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Centre for Advocacy and Research

Prevention of Transmission of HIV among Drug Users in SAARC Countries

Gender Strategy

"Developing a Gender Strategy for Prevention and Transmission of HIV among Drug Users in SAARC Countries"

Gender Strategy

By

Centre for Advocacy and Research

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I. Project Background

The "Prevention of Transmission of HIV among Drug Users in SAARC Countries" is a regional initiative that seeks to strengthen regional co-operation and foster partnerships in a concerted effort to achieve the following:

- Combat the spread of HIV-AIDS among IDUs, other affected groups and sub-populations.
- Mainstream the on-going drug demand reduction and control programme into a well–coordinated, technically supported and standardized national and regional HIV prevention and risk reduction programme that targets marginalized populations with vulnerabilities to HIV and drug dependence. These include gender discrimination, unsafe migration, and large population movements including homelessness as cross-border refugees. The latter are known to indulge in highly risky survival practices such as mobile, low-paid and often transient sex work.
- Harness, scale-up, standardize, strengthen and then disseminate multi-sector involvement in the programme.
- Learn from the micro, nascent and pilot initiatives in different parts of the region that have introduced varied strategies to strengthen outreach, particularly among hidden drug-users; provide these people with services that address the basic issues including treatment using substitution based drug therapies.

Since the Programme seeks to create a long-term impact on the quality of response to the twin problems of HIV prevention and drug use, the strategy options reflect ***structural and process-centered priorities*.** These priorities are to:

- **Firstly,** improve the capacity of service-providers for more effective outreach with target populations and provide services in a community setting. It is hoped that these will help to create much-needed confidence in the communities at many levels, enable them to specifically perceive the service as affordable, doing least or no-harm and thereby encourage the hitherto neglected and marginalized drug-users to seek the services on a sustained basis.

- **Secondly**, to recognize the growing feminization of the drug-driven HIV epidemic and develop the necessary grassroots processes and interventions so as to strengthen the practical approach to building a gendered response that addresses the vulnerability of women to drug use and HIV-AIDS.

- **Thirdly,** ensure that through consistent regional and national advocacy, attention is drawn to the "changes" brought about in the quality of responses to drug-demand reduction intervention in the context of HIV-AIDS, with identifiable processes that evoke an-across-the-board ownership among different stakeholders.

With Project H-13 committed to "making the response to drug use and HIV-AIDS gender-sensitive" ***the major challenge of developing a gender strategy*** lay in being able ***to recognize***

the ***potential*** and ***actual opportunities*** for ***establishing more gender inclusive initiatives*** and ***interventions.***

Across the region, it is widely recognized that gender discrimination has fuelled the epidemic and increased women's vulnerability to HIV. This, in particular, holds true for populations that are addicted to substance use in various forms from injecting drug use and oral drug use to the almost all-pervasive habit of alcohol intake. According to the Project Document, in this region much of the problem is compounded by the fact that "drugs users are a hidden population". They are "hard to reach" and in the case of women who are wives and partners, they can experience the double disease burden of HIV and drug use.

Feedback from the stakeholders across the region clearly indicates that interventions particularly with women, who are wives and partners of drug users, are seriously hampered by barriers of stigma, discrimination and marginalisation.

Even where there is a will to confront or overcome these barriers, it is widely accepted that the capability to reach out to women and design appropriate and sustainable interventions is lacking. The H-13 programme will provide the much needed opportunity to "create the enabling environment" and the framework for strengthening programmatic and "technical capacities of service-providers" and programme leadership. More importantly, it will aim for saturated coverage as high as 80 to 90 per cent.

Given the Project Mandate, how did CFAR interpret its task to conduct a baseline study to develop a gender strategy for the Project H-13?

II. Methodology

Our methodology used a combination of tools. These included an extensive desk review followed by comprehensive field studies that included in-depth interviews, focus group discussions and regional and national workshops for National Focal Points and Regional Resource Training Centers.

Desk review

The desk research was conducted to identify the concerns and quality of responses from situational and programmatic assessments by concerned stakeholders, in particular, their perceptions of the critical linkages between the drug use scenario and its impact on different marginal groups. The stakeholders also gave their assessment of the legal and policy framework that mandates the response.

We examined the current debates and practices in the area of drug demand reduction in order to assess whether or not existing responses to drug demand reduction recognize the differential impact that drug use has on the lives of women and men. For instance, has there been any

mention, discussion or analysis of gender issues? Has any action been undertaken to reach out to women and if so, in where have these succeeded in establishing linkages with women? Moreover, if there are no well-developed women-centered initiatives then how should such nascent endeavours be strengthened? If there is no meaningful and sustained experience of working with women, should we recommend an agenda-setting approach and support interventions such as sensitization programs for institutions as a pre-requisite for the implementation of a gender-sensitive program?

Many of these concerns have been raised in the project proposal document and some were prioritized at a Stakeholders Consultation held at Agra. Although the desk review yielded rich evidence much of it was at the micro-level and piecemeal - it did not provide a comprehensive sense of the problem.

Regional Consultation

Participation in Regional Workshop for the National Focal Point

The Regional Workshop for National Focal Point, held in Kolkata, July 1-3, 2004 to develop a strategic monitoring and evaluation framework, provided us with an opportunity to meet representatives of key stakeholders including the National Focal Points from Bhutan, Maldives, Sri Lanka, Pakistan and India.

These interactions helped us form an overview of country-specific issues and common concerns. It also gave us some understanding of the efficacy of existing mechanisms for inter-sector collaboration between drug law enforcement, drug demand reduction and HIV prevention within the countries and in the region.

Similarly, the workshop held for RRTC's in Kolkata, February 11-12, 2005 was an important learning opportunity: presentations were made by experts with hands-on experience on the training and capacity-building strategies required at the regional level. CFAR made a brief presentation based on an FGD conducted among women drug users at the Sahara Home for Women and Children in New Delhi.

Key informant interviews

After these workshops, detailed questionnaires were sent to key representatives of different stakeholders in all the SAARC countries. These included government representatives at the policy and decision-making levels as well as to program heads, implementing agencies, grassroots groups and networks.

The questionnaire to decision-makers related to the issues of reduction of drug supply and demand, the mechanisms that had been put in place to tackle these and the effectiveness of existing linkages between different governments agencies in tackling different vulnerabilities, drug use and HIV-AIDS. An attempt was also made to document each country's experience in

addressing gender disparity, even if at the micro level, through women-friendly programs in life skill development, micro-credit or health schemes.

The questionnaire for program implementers, grassroots groups tried to shed light on innovative practices and initiatives undertaken in each country to reach out to women in difficult circumstances, including drug users. The emphasis was on outreach, drop-in-centers, rehabilitation or community-based care and support and women-friendly services or schemes suitable for women affected by drug-use that ensure a continuum of services.

Country Visits

Besides the questionnaires, field studies were undertaken in Bangladesh, Sri Lanka, the Maldives and India. These provided us with an opportunity to meet people working with various aspects of drug demand and supply in each country. They included official representatives, policy makers, administrative heads associated with drug demand /reduction/gender, trafficking, and law as well as those affected by the problems of drug use.

We were able to identify and visit programs and projects that attempt to integrate gender components or work to identify and reach out to hidden populations like women drug users.

Focus Group Discussion

One focus group discussion with an affected group of women was held in New Delhi, India**.** The participants were inmates of Sahara Women and Child Home, New Delhi. The FGD was conducted to help us, at the very outset, understand the reasons or factors that turn women into drug users. The women spoke of their personal experiences and those of others they knew and the disabling conditions that prevent their reintegration in society.

III. What were the common challenges that emerged?

a. Gender and Development: Regional Scenario

Since the proposed strategy is expected to reflect a regional perspective and approach, it is essential that we build on regional needs, expectations and experiences.

