001; early marriage (nearly 50% of women are married before the age of 18 years), the problem of anemia that affects 57.9% of pregnant women and high maternal mortality rates, still at 301 maternal deaths per 100,000 live births in 2006 (NIPCCD 2007).

Solutions to address the problems of NSUPs and FSUs must be viewed in these contexts, many of which are highlighted in the study.

Stigma and discrimination with substance use- the double burden

FSUs are more stigmatized than their male counterparts because their activities are considered a 'double deviance' by society: taking drugs is seen as a deviance from accepted social codes of behavior and from the traditional expectations of a wife, mother and family nurturer. Add to this the stigma of HIV, and the burden increases exponentially, and can lead to catastrophic consequences in the absence of help and support.

There is a general lack of knowledge regarding women-oriented substance abuse treatment. There is a greater need to understand the gender issue and how it relates to substance abuse and HIV. There is a need to develop strategies that discourage substance abuse, deal with situations that may foster its development, promote recovery and rehabilitation. Services for women need to be developed for all stages of life.

Specific services for women using substances

There is an urgent need to develop services that are women friendly, community based, and easily accessible. Women do not readily approach formal services, and receive relatively less support from their families to seek treatment for substance use related problems.

There are several barriers to the development of comprehensive services for NSUPs and FSUs. These include systemic, structural, social and personal barriers (UNODC 2004).

Systemic barriers: Lack of decision-making powers

Lack of gender sensitivity (for e.g. women are less able to negotiate condom use), lack of knowledge of specific socio-cultural needs of FSUs, lack of appropriate gender responsive, low-cost evidence based treatment, lack of a comprehensive array of services.

Structural barriers: Include childcare, structure of treatment programs, inflexibility, immediate response capacity, location of treatment services, physical safety, service co-ordination and linkage, information on treatment options.

Social and personal barriers: Include disadvantaged life circumstances, stigma shame and guilt, fear of losing custody of children, lack of support from spouse, in-laws and family of origin, not being allowed to seek treatment till very sick and unable to fulfill family responsibilities, perception of wanting to handle it themselves and lack of faith in treatment efficacy.

Action from the specifics to the general

1. Comprehensive assessment and treatment programme that ensures the development of a client-centred treatment plan and focuses on issues concerning partners, family relationships and responsibilities, pregnancy, high-risk behaviors, trauma history and mental health problems. It should also include client's willingness to participate in treatment, possible inclination to suicide and possible obstacles involved in participation (UNODC 2004). Although some women require residential services, community based outpatient or day services may have many advantages in terms of being more accessible and less costly. Aftercare and social integration components, particularly skill development, employment training and help with a place to stay, especially for women on the streets, are important interventions. Women injecting users need harm minimization approaches, in-depth education about risky injecting practices and drug substitution. Reducing risky sexual behaviors is an urgent need. The availability of female condoms in India is low, even though this is a perceived need among many respondents.
2. Comprehensive interventions include gender specific treatment services, childcare, care during pregnancy, parenting skills and psychosocial interventions to address mental health care and living issues. Relapse prevention, inter-personal communication, engaging extra-treatment support, and attention to practical aspects of food, shelter and medical care, all need to take gender into consideration.
3. These services need to be developed both in the community and in institutions. NGOs offering substance use services should be strengthened and trained to offer gender sensitive services. Such services need to be expanded in the community
4. Primary health-care models should be much more broad-based.
5. Government facilities need to undergo a sea change, and become more receptive and sensitive to people, especially women's needs
6. Intervention services for men must involve care for women partners, especially spouses, and address issues of

physical and emotional health, gender specific vulnerabilities and children's concerns

7. Community based, family-centered follow-up and aftercare services need to be developed
8. It is necessary to pay attention to training and capacity building in order to reduce drug use, support programs that address HIV risk prevention for NSUPs and FSUs engaged in high risk sexual behavior, and increase participation of women in drug demand reduction programs.
9. Networked services within the community, so that women can easily access medical services, gynecological services, STI and HIV counseling, pediatric and adolescent services (which need to be developed), mental health services, legal aid services, employment services, women's wings in government, self-help and vocational training facilities.
10. Sensitization of the police, judiciary and other protective agencies towards developing gender sensitive approaches
11. Special facilities for women with special needs the elderly, street children, pregnant mothers, women engaged in commercial sex, women with mental health problems, and women in institutional care, including prisons
12. Interventions for children at high risk
13. Women's knowledge of what services they need, what exists and how to access them is low. They have a desire to know more and the need for services to be provided in the community. Access to correct information on the problem,