The objective of the interaction with various stakeholders was primarily to comprehend each country's perspective on what they considered as an appropriate approach, as well as any enabling process or a focused strategy they have used to use to build a gendered response to drug-use and HIV-AIDS.

We asked stakeholders to identify major opportunities and challenges for the Project, given that the lowly status of women across the region fuels the spread of HIV-AIDS and has a negative influence on women's risk perception of HIV-AIDS, irrespective of the context.

The region as a whole marked by uneven development, five countries - Nepal, Bangladesh, Pakistan, Bhutan and India - rank between 127 to 144 on the Human Development Index. In relation to Gender-Related Development Index (GDI), we find that countries such as Pakistan and Nepal rank as low as 120 and 119, respectively, closely followed by Bangladesh and India with a ranking of 112 and 103, respectively. GDI disaggregates the three dimensions in the Human Development Index to examine the prevailing inequalities between men and women.

Similarly, many other socio-economic indices such as access to health care or education reveal a highly discriminatory and exploitative scenario. The most damaging indices are those related to maternal mortality. The global human rights organization, Amnesty International, states that in 2000 the South Asian region has a maternal mortality rate of 566 deaths per 100,000 live births. Pakistan, India and Nepal have a rate as high as 500, 540 and 740, respectively. Anemia affects 88 per cent of pregnant women in India, 65 per cent in Nepal and 53 per cent in Bangladesh. The average regional illiteracy rate for women is 59 per cent for women and 35 per cent for men.

In the context of strategy formulation, these indicators present a stark picture of the disempowering conditions faced by women in the region. It is also apparent that the inability to deal with these adverse indicators could further weaken responses to the inter-linked concerns of drug use, HIV-AIDS and gender discrimination.

Already across the region - be it in highly literate country like Sri Lanka or less literate like Bangladesh, Nepal and India - there is low and uneven awareness among women, young and the poor on HIV-AIDS. [1]In Sri Lanka, only 40 per cent of women working in the rural tea estates have heard of HIV-AIDS. [2]A study done in Bangladesh showed that over 95 per cent of the 15-19 year old Bangladeshi did not know a single method of HIV prevention. [3]In India, the Behavioral Surveillance Study showed that a mere 20.7 per cent aware of STD-HIV linkages.

It is estimated (by UNIFEM) that across the region prevalence of domestic violence ranges between 50 to 80 per cent. [4]While 90 per cent Pakistani women report spousal abuse, [5]a recent study in India indicates that 24-60 per cent of female family members of male drug users reported “substance-use related physical and verbal violence against women”.

The linkage between sexual violence and HIV-AIDS are clear. Sometimes the transmission of HIV-AIDS is a “consequence of sexual violence” and at other times denies women the “power to insist on safe and responsible sex practices”.

[1] Regional HIV/AIDS Updates 2002, Sri Lanka, www.Inweb18.worldbank.org

[2] Regional HIV/AIDS Updates 2002, Bangladesh, www.Inweb18.worldbank.org
[3] Regional HIV/AIDS Updates 2002, India, www.Inweb18.worldbank.org
[4] Amnesty International, Media Briefing, News Service, 5th March 2004.

[5] Women and Drug Abuse, the Problem in India, UNODC and Ministry of social Justice and Empowerment Government of India.

b. Human trafficking

An equally disturbing trend is the linkage between domestic and cross-border trafficking and women's vulnerability to HIV-AIDS. In the context of gender inequality, low social status of women and lack of access to information and services, there is a lateral linkage rather than a linear cause and effect relationship.

When trafficking and unsafe migration in the region overlap with other vulnerabilities, they undermine human rights of women and question the validity of borders. Across the different phases of trafficking, women's vulnerability is increased by the loss or lack of livelihood opportunities and indebtedness, the lack of access to social and health services, as well as their marginalisation and exploitation by middlemen and employers

c. Women and Drug use

The main problem for women drug users is that because of the lack of support systems and the greater degree of stigmatization, most do not seek any treatment or any other form of help. They practice extreme forms of self-denial and persecution, often resulting in acute forms of emotional and mental stress and turmoil. In practical terms, this means that the women who are drug users or are married to users, predominantly, constitute a "hidden and a highly under-served population".

In South Asia, statistics on women drug users tend to be limited in nature and even contradictory because drug use data is seldom gender disaggregated. So they are not seen as a distinct group and hence substance abuse is generally perceived as a male problem. In fact, even those working in the area of drug use hesitate to speak in terms of numbers when it comes to women. However, a Rapid Assessment Survey (RAS)[6] done in 14 urban sites in India in 2001 has found that of the 4,648 drug users interviewed 371 or about 8 per cent were women while the number of female IDUs at 11 sites varied from 3 to 73.

A RAS conducted by the Narcotics Control Board in the Maldives (2003) found that of the 3,909 respondents 204 were drug users and of them 3 per cent were women while the National HIV Serological and Behavioral Surveillance, conducted in Bangladesh in 2000-2001 found 2-3 per cent of IDUs were women. These figures establish that in South Asia there is a significant number of women drug users and the chances are their numbers are growing.

Stereotypes of women drug users as poor, marginalized slum-dwellers, wives/partners of drug users, commercial sex workers who sell sex to support their habit or abuse drugs to deal with the stress of their profession, is also being challenged: women ***from all strata of society*** are turning to drugs. This phenomenon coincides with "the rise of mobile populations, broken families and

[6] The Extent, Pattern and Trends of Drug Abuse in India. National survey 2004 – UNODC and Ministry of social Justice and Empowerment Government of India.

collapsing communities." [7]In the Maldives' RAS, female drug users were educated with a mean age of 20.7 years and the age of initiation of first drug use was as low as 15.6 years while in Bangladesh a cohort study by the ICDDR, Dhaka found one woman IDU in the university and a circle of 40-60 teachers and students. The RAS done in [8]India found that in a conservative city like Chennai, "some women from higher socio-economic groups had been introduced to heroin by their boyfriends" and that "the drinking of alcohol by young girls was acceptable in social gatherings." The RAS also notes that "uniformly, the commonest drug of abuse to begin with was alcohol followed by cannabis and heroin". It added that the abuse of pharmaceutical substances was on the rise. What is perhaps more worrying is the finding that "between 50 to 83 per cent had positive family history of drug abuse" and a "large majority 75-90 percent had drug using friends."

It is widely accepted that the stigmatization of women drug users is far higher than men and discourages their reintegration into society. This situation is compounded by the lack of much-needed critical support from the family and community to overcome the problem.

d. Women and HIV-AIDS

Most women drug users are also in high-risk situations that make them vulnerable to HIV-AIDS, living as they do in male-dominated relationships and they have no authority to negotiate condom use. Women and young girls are often tortured and exploited by their husbands and boyfriends and pushed into selling themselves for sex to earn money. Some take to peddling and do it under cover of other petty business like selling vegetables or clothes. Men are known to lure female partners and wives into drugs because there are not many ways in which they can raise money for drugs apart from criminal activities which could lead to a prison sentence. A woman, however, can sell herself for sex and not get caught. So women smoke, chase and inject drugs and many of the proactive substances, whether they are injected or not, do affect the decision making ability about safer sexual behavior. [9]A recent BSS in Bangladesh indicated an increase in risky behavior vis-à-vis sharing of equipment and a decline in condom use in sexual encounters between IDUs and SWs.

It is also known that the stigma attached to HIV-AIDS or a woman in drug use is so great that it deters women from talking about either or seeking treatment. It is not unusual for families and communities to give up on them. In contrast, men will talk about HIV-AIDS or drug abuse and receive community assistance. Even when women drug users try to seek help, they are not able to do so because of the lack of adequate rehabilitation services for women. The Sri Lanka Anti-Narcotics Association (SLANA), for instance, notes that no woman has sought help at its referral

[7] Women and Drug Abuse, AHRN Newsletter, 16, July-August 1999.
[8] Women and Drug Abuse, the Problem in India, UNODC and Ministry of social Justice and Empowerment Government of India.