A comprehensive approach would include the following:

- Community and institution based, gender sensitive, user friendly interventions in both the non-government and government sectors
- Gender sensitive interventions for NSUPs
- Gender sensitive treatment services for FSUs
- Women centered self-help groups for FSUs
- Early intervention for the emotional difficulties of both groups
- Networking of services in the community for women (medical, gynecological, STD clinics, mental health services, women in institutional settings)
- Vocational training, self help groups for recovering women
- Life skills enhancement focused on building self-confidence, good coping, assertiveness to handle pressure to use substances or engage in early sex
- Education of girls, focus on skill- based learning
- Addressing practices/policies/laws discriminatory to women
- Making systems within the community (health, legal, police) more socially receptive and gender sensitive
- Alliance with civil society including NGOs, community leaders, panchayats, municipality leaders, and the private sector
- Building up pro-social affiliations including religious and faith-based organizations to address women's issues and needs
- Fostering healthy interdependence, strengthening families, enhancing support within family systems
- Gender equality from the grass roots to the national level
- Self help initiatives that translate into collective action at the community level
- Sustained poverty alleviation programs
- Advocacy for a drug free society
- De-normalization of licit substance abuse

Low threshold community services

- Safety/protection from violence, a place where women can rest and are not pressured by male partners or other men in their lives such as sex partners;
- Health care and women-specific health promotion, either in-house or through active referral networks-gynecological care was identified as being particularly important;
- Harm-reduction information to reduce women's risk of contracting blood-borne diseases by providing specific information on safer injecting and safer sex practices;
- Crisis intervention through staff of some services that have been trained to provide immediate assistance to women who have been sexually or physically abused;
- Motivational counseling, case management and 'qualified' referral, recognizing the importance of developing a trusting relationship with women clients, in order to work in the context of the priorities and needs they identify and to make appropriate referrals. A relationship with a particular worker is also important.

Recommendations of the Pompidou group- in UNODC (2004)

At the societal level, several initiatives focusing on the social milieu, which facilitate or encourage the development of problems related to substance abuse need to be taken. While some of these already exist in a rudimentary form, others need to be developed. Some of the common cultural practices in the region, which may have a protective effect against substance use development, need to be identified and strengthened. The following list may read more like a wish list, but the processes of change within society need to be set in motion, if any change is to be expected.

Thus, at the societal level, there is a need for the following:

- Identification and correction of discriminatory laws, practices and policies against women
- Opportunities in the community for people to ventilate and share distress
- Facilities in the community for people to clarify doubts and misconceptions and obtain support for any distress, present or anticipated
- Strengthen well-known and potentially supportive structures in the community such as the family unit. Hostility perceived from families often emerges from helplessness. Families must be supported to be able, in turn, to provide support to their members
- For persons without families or when families are irreparably damaged, the presence of other informal structures like self-help groups
- Stepped care approach for people needing help: community care workers, local NGO networks and more specialized services and dialogue across such service providers
- Confidential reproductive health and sexual counselling
- Strengthening community belongingness through pro-social activities. Spiritual and faith-based affiliations may be part of this
- Review of the education system to make education more relevant, vocation-based education for children with limited academic ability or interest, informal education programmes for girls unable to attend school

- Life skills components to address issues of sexual vulnerability, developing assertiveness and critical thinking especially on issues of substance use and sexual coercion, as well as developing skills to handle and cope effectively with stress

There is an overwhelming need for research in the area of women and substance use, especially in addressing violence and mental distress, ensuring sexual and reproductive well-being and protection of children in high-risk households.

Comprehensive services: The beginnings

The Eleventh Five Year Plan proposes to undertake special measures for gender empowerment and equity. During the last decade, several schemes of assistance have been developed in the government sector through the Ministry of Women and Child Development, Central Social Welfare Board, Department of Education, Ministry of Rural Development, Ministry of Housing and Urban Poverty Alleviation, Ministry of Social Justice and Empowerment, Ministry of Health and Family Welfare, and many other ministries. A National Policy for Empowerment of women has been formulated, and the critical areas of concern raised are poverty, education and training, health, violence, economy, decision-making, human rights and empowerment (NIPCCD 2007). India is a signatory to several major international human rights instruments. Interventions for women partners and women substance users must take into cognizance these developments, and both government and non-government sectors need to participate in addressing the enormous social, health and economic consequences of substance use for women.