[9] HIV in Bangladesh: the present scenario, National AIDS/STD Programme DGHS, MOHFW, Bangladesh, November 2004.

desk since its inception in 1989. In [10]India key informants have reported that family members express "irritability and anger" towards women drug users, and that "women receive little support and service facilities were inadequate". In fact, women drug users will continue to remain a "hidden population" and vulnerable to HIV-AIDS, especially if they are partners of drug users or drug users themselves, if these lacunae are not urgently addressed.

IV. Mainstreaming Gender into HIV-AIDS Preventive Strategy

To bring women and girls into the ambit of a drug-demand intervention, a conscious effort has to be made; there must be the capacity and leadership to deal and engage with the concern at many levels. This must range from enhancing the confidence of girls and women and providing gender-sensitive services to creating an enabling and supportive environment for them.

It is clear that the imperatives of a gender strategy increase when the intervention on drug demand reduction is mainstreamed with an HIV-AIDS preventive strategy. There is also, the growing realization that many factors including drug use are fuelling the epidemic; more importantly these factors overlap and even converge in specific milieu and circumstances.

For instance, it is clear that gender inequality plays a major role in enhancing the risk for women. Studies conducted at ante-natal sites indicate that many more expectant women are testing positive. This indicates that the sexual route - be it as wife or as partner or as commercial sex worker - is the major form of transmission for women. What needs emphasis here is that women across the board are unable to demand or negotiate safe sex.

It is this combination of extreme vulnerability, entrenched discrimination and exposure to high-risk behavior that drives the epidemic among women. Therefore, any enabling strategy must incorporate the issue of high vulnerability as a concrete barrier and impediment.

Two parallel processes are required: firstly, the need to enhance the agency of the women and encourage a participatory process that helps women to self-assess the problem, develop ownership of the process and identify possible alternatives and solutions. Secondly, ensure that the concerned representatives of government or civil society are constantly sensitized to women's needs and are able to use the dialogue and feedback to develop interventions that are gender-sensitive. Such a response will be complex and necessitates a supportive legal and policy framework.

Rationale for a Gender Strategy to address the concerns of drug use and HIV

With the country-specific surveillance studies establishing the link between HIV-AIDS and drug use there is the growing realization that fresh strategies are required to understand and manage

[10] The Extent, Pattern and Trends of Drug Abuse in India. National Survey 2004 – UNODC and Ministry of Social Justice and Empowerment Government of India.

the transmission and behavioral dynamics that make people exceedingly vulnerable to either or both.

HIV has moved from small, scattered clusters of high-risk groups into the general population, affecting men, women and children even as the world watches with alarm. Drug abuse has made rapid inroads into all strata of society, unmindful of class, creed or gender. Another growing concern is that the number of injecting drug users (IDUs) is on the increase and is fuelling the HIV epidemic. In Bangladesh an estimated 10-20 per cent of drug users joined the ranks of IDUs every year during the last five years; in the Indian states of Nagaland and Manipur 75 per cent of HIV transmission has been through IDUs who share needles and syringes. One study found that 45 per cent of the wives of HIV positive IDUs are also HIV positive, providing ample evidence of the links between HIV, drug use and sexual relationships.

Identifying needs and concerns

The strategies that evolve must take into account the links between trafficking and HIV, between violence against women and HIV and provide "greater protection for women then they have received so far". Therefore, it is crucial that the strategies create and sustain an enabling environment that helps the women break the culture of "silence" and develop coping mechanisms to collectively address the problem.

Scope of the Strategy

The core objective of the Project is to develop the "capacity in the region for scaling up of HIV intervention among IDUs and other opiate users". The focus of the strategy is to recommend gender sensitive inputs. The **Stakeholders Consultations at Agra** stipulated that the gender strategy should aim at the following:

- To strengthen the evidence from the grassroots level on women drug users and those affected by the problem.
- To gain practical experience on how best to build linkages and interface with on-going programmes and advocacy interventions of the government and civil society organizations.
- To evolve relevant sensitization modules for policy makers, service providers and media.
- To develop essential monitoring and evaluation indicators to track the process and level of gender integration.
- To demonstrate in one dedicated project site the *modus operandi* of gender sensitive outreach and service.
- To obtain concrete experience and evidence for scaling up the project.

Given this emphasis on enhancing gender-friendly initiatives in these spheres, the strategy has to match the organizational experience, capacity and willingness of the drug-demand reduction sector to engage with gender. Moreover, this engagement with gender has to extend to different locations, through different processes and forms.

Therefore, the project document stresses that based on the recognition and assessment of these disabling conditions, there is a need to identify specific strategies and forge essential alliances and partnerships with organizations involved in on-going programmes and interventions at the regional and national scale.

Some of this should aim at strengthening advocacy on enabling and empowering conditions for women, improving their access to services aimed at HIV prevention and drug demand reduction including "sensitizing male drug users on reducing vulnerability". Some could be more specific responses to ground level situations and could contribute to pilot projects and micro-responses that the project is seeking to build to demonstrate do-able interventions.

V. Seeking to Mainstream Drug Demand Reduction Intervention into an HIV-AIDS Prevention Programme by Building on Existing National Responses: Country-Specific Experiences and Capabilities

a. Bangladesh

As the Project document has observed, in Bangladesh HIV-AIDS is being fuelled by the huge increase in risky behavior among IDUs who were first detected with HIV infections. In all the surveillance rounds conducted between 1998-2004, prevalence rates had remained below 1 per cent despite an estimated drug-use population of [11] "two million and growing." However, the [12]fifth surveillance round that prevalence rates among a small group of IDUs under second generation surveillance in one locality of central Bangladesh had escalated over the last three years from 1.4 per cent to 4 per cent to 8 per cent. More relevant to this project, 2.3 per cent of them were female IDUs.

The BSS also noted that 60 per cent of all IDUs had started to inject over the last two years, that sharing of drugs and equipment was common with 93.4 percent of over 500 IDUs in central Bangladesh saying that needle sharing was routine. More then half of heroin smokers in the survey said they had injected at some time in their lives. All of which has huge implications on their sexual partners.

The problem is compounded by other high risk factors: of the three-quarters of rickshaw pullers and truckers who had `bought' sex over the past one year, 83 per cent had never used a condom. Condom use was also as low as 4-28 percent among the country's 36,000 commercial sex workers who boast the highest clientele in Asia – 18.8 clients per week among brothel based sex workers and 44 among those who are hotel based. Interestingly, many of those surveyed said they had participated in or had been touched by intervention programs and that this exposure had been increasing over time.

[11] A DNC Study quoted in the International Narcotic Control Strategy Report-2003.
[12] HIV in Bangladesh: The present scenario. National AIDS/STD Program DGHS, MOHFW, November 2004.

Risk perceptions

HIV-AIDS prevention and control programs have been uneven as can be seen from the low levels of perception of personal risk even among high-risk groups like CSW, IDUs, rickshaw pullers and truckers who are the focus of targeted interventions. A National Assessment of the Situation and Response to Opioid/Opiate Use in Bangladesh (NASROB) notes that only 66 per cent of IDUs in districts without interventions knew that needle sharing could spread HIV while the BSS 2000-2001 found "very few rickshaw pullers and truckers knew how HIV was transmitted." It also found wide variations in self perceptions of risk with only one in three male sex workers and one in ten *hijras* considering themselves to be at any risk to HIV".

In such a scenario, an attempt was made to understand how various stakeholders perceive the Surveillance trends, where they locate the problem and their attitude to IDUs. In particular, do they have a gender strategy? What hurdles do they face in providing information and services to women and do the opportunities exist to reach out to them?

While, HIV-AIDS may not have a visible presence the same cannot be said for drug use in the country. Learning from other countries indicates that, "the presence of an HIV-AIDS epidemic among IDUs makes a huge difference over time in the number of people who are infected." Moreover, though HIV prevalence may be low the incidence of syphilis is high among IDUs in central Bangladesh[13] – as high as 40 per cent among brothel based sex workers. So the risk of transmission of HIV remains high.

With 23 female drug users infected with the HIV virus out of 95 new cases reported in 2004, there appears to be a growing resolve both among Government and NGO to address the issue of women drug users.

Policy response

The Bangladesh Government has been swift and positive in recognizing the need to control drug abuse. It has been a signatory to various international, regional and bilateral conventions aimed at preventing and controlling drug abuse. Its Narcotics Control Act 1990 has been strengthened by amendments in 2000, 2002 and 2004. It now provides direction for drug supply intervention and demand reduction activities in the country including the establishment of treatment centers.

A Master Plan for Drug Abuse Control prepared by the Department of Narcotics Control and UNDCP has put forward no less than 19 specific strategies to deal with drug demand reduction activities.

A National AIDS Committee was set up as far back as 1985 to deal with policy issues, mobilize resources and implement programs relating to HIV-AIDS. By 1997 a policy document that outlined the government's AIDS prevention management program was put in place and partnerships were forged with NGOs to support government activities in behavioral change and prevention activities.

[13] HIV in Bangladesh: Is time running out? National AIDS/STD Program DGHS, MOHFW, June 2003.

Donor support

The government has also received considerable support from the World Bank, which approved $40 million in 2000 for scaling up interventions among high-risk groups and strengthening program management. USAID, DFID and other agencies have also been financing social marketing, peer education and condom promotion activities.

Programmatic Gaps and Challenges

Yet Stakeholders admitted that in the context of drug use, technical capabilities and processes were still in the making and the country was currently engaging with the need to strengthen and develop capacities be it in outreach, mobilization or service delivery. The National Assessment of the Situation and Response to Opioid/Opiate Use in Bangladesh (NASROB) 2002 found IDUs in all the 24 districts it had surveyed with harm reduction services available in only four of them -Dhaka, Khulna, Rajshahi and Chittagong - for the estimated 200,000 drug users in the country. Equally alarming was that one-fifth of heroin smokers and one fourth of current IDUs had near death experiences due to poly drug use or initiation of drug use but barring Dhaka no services were available in the country to address this complication.

Interventions for Women

Mr. Kamaluddin Ahmed, Director General, Department of Narcotics Control said, “a separate ward had been earmarked for female drug users” in the 250-bed drug addiction, treatment and rehabilitation centre that is coming up in Dhaka. He admitted that in Bangladesh, “since the apprehended numbers of female drug users were less than that of male users, much of the service provision focused on the men’. He added that the Government is “keen” to address on an “equal footing” the female drug user with the male drug user. In principle, gender issues are always duly considered when the question of fighting drugs comes up in the agenda and therefore “joint efforts are underway (by government and civil society) to sensitize all stakeholders to the needs of women as drug users”, he stated.

Civil society initiatives for women

NGOs have been in the forefront of initiatives in the areas of HIV-AIDS and drug abuse, using such instruments as drop in centers, self-help groups, home-based de-toxification programs and residential de-toxification and rehabilitation programs. They have been involved with all sections of society from slum to middle class housewives and college girls. In fact, the low HIV prevalence rates being witnessed in Bangladesh despite a high risk situation is attributed to the various HIV-AIDS awareness and prevention programs initiated by NGOs among SWs and the needle and syringe exchange programs underway with IDUs.

APON has become synonymous with drug rehabilitation in Bangladesh. It started the very first residential detoxification and rehabilitation program in the country for male drug users in 1994. Over the years, APON has made several attempts to provide support and services for women. In June 2003 it started a community-based outreach work in Dhaka City Corporation for both men and women addicts in which outreach workers work along with peer volunteers from groups of drug-users. The latter are trained to act as role models and given basic information on how to negotiate safe sex, proper use of condom and other issues related to HIV, Hepatitis B and C. The outcomes according to Br. Ronald "are remarkable". Peer volunteers are motivated to change, frequency of drug use has been reduced, many drug users are on trial programs to stop drug consumption and some are already off drugs. Also, communities have been supportive and one detoxification camp for men was organized with community support.

Outreach among slum dwellers

In another initiative, APON has is working among street and slum based women drug users with a focus on risk reduction and demand reduction. Four female outreach workers go to the drug spots, meet with the women individually or in-groups and provide information on HIV-AIDS related issues and the dangers of high-risk behavior. They also discuss difficulties staying off drugs and how to go about it. Since this program began in 2003 it has touched nearly 400 women, 70 of whom continue to be in regular touch with APON. According to Humayun Kabir, the Program Coordinator, the women - many of whom are street based sex workers - repeatedly say, "now we are clear how STI and HIV is transmitted. Please do something for us: we want to get off drugs. It is ruining our health; we want to get off it."

Given this success, efforts are now on to reach out to girls in colleges through peer educators and out reach workers, "because their numbers are going up and they would not come to a place like APON for fear of being seen and the stigma. However, many do call and ask for addresses of detoxification centers. The focus of this program will be on staying off drugs and not crossing the line with risky behavior.'' The outreach workers will create awareness about drug-related harm, by giving them information on HIV-AIDS and try to make them realize they have a problem through questionnaires on high-risk behavior that will make them conscious of their vulnerability to HIV-AIDS. Referrals will also be provided for VCTCs and rehabilitation services in private clinics.
Similarly, CARE is doing outreach work among the sexual partners of IDUs with outreach workers going from door to door speak to them individually or in groups on HIV-AIDS related issues.

Drop-in-centers

HASAB (HIV-AIDS &STD Alliance Bangladesh) has opened two drop-in-centers exclusively for women with an all women staff, with the aim to give women drug users a place to meet, talk, bathe and sleep. Many of them as Selina Ferdous, Project Manager explained are "from less privileged strata. We motivate them to come to the center. Initially, we just chat with them, play cards and make them feel the center is their space. Give them the respect they are denied by

society. Then gradually peer workers talk to them and help them to, look back on their lives and the cause for starting drug use. This is done strategically. The peers speak of their own experiences, which lead to a sense of solidarity. They motivate them to go for treatment, make them realize what they are missing".

Community –based low cost detoxification programs

Civil society organizations have reservations about organizing detoxification camps for women because of the stigma attached to women drug users. However, APON did hold a 15-day residential detoxification camp in June 2004 for 8-10 women, all of whom were SWs who had been motivated to seek treatment by their outreach workers.

The space was provided in an office building of the local ward councilor and though they found the detoxification process painful and unpleasant the women completed it. They realized the need to stay off drugs and asked for longer treatment period as is done with men. The efficacy of such an initiative is difficult to judge because APON has lost touch with all but one of the women who all continue to remain clean. But Br. Ronald feels that the camp "proved that it could be done and that women were interested in undergoing detoxification."

Home-based detoxification for middle and upper class women

CREA (Society for Community Health Rehabilitation, Education and Awareness) has experience in detoxification and rehabilitation services to middle class and upper class males. It has also attempted out reach programs for middle class women. In 2003, it trained 8 female and two male students for outreach work among their friends on HIV-AIDS and drug abuse. However, they were unable to motivate anyone to seek treatment.
Over the last year, six women have independently sought treatment and CREA devised a seven-day home-based detoxification program in which they were treated symptomatically for withdrawal symptoms. This was followed by two months of regular counseling and sessions on sexual health and other related issues. While one of the girls continues to be on and off drugs, the remaining five remain clean and come once a week for counseling.

Self-help groups

CARE Bangladesh which has been one of the lead partners in HIV prevention activities since it launched a primary prevention program in 1995, provides space and technical support to Muktoakash, a self- help group of 56 positive people including 26 women and one child. All of them are from the lower middle class, unemployed, and the men are all IDUs. Sexual transmission has been the main route of infection in all cases. The group runs a help line from the center and provides pre and post-test counseling and referrals for testing and treatment of opportunistic diseases.