Demand reduction work in the northeastern states of India, focuses on women stigmatized and facing social ostracization, with compounding problems of HIV positivity through the CHARCA initiative (Singh et al 2004). This work has resulted in funding for a treatment and rehabilitation centre and the employment of gender sensitive peer educators. Income generating activities have been initiated through self-help groups. A project on Prevention of Transmission of HIV among substance users in the South Asian Association for Regional Cooperation (SAARC) countries is making key stakeholders aware of the gender dimensions of the problem. It ensures that FSUs have better access to easily available and accessible services for HIV prevention. It includes issues of gender and sexuality in a project related to substance abuse and HIV/AIDS among young people.

Examples of comprehensive programs are also emerging from the private and voluntary sector. Sharan, an NGO, has trained women staff to provide gender sensitive women's programs that include detoxification, awareness and counseling, adult education, vocational guidance and skill building, child facilities like immunization, education and crèches, self-help groups, interventions to improve nutrition, etc.

In Imphal, IDUs and their families have been provided comprehensive care, which includes substitution therapy, abscess management, needle syringe exchange programs and DOTS treatment for tuberculosis. The services are provided through drop-in centers operated by the Social Awareness Service Organization (SASO) founded by former drug users. Services that were added later, include HIV voluntary counseling and testing, programs to prevent mother-child transmission of HIV, prophylaxis and treatment of HIV related opportunistic infection and antiretroviral therapy. The organization collaborates and receives support from local government, communities and international agencies.

Prevention requires extending the interventions much beyond tertiary care, de-addiction care centers and specialized HIV units. Such efforts need to be based in the community and involve education departments at the school and college level, departments of women and child welfare, as well as service providers engaged in delivering national programmes for women's empowerment.

The format provided below, may help to guide treatment providers and policy makers in formulating interventions and programmes for women affected by substances. These are by no means exhaustive, as the prevention of substance use and timely intervention needs more than just the participation of government and non-governmental agencies. It needs an active participation of all key players, including the private sector and civil society.

Table 41: Addressing the problems of women and substance use

Problem	Domain	Action	Responsibility for Programming and Policy (Recommendations)
Women partners are completely neglected in treatment	Treatment services	Evaluation, counseling and support for women partners must be a routine component of all treatment services	Centres providing treatment and aftercare services in the non-government, government, and private sectors To be included in minimum standards of care of NGO (MSJE)and GO (MOHFW) centers
Women partners have high vulnerability to HIV/other STIs Despite being at high risk few partners/women users have been offered testing, counseling and treatment	Knowledge/attitude/practice /accessibility to counseling and treatment	Counseling, testing, information and treatment to all women partners	Treatment providers Networks with Integrated Counseling and Testing Centers (ICTC) , ART centers, STD clinics (NACO/SACS/NRHM)
Women substance users have little knowledge of the consequences of harm from specific substances and do not seek treatment until serious complications occur	Poor knowledge Delay in identification and referral to services	Awareness of the risks of substance use Specific focus on addiction potential of psychotropic drugs Early identification	Service providers through outreach Mass awareness through media Training of health care providers regarding judicious prescribing and recognition of early signs of addiction Early counseling/referral
Women with drug use hardly access treatment services Caring for dependent children	Gender sensitive treatment facilities Inadequate knowledge among potential users and poor service utilization Lack of dependent child care service	Develop specialized services for women and dependent children	NGOs/GOs with support from MSJE/MOHFW
Even those who access treatment tend to relapse because of interpersonal difficulties as well as craving and peer pressure	Interpersonal difficulties Craving and peer pressure also contribute to relapse	Relapse prevention as part of every addiction treatment program Community based follow up and after care	NGOs CBOs FBOs MSJE