Challenges in providing services to women

To some extent the diffidence to tailor programs and services to suit women drug users and those infected by HIV-AIDS could be attributed to a lack of trained personnel, paucity of resources and space. This has been compounded by the lack of reliable statistics and baseline studies that go beyond known pockets of SWs, MSMs and IDUs to the hidden population of women drug users. There is also the extreme stigma attached to women drug users and those living with HIV-AIDS.

Felt needs - prioritizing the issues

Given the above scenario, stakeholders feel there is urgent need for the following measures:

- **Reliable statistics:** Alongside serological and behavioral surveillance surveys, there must be baseline studies among general population especially targeting hidden and vulnerable population such as women drug users.
- Bangladesh must **take into account the growing numbers of IDUs**, an estimated 10-20 per cent each year and the 100 per cent increase of HIV reported among them last year. Given the lack of evidence about women it must be realized that embedded within this population is the presence of partners, spouse, associates, dependents-children, women, young people-who could be directly or indirectly impacted by the problem as drug users or as care givers
- **Heroin smokers, particularly women must be included in interventions** many of them occasionally resort to injecting drug use.
- Program interventions have little **impact on those at high-risk (drugs or HIV)**, especially women because risk perceptions is very low among them.
- **Regular advocacy** to sensitize and motivate policy makers, government officials and community and religious leaders on issues related to women drug users and their vulnerability to HIV-AIDS.
- **Stigma is hampering providers' efforts to reach drug users**, especially women from breaking the silence, seeking help and availing of services. Therefore, communities must be mobilized to overcome the extreme stigma attached to women drug users and living with HIV-AIDS in order to build community-led responses.
- **Need to increase programs efficacy by putting in place HIV testing and counseling facilities**.

b. Sri Lanka

Historical Background

Sri Lanka has a long tradition of drug use as well as efforts to restrict and prohibit imports and exports. Way back as 1893, over 27,000 Sri Lankan had signed a memorandum that called on the government to take action and reduce the number of opium users and over the years numerous legislative efforts were made in this regard. Despite these efforts with the opening of the

economy in the 70s and the advent of civil strife, drug use has become more common and also spread from urban to rural areas.

Substance abuse- Present scenario

Nevertheless, it remains a "small-scale problem" with an estimated 50,000 heroin users and 20,000 cannabis users[14]. Of these less then 1 per cent of women are in drug abuse but many peddle drugs for economic reasons. Some end up becoming users. Many help their husbands in packaging and selling and even turn their homes into "pot houses" where drugs are sold and the necessary paraphernalia for smoking is provided. It has also been seen that if the husband is killed or arrested, the spouse steps in and takes over the business. It also not uncommon for a wife or mother to serve the jail sentence if the man is caught because he is the bread-winner. They do this because judges are generally more lenient with women and if they are pregnant they can be set free immediately. Of the 22,063 drug related arrests made in 2003, one in every 35 was a woman.

Trends relating to women and alcohol

If there is a problem in Sri Lanka it is with alcohol. The island country is among the top ten countries in the world where alcohol is consumed and viewed as a recreational drink, not as something that could cause problems. Most Singhalese women don't smoke or drink for cultural reasons but Tamil women who work as coolies have been found to be addicted to alcohol. A study by the Alcohol and Drug Information Centre (ADIC) found that 65 per cent of who drink lived below the poverty line suggesting a link between alcohol and poverty. However, given the increasing use of alcohol by upper class women and young girls who are hooked on beer, this view is being increasingly questioned. Activists contend that liquor companies are in fact nurturing this constituency with sponsor fashion shows and musical events. There is also a misuse of prescription drugs by women who start taking them during pregnancy, as painkillers during the menstrual cycle or to beat stress in the industrial sector[15].

Increase use of tobacco among women

Drug choice is seen to depend on setting, availability, affordability and social or cultural acceptability. Tobacco use is estimated at between 20-25 per cent among the general population with about 40 per cent among males over 15 years of age so an aggressive campaign has been launched to counter the multi-drug capacity of tobacco, which diverts people to heroin use. Similarly, smoking among girls and women used to be 0.001 percent - in 1995 five women smokers could not be found for a campaign and girls had to be brought from India. However, smoking is on the increase among upper class women and girls; there is also a tradition of cigar smoking among its large fisher women population. WHO annually records an estimated 22,000 deaths related to tobacco use in the Sri Lanka. Young people in mainstream educational system

[14] Handbook of Drug Abuse Information-2004, National Dangerous Drugs Control Board, Sri Lanka.
[15] Ms. Padmodinee Wijayanayaka, Executive Director, Alcohol and Drug Information Center.

abuse cannabis, small quantities of which are grown in the eastern and southern provinces. And the party pill Ecstasy is popular with elitist groups while Madamodaka an ayurvedic chewing gum cannabis based product, is being abused by school children.

Incidence of HIV-AIDS

HIV prevalence is low with an estimated infection rate of 0.07 percent among adults in the 15-49 age group. As of 2003, only 523 positive cases were reported including 214 women[16]. But the risk factors and behavior patterns that facilitate the spread of infection are all too visible making the country extremely vulnerable to an epidemic.

For instance, there are estimated 30,000 women and girls and 15,000 boys in commercial sex and according to one study[17] "45 per cent of female sex workers had experienced multiple STDs while 70 per cent of male patients at STD clines said they had visited sex workers." Moreover, an estimated 200,000 new STD cases are being recorded every year.

Other vulnerabilities to HIV

Another problem is large-scale migration both internal to plantations and free trade zones and external to India, the Middle East and elsewhere. Trafficking from rural to urban centers is promoting unsafe sexual behavior. Many of migrants are young, single girls who indulge in casual and commercial sex, multiple partners and unsafe sexual practices that make them vulnerable to sexual abuse and HIV-AIDS. An additional factor is that the marriage age for women has gone up from 21 to 28 and for men from 24 to 32 because of job opportunities resulting in a lot of casual sex. While men outnumbered women in the early phases of the epidemic in 2002, the male /female ratio was 1.4 to 1 with the number of women infected almost equal to that of men. The majority of them required an HIV test for travel to the Middle East.

Low incidence of IDU

If injecting drug use is low it is being attributed to the fact that Sri Lankan have a mental barrier against pricking themselves. Moreover, purity levels of available drugs are high so people turn to IDU only when there is a heroin drought. In 2003 they accounted for just 1 per cent of all drug users and a few of them were female sex workers. However, no case of HIV-AIDS infection due to IDU has been reported so far.

[16] Handbook of Drug Abuse Information-2004, National Dangerous Drugs Control Board, Sri Lanka.

[17] Sri Lanka HIV Updates 2002, World Bank Group.

Policy initiatives- targeting supply and demand

Much of the credit for containing drug use and HIV-AIDS goes to the government which has from the outset, encouraged a multi-sectoral response that involved other ministries, religious groups and NGOs. The government guided by the Sri Lankan Counter Narcotics Master Plan has relentlessly targeted drug traffickers and a plethora of drug demand reduction programs. As with HIV, a multi-sectoral approach has been adopted with the Police, Customs, Ministry of Health and the Courts working in tandem. The police is also engaged in locating and eradicating cannabis crops grown in the jungles of southern and eastern parts of the island and the Commission set up to check corruption in the bureaucracy has also been vigorously pursuing drug-related cases.

Containing HIV-AIDS

HIV prevention programs have been initiated through the National STD Control Program managed by the Directorate of Health Services because the government is aware that the window of opportunity is there to contain the spread of HIV-AIDS especially in view of the fact that it has a highly literate population and a well-established health system. With World Bank support it has upgraded blood banks, ensured blood safety through the screening of transfusions for HIV, established outreach camps and spread awareness and HIV-AIDS prevention messages among the general population. Efforts are now on to put in place community based preventive and care services for vulnerable populations.