Women partners and substance users have high levels of depression, anxiety and suicidal thoughts	Psychological distress	Psychological support Access to mental health care Distress help lines	Treatment providers for de-addiction Use of peer counselors Training of mental health professionals Community support groups (NGOs, FBOs and CBOs)
Women users perceive lack of support from families	Poor understanding of addiction Helplessness, hopelessness and lack of resources	Family centred counseling and support for families Strengthen community support systems	CBOs NGOs FBOs SHGs Media
Women partners face extreme financial hardship Women using substances are more likely to be involved in peddling and selling sex than women who do not use	Impoverishment and financial distress	Vocational rehabilitation And income generation	Ministry of Women and Child welfare Extend schemes of the GOI /voluntary sector to such women Ministry of Labor
Women substance users have very little knowledge of harm minimization	Poor availability and lack of knowledge of safer evidence based harm minimization practices	Equitable access to needle/syringe exchange, oral substitution, antiretrovirals, treatment of medical complications	Treatment providers NGOs, CBOs, FBOs MOHFW NACO MSJE
Women partners and women substance users are unable to negotiate safe sex	Assertiveness skills	Training programs for women	CBOs, NGOs, FBOs Ministry of Women and Child Welfare Ministry of Education NACO
Prescription opiates and other drugs are common drugs of misuse by women throughout the country	Poor monitoring of distribution and sales of psychotropics Poor prescription monitoring Over the counter dispensing of scheduled drugs/drugs prone to addiction	Ensure dispensing at pharmacies through prescription only Increase awareness of dispensing staff	MOHFW DCGI Drug Controller IMA and regional branches Sensitization of medical officers (government and private sector) Media
'Licit' substance use (alcohol and tobacco) among women users is high	Lack of knowledge of public health problems Dichotomous thinking (illegal bad, legal not so bad)	Social awareness	MOHFW Ministry of Education Media

Illiteracy and Poverty	Lack of literacy skills and money	Maximise coverage through literacy mission, Ensure that the needy are reached by various Government schemes	Informal education schemes Vocational training Ministry of Education Poverty alleviation programmes Women welfare schemes
Many partners and women users are unable to make decisions about protecting their own health and well-being	Lack of autonomy and disenfranchisement	Challenging practices, policies and laws that disempower people or prevent access to equitable resources and care	Ministries of Education, Law, Women and Child Welfare, Rural Development, Health and Family welfare National Commission for Women
Early coercion into sexual activity, adverse family situations are related to later substance use	Life skills including assertiveness skills Child labor Domestic abuse	Equitable access to education Preventing child labor Protection against domestic abuse Teaching life skills to girl children Prevent trafficking	Ministries of Education Women and Child Welfare Law, Home Affairs CBOs, NGOs, FBOs SHGs National Commission for Women NACO
The issues of women partners and women substance users and their	Scientific understanding of problems, treatment and	Research and demonstration projects	Ministries of Science and Technology, MSJE, MOWCW, MOHFW,

CBO Community Based Organization, FBO Faith Based Organization, ICTC- Integrated Counseling and Treatment Centers, MOHFW Ministry of Health and Family Welfare, MOWCW Ministry of Women and Child Welfare, MSJE Ministry of Social Justice and Empowerment, NACO National AIDS Control Organization, NCW National Commission for Women, NGO Non Governmental Organization, NRHM National Rural Health Mission, SACS State AIDS Control Societies, SHG Self Help Group.

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List of Abbreviations

AIDS	Acquired Immune-Deficiency Syndrome
C B O	Community Based Organization
DAMS	Drug Abuse Monitoring System
DOTS	Directly Observed Therapy Short-course
FIDU	Female Injecting Drug User
FSU	Female Substance User
HIV	Human Immunodeficiency Virus
ICRW	International Center for Research on Women
IDU	Injecting Drug User
IIPS	International Institute for Population Sciences
MSM	Men having sex with men
NACO	National AIDS Control Organisation
NCAER	National Council of Applied Economic Research
NFHS	National Family Health Survey
NGO	Non Governmental Organization
NHS	National Household Survey
NIDA	National Institute of Drug Abuse (USA)
NSUP	Non substance using (woman) partner
RAS	Rapid Assessment Survey
RSRA	Rapid Situation Response Assessment
RTI	Reproductive Tract Infection
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNDCP	United Nations International Drug Control Programme
UNDP	United Nations Development Programme
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNIFEM	United Nations Development Fund for Women
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

List of Partner NGOs

Reducing Substance Use Related HIV Vulnerability in Female Drug Users & Female Partners of Male Drug Users

AD/IND/05/I49

PNGOs				
Serial No.	Zone	NGO Name	City	State
	NORTH EAST			
1		Social Care Ministry	Churachandpu	Manipur
2		Rural Health Organisation	Imphal West	Manipur
3		Born Again Rehabilitation Centre	Ukhrul	Manipur
4		Manipur Rural Institute Society	Imphal	Manipur
5		Integrated Women and Children Development	Imphal	Manipur
6		Chain Group of Positive People	Imphal	Manipur
7		Centre for Mental Hygiene	Imphal	Manipur
8		The People's Welfare Organization	Imphal	Manipur
9		North East Society for The Promotion of Youth & Masses	Guwahati	Assam
10		SASO	Imphal	Manipur
11		Sneha Bhawan	Imphal	Manipur
12		Nirvana Foundation	Imphal	Manipur
13		Kalyan Samity	Agartala	Tripura
14		Nagaland Users Network	Kohima	Nagaland
15		Shalom Rehabilitation Centre	Chumukedima	Nagaland
16		Prodigal's Home	Dimapur	Nagaland
17		Shansham Organisation	Mon	Nagaland
18		Jerrimen Youth Society	Mokokchung	Nagaland
19		Manbha Foundation	Shillong	Meghalaya
20		Voluntary Health Association	Itanagar	Arunachal Pradesh
21		Blessing Home	Aizawl	Mizoram
22		Faith Home	Aizawl	Mizoram
23		New Life Home Society	Aizawl	Mizoram
24		Social Guidance Agency	Aizawl	Mizoram
25		Women Anti Drug Association	Lunglei	Mizoram
26		Zoram Drivers Romthim Board	Aizawl	Mizoram
27		Ferrando Integrated Women Development Centre	Aizawl	Mizoram
28		Sikkim Rehabilitation Detoxification Centre	Gangtok	Sikkim
	EAST			
29		Vivekananda Education Society	Kolkata	West Bengal
30		West Bengal Voluntary Health Association	Darjeeling	West Bengal
31		Indian Research Institute for Integrated Medicine	Howrah	West Bengal

32		Drive for United Victory Over Addiction (DUVA)	Kolkata	West Bengal
33		Bikash Bharati Welfare Society	Kolkata	West Bengal
34		Human Development and Research Institute	Kolkata	West Bengal
35		Elmhirst Institute of Community Studies	Santiniketan	West Bengal
36		The Calcutta Samaritans	Kolkata	West Bengal
37		Probudha Bharati Sishutirtha	Medinipur	West Bengal
38		Bhairavi Club	Khurda	Orissa
39		Arun Institute of Rural Affairs (AIRA)	Dhenakanal	Orissa
40		Nikhila Utkal Harijan Adivasi Seva Sangha	Bhubaneshwar	Orissa
41		Vishwa Jeevan Sewa Sangh (VJSS)	Bhubaneshwar	Orissa
42		National Institute for Community & Child Development (NICCD)	Khurda	Orissa
43		JKYC	Puri	Orissa
44		RDAC	Mayurbhanj	Orissa
45		GITA	Bhubaneshwar	Orissa
46		Mahila Shishu Kendra	Muzaffarpur	Bihar
47		Ekta Gram Seva Sansthan	Hajipur	Bihar
48		Sister Nivedita Memorial Trust	Patna	Bihar
49		Central English Academy	Gaya	Bihar
50		Bihar Vikas Parishad	Motihari	Bihar
51		Bharatiya Gramotthan Evam Janhit Seva Sansthan	Bokaro	Jharkhand
52		The Calcutta Samaritans	Jamshedpur	Jharkhand
53		Kripa Foundation	Darjeeling	West Bengal
	SOUTH			
54		WORD	Namakkal	Tamil Nadu
55		CENDECT De-addction Centre	Theni	Tamil Nadu
56		Khajmalai Ladies Association	Trichy	Tamil Nadu
57		M.S. Chellamuthu Trust & Research Foundation	Madurai	Tamil Nadu
58		Athencottasan Muthamizh Kazhagam-AMK	Kanyakumari	Tamil Nadu
59		Trivandrum Social Service Society	Thiruvananthapuram	Kerala
60		Navadarsangaram Treatment Centre	Idukki	Kerala
61		CSRD	Calicut	Kerala
62		Empower	Tuticurin	Kerala
63		Link De addiction and Counseling Centre	Mangalore	Karnataka
64		Prajna Counseling Centre	Mangalore	Karnataka
65		People's Action for Social Service	Tirupati	Andhra Pradesh
66		Helping Hand Society	Warangal	Andhra Pradesh
	WEST			
67		"Jhep" De-addiction & Rehabilitation Centre/Janhitay Mandal	Chandrapur	Maharashtra
68		Shree Shivaji Shikshan Prasarak Mandal	Hingoli	Maharashtra
69		NARC	Mumbai	Maharashtra
70		Muktangan Mitra	Pune	Maharashtra
71		Nav Jeevan De- addiction Center/Bharatiya Adim Jati Sevak Sangha	Nagpur	Maharashtra