Inter-sectoral collaborations

A national volunteer program has just been set up under the government program for the control of crime and drug-related offences. Under it, both government and civil society, including representatives from the police, schools, health care institutions and government officials familiar with rural areas and poverty alleviation programs will come together in prevention activities and awareness raising programs.

Programs in prisons

The government and NGOs are also collaborating on initiatives for the rehabilitation of drug users in jails. This has become necessary in view of the growing numbers of drug-related convictions. In 2002, narcotic offenders accounted for 39 per cent or the single largest category and in 2003 there were 22,063 drug related arrests of which the male /female ratio was 35 to 1. A majority of arrests were for distilling and peddling. At present if an arrested addict has withdrawal symptoms he/she is sent to the jail hospital for a few days where they treated sympathetically and provided symptomatic treatment. Since addiction is not seen as an offence, it is required that they be treated humanely. They are then sent to the wards where NGOs and the Ministry of Social Justice step in and provide them with individual and group counseling to give

up drugs and rebuild their lives. At present, the government is considering legislation that will enable them to serve their term in rehabilitation. Prison officials say that these initiatives do make a difference and changes do take place in their attitudes and thinking. The prisoners are also given vocational training as a step towards their re-integration into society.

Civil society interventions for women

In the 1980s, a need was felt for coordinated action among NGOs. Cannabis use was on the increase as was heroin addiction with the first case being detected in 1981. In 1987, 10 organizations came together and formed the Federation of Non-Government Organizations against Drug Abuse (FONGODA). Some have conducted advocacy and awareness and prevention programs in schools and communities while others have provided rehabilitation and treatment for alcohol and drug addiction.

Residential detoxification and rehabilitation program for women

Prior to mid-2004 when the Mithuru Mithuro Movement led by Rev. Kuppiyawatte Bodhananada Thero, a Buddhist monk, decided to start a small facility exclusively for women there were no de-toxification and rehabilitation programs for them. At the women's center most of those seeking rehabilitation had come from prisons where NGOs had told them about the center. Several of them had been in commercial sex work prior to going to jail. The treatment pattern is the same as at the other centers with de-toxification for those who require it followed by rehabilitation using the therapeutic community model. Perhaps the only concession made is that women are permitted to keep their infants with them.

According to Singhe, Project Coordinator, "Finding women staffers is the biggest problem we have so we are forced to use male staff from another MMM center close to run this center". But in a novel experiment mothers of male drug addicts from that center are being trained to provide counseling through a professional counselor who comes in once a week to conduct one-to-one and group sessions. As Singhe noted, "as women and mothers of drug addicts they can empathize with the women addicts and we have found them to be very effective, especially for providing counseling." Family support sessions are also conducted and skill training is also being provided as part of the re-integration process.

Raising awareness

The Sri Lankan Anti-Narcotics Alliance (SLANA) has since 1988 provide a broad spectrum of programs for raising public awareness on the issues, challenges and benefits that prevention practices can have for individuals, communities and the country. Its 9.000 members, ranging from government officials to high school students are a key resource for inter-personal communications as well as a direct link to communities. Programs are held among vulnerable groups like SWs, in schools and in orphanages where children, due to lack of support systems have been found to stray into sex work and drugs. Though SLANA has no program exclusively

for women, considerable effort is made in all their programs to sensitize the public to the gender perspective of drug abuse because people tend to associate drug abuse only with men.

Building capacities of recovering drug users

Under a novel program started in 1999 by SLANA, drug addicts at the street level or in rehabilitation programs, who have remained free of drugs for a year, are put through a 14-day personality development program. They are taught how to function in an office environment and basic office skills like running a FAX machine, a printer or computer. SLANA also helps them to find jobs for them. So far 200 recovering addicts have been touched and 60 of them have found placements.

Work place initiative

SLANA did a year-long program with World Bank support in the industrial sector of Colombo that focused on developing risk resilient skills among industrial workers to minimize exposure to HIV-AIDS. The program covered migrant women, most of whom were single and in the 18 to 25 age group and a few men. The main risk factors among them were found to be environmental adjustment problems, work pressures, loneliness with no one to provide emotional or other support and brief relationships.

Advocacy initiatives among adolescents

Alcohol and Drug Information Centre (ADIC) has worked since 1990 to prevent drug use through social change and education. At one level it has been working closely with the Education Department to design books and ensure that the right content is provided in books and the curriculum on smoking and alcohol consumption.

Anti-tobacco campaign

At the same time it has been working in schools through peer-led interventions by students who are in the high-risk groups like those from dysfunctional family backgrounds. These students, most of them are already into alcohol and tobacco use, are trained to discuss the factors that lead to drug use and their chemical effects. They to alter the image of a smoker as a cool, high society person. At the same time they expose the companies and commerce of tobacco.

The issue of reversing tobacco promotions is also taken up and these interventions have been able to motivate classmates and the areas surrounding their schools. If there are no tobacco billboards to be seen anywhere in the country despite the fact that there is no legislation prohibiting them, the credit goes to this intervention, according to Pamodinee Wijayanayaka, Executive Director of ADIC. “They deface any billboard that goes up so the industry has stopped putting them up and are instead doing point of sale advertising. So students have now taken the

campaign to shops near the schools to stop stocking tobacco products. The practice of using live models by industry to promote smoking has also been exposed with students walking up to them and asking them how much they are being paid to stand there and smoke".

Removing myths and misconceptions

ADIC has launched a campaign to expose the over-hyped influence of alcohol and drugs and the widely held myths about the effects they have on the user. Students are asked to check when the high sets in, because very often people feel an immediate high when in fact it takes a while for alcohol to get absorbed in the blood stream and affect the brain. Similarly, there is no high for heroin it is something the drug user creates for him or her.

Campaign against violence

In an intervention at the Hapugastenne plantation where alcoholism and related violence was a huge problem, ADIC made the women realize that, "with men using alcohol as an excuse for inflicting violence on women, it became clear to women that they had to resist this violence and not reconcile to the fact that alcohol makes a person violent." According to Wijayanayaka, subsequent to this, "women stopped excusing their husbands for alcohol-related violence and this has resulted in a marked fall in the incidence of violence from 78 in one quarter to 17 in three months and just 7 over six months."

Condom promotion

The NGO Community Development Services has since June 2001 provided training and developed the capacities of peer groups from among the commercial sex workers community in Colombo as educators and promoters of condom usage in an cost effective and sustainable way. The aim of this project being to promote health-seeking behavior among this community through peer education, peer support and peer counseling. It also reaches out to clients and families of SWs both men and women. The focus is on developing skills to negotiate safer sex with permanent and transient sex partners. It is hoped that in time the program will develop into a self governed, independent health and development project that is managed and implemented by leaders chosen by the community.

Challenges in providing services to women

Although there has been no diffidence on the part of government and civil society in providing services to women, the lack of adequate women-centric services is primarily due to the following:

- The stigma attached to drug use, especially against women prevents women and their families from seeking treatment and care.

- The stigma attached to working with SWs and drug users.
- Non -availability of trained female staff.
- The difficult in getting women outreach workers to work in slums because of the violence and criminality in such places.
- Accessibility, in terms of far flung tea plantations, where women work.

Felt needs

- **Awareness campaigns must be extended and up-scaled** to address the myths that deepen the stigma associated with drug use, particularly the long-standing myth that women in drug use are sex workers.
- **Home-based interventions** will be needed for women because they won't be part of a community based intervention for fear of stigma and domestic compulsions.
- **Pre-marital counseling must be designed to reach women**.
- A **parole system should be developed** to enable drug users, especially women in drug use to undergo treatment during their prison terms. Those who recover could be given the option of doing community service.

c. Maldives

Present scenario

"In the Maldives, drugs are no longer just an emerging problem," says Razeena Tutu'Didi, the Assistant Director General, Narcotics Control Board, "it is the main problem - a mega tsunami." In fact, as Razeena pointed out, "the picture could not be bleaker. Forty nine per cent of all drug users are young people, the relapse rates are high and many more young people are coming into it." This, despite the government's efforts to address the problem since the 1990s.