72		Mukti Sadan	Pune	Maharashtra
73		Bahekarji Vyasan Mukti Kendra/Shri Ganesh Gramin Vikas Shikshan Sanstha	Gondia	Maharashtra
74		Jeevan Rekha Prathishthan	Latur	Maharashtra
75		Mukti Sadan	Mumbai	Maharashtra
76		Sankalp De addiction Centre	Raipur	Chhattisgarh
77		Nav Jeevan De- addiction Center	Bhopal	Madhya Pradesh
78		Shanti Niketan De-addiction Centre/Shanti Niketan Mahila Kalyan Samiti	Bhopal	Madhya Pradesh
79		Assem Jyoti Sanskritik Siksha Parishad	Gwalior	Madhya Pradesh
80		Ajay Arvind Shiksha Samiti	Gwalior	Madhya Pradesh
81		Ruby Shiksha Evam Samaj Kalyan Samiti	Gwalior	Madhya Pradesh
	NORTH			
82		Prerana	Lucknow	Uttar Pradesh
83		Jan Kalyan Sewa Samiti	Kanpur	Uttar Pradesh
84		Bharatiya Samaj Sewa Sansthan	Lucknow	Uttar Pradesh
85		Shakti Sadhana Sansthan	Sitapur	Uttar Pradesh
86		Smt. Kaushilya Devi Poorva Madhyam Vidhyalaya Samiti	Etawah	Uttar Pradesh
87		Archna Mahila Kalyan Samiti	Barabanki	Uttar Pradesh
88		Dwaba Kalyan Samiti	Allahabad	Uttar Pradesh
89		Gram Sewa Niketan	Lucknow	Uttar Pradesh
90		Harijan Vikas Avam Samajik Utthan Samiti	Allahabad	Uttar Pradesh
91		Hasrat Mohani Charitable Society (Hospital)	Kanpur	Uttar Pradesh
92		Khandwari Devi Shiksha Prasar Samiti	Chandauli	Uttar Pradesh
93		Lakshya Service Foundation	Varanasi	Uttar Pradesh
94		Shanti Sarvodaya Sansthan	Gonda	Uttar Pradesh
95		Gunjan	Dharamsala	Himachal Pradesh
96		Red Cross	Gurdaspur	Punjab
97		Guru Gobind Singh Study Circle	Ludhiana	Punjab
98		Guru Nanak Charitable Trust	Ludhiana	Punjab
99		SEHAT	Mohali	Punjab
100		Nirashrit Mahila Balvikas Gramodyog Shiksha Samiti	Bharatpur	Rajasthan
101		Dantour Vikas Sarvajanik Puniyarth Trust	Bikaner	Rajasthan
102		Adarsh Bikaner Bal Shikshan Parishad	Bikaner	Rajasthan
103		J.R. Tantia Charitable Trust	Sri Ganganagar	Rajasthan
104		H.N.S.S De-addiction- cum Rehabilitation Center	Sri Nagar	Jammu & Kashmir
105		J & K Society for The Promotion of Youth and Masses	Jammu	Jammu & Kashmir
106		Navjyoti Foundation	Delhi	Delhi
107		Bapu Nature Cure Hospital and Yogashram	Delhi	Delhi
108		NADA	Delhi	Delhi
109		SAHARA	New Delhi	New Delhi

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