Historical background

There is no historical evidence of drug use in the Maldives apart from the use of opium in traditional medicinal practices. It is in the wake of the growing drug use in the region that the problem emerged in the mid-70s. "Drug abuse in the Maldives has reportedly increased 40-fold between 1977 and 1995"[18] and it continues to rise. Initially, it was noticed only among foreign tourists who used cannabis or hashish oil and heroin. But since the 1990s, concern has been growing because a "high percentage of young people between 15-25 years" turned to substance use. This is alarming given that nearly 44 per cent of the country's population is below the age of 15 and half the population is female.[19] As of now, there are an estimated 35,000 drug users in a population of 270,101[20].

[18] Rapid Situation assessment of Drug Abuse in Maldives 2003, Narcotics Control Board.
[19] Rapid Situation assessment of Drug Abuse in Maldives 2003, Narcotics Control Board
[20] Census 2000.

Substance abuse- opiates to glues

A Rapid Assessment Survey (RAS)[21] conducted in three atolls with high incidence of drug use found that opiates, especially brown sugar and cannabinoids, are the most commonly available drugs and in most cases, the drugs of initiation. The use of 'cola water' (eau de cologne) and 'dunlop' (a glue that is used to stick wood) as inhalants has been reported as well as pharmaceuticals, party pills like Ecstasy, cannabis and the local brew *oshani*. The majority of drug users are male (97 per cent), over 80 per cent are unmarried and 70 per cent are living with their families while 91 per cent of them had not reached the desired level of education. Ninety eight per cent of drug users reported a history of smoking and said that peer pressure and the desire to experiment were the reasons for their addictions. Some also mentioned easy accessibility, family problems, lack of awareness, absence of educational and job opportunities, boredom and stress as other reasons for drug use.

Women and drug use

Female drug users accounted for 3 per cent of all respondents but police arrest records and the referral service provided by NCB indicates that there could be many more. Most girls who come for rehabilitation after being caught by the police have been found to very young - between 13-22 years of age. The RAS found that women were between 18 and 27 years and of the seven respondents all but one had completed secondary school and three were employed. More than half attributed drug initiation to family problems. Very few married women are drug users and if they are it is because of their husbands. It is not unusual for couples to come for treatment, together. What has also been noticed is that, "island women are less prone than those living on Male perhaps because island communities are very close and supportive and that island girls who go to Male for jobs fall prey to drugs when they are away from their communities"[22].

Vulnerability to HIV-AIDS -High-risk sexual behavior

Multiple partners and low condom use are common among both married and single men. About 75 per cent of unmarried respondents reported sexual experiences, 68 per cent of married respondents said they had extra-marital sexual encounters. Often, the first sexual experience was between 7-24 years. One in four went to commercial sex workers, 43 per cent reported group sex and one per cent had homosexual encounters. A very high percentage also had multiple sexual partners but condom use was as low as 30 per cent among all respondents.

In spite of such sexual profligacy Maldives has remained relatively free of HIV-AIDS. The first case of HIV positive was reported in 1991 and subsequent to that 11 Maldivians were detected positive between 1991-2000. In 2003, random testing was done of all pregnant women, those going in for minor surgery and those going overseas to work. Thirteen cases of HIV infection were detected, all sexually transmitted while the women were abroad.

[21] Rapid Situation Assessment of Drug Abuse in Maldives, 2003- UNODC, FASHON/UNESCAP.
[22] Razeena Tutu Didi, Assistant Director General, National Narcotics Control Board, Male, in an interview.

Lack of risk perception

IDUs are few in number - just 8 per cent of all respondents reported injecting drugs. Police have not found the paraphernalia associated with drug user during raids and none of those who entered detoxification programs have been IDUs. Nevertheless, drug use associated with sexual behavior poses immense possibilities for the spread of HIV-AIDS because sex is being sold in exchange for drugs resulting in multiple partnerships and dependence. Sixty five per cent of men reported drug use with a member of the opposite sex usually in the context of a sexual relationship. Over 50 per cent of this group was 16 years of age or below. More worrisome is that although many of the respondents were aware of the modes of HIV transmission, 73 per cent of did not perceive being at risk from the infection.

Socio-cultural dynamics

In the Maldives, socio-cultural dynamics affecting women also need to be addressed. One is the accepted practice of serial monogamy and easy divorce procedures that have led to high rates of marriage, remarriage and divorce. These have contributed to weak family ties and unstable marriages. In 1998, there were 70 divorces per 100 marriages. “On an average a woman weds four times, three of them by age 30.” The Census cohort analysis finding was that Maldivian women had four marriages on an average by age 50. The RAS noted that, “this means that many women spend a significant part of their life without a partner.”

High mobility- an added factor

External and internal mobility are other important factors. On the one hand, there is a huge expatriate population, on another high internal and overseas mobility among Maldivians seeking job opportunities. This results in long separations from family members which make people vulnerable to the stresses of single parenthood and other psychological strains.

Policy initiatives

In 1997 the government set up the Narcotics Control Board directly under the President’s office. The aim was to reduce the demand and supply of illicit drugs and also run a drug rehabilitation center on Himmafushi Island. Stringent laws have since been put in place. Under the principle legislative act-17/77- a 25-year sentence can be handed down for cultivating drugs, manufacturing, exporting, importing, selling or buying, giving or possessing one gram and above. The penalty for the consumption of prohibited drugs and use or possession for personal use of less than one gram is imprisonment, banishment to another island, or house arrest for a period of 5-12 years.

Alternately, the person could be referred to rehabilitation. If the person completes the rehabilitation satisfactorily and does not commit any offence for a period of three years the

sentence is deemed as fulfilled and the person is released. If the person is unable to complete the rehabilitation he/she is handed back to the Department of Corrections and the previous sentence is enforced. The law, however, does not cover abuse of 'dunlop' or 'cola water', which is growing in popularity among young people. For offenders under the age of 16 the law permits the sentence to be suspended for three years; the person is handed over to the NCB, which can recommend him/her for rehabilitation.

In 1987 the National AIDS Control Program was put in place and in 1996 the Ministry of Health introduced a sentinel surveillance which makes it mandatory for all foreigners who seek employment in the Maldives to undergo an HIV test before being granted a work visa. Similarly, all Maldivians who return after spending more than a year abroad are required to be tested. The Department of Public Health also networks with NGOs to create awareness and provide counseling.

Government interventions for women
Services on par with male users

There are no specific interventions for women but the rehabilitation center at Himmafushi Island, - the only one in the country - has a residential program for both boys and girls. It has provision for 150 people at any given time. Ali Shareef, Coordinator at the Drug Rehabilitation Center, who has been with the program since its onset spoke of how "earlier the clients were generally older, in their late 20s but now they are getting younger and younger and most are between 16 to 22 years". The center, which started with one client, has treated over 1,000 clients since its inception. No study has been done to ascertain the relapse rate but according to Ali Shareef, "in the first six months it is about 30 per cent and for those in rehabilitation during the next six months it is also not bad. But once they leave it is not so good."

The Himmafushi program

The detoxification and rehabilitation program for both male and female users follows the therapeutic community model. It uses clinical, psychological, social and spiritual behavior shaping tools including lectures, counseling, group and individual sessions. Clients and counselors do everything together, the philosophy being that rehabilitation is a collective process. The same staff looks after the girls and the sessions are held together but they have separate quarters for eating and sleeping. The rehabilitation period spread over six to nine months; it has different phases and regular board meetings held between counselors, family and clients decide the treatment. In the first month, the clients are assigned jobs that entail a lot of physical work - housekeeping, gardening etc., and are also assigned a peer educator.

The physical work, then, gives away to mental activities in classes and sessions. After 2 months the pre-re-entry phases commences, when they are assigned jobs in various departments like maintenance, data processing etc. For the actual re-entry they are sent to the halfway home at Male where they receive educational and vocational training and counseling and are encouraged to contact possible employers. Then begins the community phase when they live at home but

attend meetings, session's etc., for six months. Finally, there is the individuation phase when each client is on his or her own. If at any time they feel they are slipping or relapsing into drug use they are asked to call the counselor or NCB and return for rehabilitation.

Initially, recovering users did not have problems finding jobs but a reluctance to employ them, is gaining ground, according to Razeena. So NNCB has appointed one person, a counselor as a Job Officer, who liaises with private companies and try to find jobs for them. Even after they are employed, he keeps in touch and intervenes if there are any problems.

Seeking civil society support

Given that the center in Himmafushi Island is very expensive (approximately, MRF 900-1000 per addict per day) and that drug use is too vast a problem for any one agency to handle alone, the government is now trying to widen the treatment net by persuading the private sector to enter this area. It is also felt that some drug users might prefer to seek private treatment because of the latter's confidentiality and anonymity as compared to community-based programs.

Home-based low cost intervention

A home-based program has just begun on Feydo Island that has a major problem with drug addiction. Under this initiative, detoxification will be conducted by the nurse at the OPD. A doctor and nurse are present for medical assistance. After seven days a counselor becomes available. At all times there will be a mentor - a combination of an outreach worker and counselor - who is assigned to each addict.

Using peers and mentors

In this initiative, youth groups on Feydo Island identity drug users. Some of the group members are recovering users and, therefore, have access to current users. They will motivate the users and bring them into the program. The members of the youth group, both men and women have undergone training on how to identify and motivate users to opt for treatment and not deviate from it. The youth group member will take users to the OPD/ health center, where the community health worker will provide them with the detoxification treatment; an IV drip is available on the premises. Before commencing detoxification, users will receive pre-counseling from a young person on the course of the treatment; it will be explained to the user that the consequences of any relapse or deviation will lead to being handed over to the Justice Department.

The **mentor's role** is to keep track of the user, guide them and ensure that the person follows the treatment. Usually an older person, whom the community looks up to, has been identified and will now be trained. The entire rehabilitation will be done in the community. If, after three attempts, users are unable to stay off drugs they will be sent to the Himmafushi Rehabilitation center. If the initiative succeeds it will be replicated on other islands.

Parallel program have been worked out with Department of Penitentiary and Rehabilitation Services in which detoxification rehabilitation will be available to men and women at a correction setting. Users will spend one third of their sentence in jail before attending a parole program at a half way house. This program will commence after it receives presidential consent.

Civil society initiatives

At one level NGOs like SHE and FASHON and some island NGOs have been running awareness programs with 8th, 9th and 10th class students on drugs, relationships, etc. Professional nurses, doctors and counselors often conduct these sessions.

Community-based peer led interventions to contain HIV-AIDS

Two islands -Velidhoo and Naifaro have been selected under UNODC's H-13 program for community based peer led interventions. Ownership of the entire process will be people-centered with islands CBOs, NGOs, recovering addicts and continuing addicts owning and conducting the program with technical support from FASHON and SHE.

Velidhoo has a population of 2,000 and is synonymous with drug use with initiating age as low as 12 years. What was not a major problem 10-15 years ago, now has assumed epidemic proportions. FASHAN (Foundation for Advancement of Self-Help in Attaining Needs) will conduct a program here. SHE will conduct a program at Naifaru which has a population of 4,000 and drug users as young as 13 years. Glue sniffing and 'Oshani'- an intoxicant berry - and drinking of cologne is high among its teenagers while heroin is the most used drug.

Civil society and government partnerships

The H-13 program is aimed at reducing HIV/STI among drug users and the component to reduce drug use has been brought in because of the problem in Maldives. For starters, a need assessment will be conducted to understand the problem in the local context and a RAS will assess risks, vulnerabilities and related issues. This will be done by the CBOs, NGOs and drug users both men and women. An attempt will be made, in partnership with local NGOs, to create an enabling environment by developing island clubs and sports for interaction with young people and to identify addicts and address their concerns. Simultaneously, there will be training of TOTs chosen from among older people. They will take on the responsibility of implementing this program; in turn, they will train peers educators - girls and boys and including drug addicts – for outreach work.

The detoxification and rehabilitation will be done as part of national program in the 5-6 regional hospitals and not on each island. It is hoped that these programs, tailored to meet local needs, will reduce the number of drug users by 15 per cent by 2006 on Velidhoo and Naifaro as well as reduce the risk of HIV and STI.

Challenges in providing services to women

- Difficult to reach women because they remain a '**hidden population'** due to the stigma attached to drug use. If a girl gets into drug use the family and even the island community will try to hide it so as not to get a bad name.
- **Paucity of funds, infrastructure and trained female professional service providers**.
- Punitive measures, as deterrents, are proving counter-productive: men and women go underground rather than seek treatment. **A rethink is required on this issue**.

Felt needs

- Mechanisms to deal with drug use from **a therapeutic rather than a penal perspective. E**nable drug users in jails to avail of treatment and rehabilitation during their sentence needs to be considered. Present punitive measures are driving them underground because of the stigma of being an addict or being convicted.
- A **variety of treatment strategies**, especially community-based that provide confidential, affordable and equitable treatment for drug users.
- Hard-core users need six years treatment and care and others three years. **There is a lack of professional counselors** – local people are being recruited who do not possess requisite skills. Currently, are only two psychiatrists in the whole country?
- Health services accessible and affordable but very few specialists. **Drug management could be part of medical training**. Sensitization and training of professionals especially doctors, counselors, teachers required.
- A constant participatory monitoring mechanism is needed.
- **Awareness programs must include all sections of the population.** Young must learn to say no to drugs. Introduce anti-smoking campaigns: 98 percent of those doing drugs in the Maldives have a history of smoking.
- **Early sexuality education** to create awareness of safe sexual practices.
- Everybody knows about drugs. **Need to get people and communities involved in helping those with a problem and in preventive schemes.**

d. India

Background

There is ample evidence of increased availability of drugs and increasing abuse of opiates as well as a wide range of pharmaceutical products from cough syrups to anxiolytics in tablet form and injectable analgesics. However, available data is unreliable: "The magnitude and dynamics of drug abuse at the national level has not been well researched in India",[23]and "much of the information on abuse of drugs is anecdotal and available reports are from small-scale surveys

[23] Dr B.S.Baswan, The Extent, Pattern and Trends of Drug Abuse in India, National Survey 2004. UNODC and the Ministry of Social Justice and Empowerment, Government of India-2002.

carried out in isolated areas of the country". [24] The reasons for the increase in drug use is India's close proximity to the golden triangle and golden crescent, smuggled drugs or domestic cultivation of cannabis and the diversion of illicitly manufactured pharmaceutical products containing narcotic drugs and psychotropic substances.

Substance abuse: **Findings from studies**

According to the National Survey 2004, based on the National Household Survey of Drug and Alcohol Abuse (NHS), Drug Abuse Monitoring System (DAMS), Rapid Assessment Survey of Drug Abuse (RAS) and five focussed thematic studies, alcohol, cannabis and opiates are the commonest forms of drug abuse. In fact 22 to 66 per cent of respondents were poly drug users, mostly male (except in studies focusing on females) and in their thirties. Between 20-49 percent had a family history of drug use. Heroin users in treatment centers were younger than opium users in treatment centers.

It was also found that only 2-33 percent had ever sought treatment because facilities were inadequate in terms of understaffing and lack of skills among providers. Many users were unaware of the treatment facilities available to them in their localities or that the treatment was unaffordable. One respondent spoke of how she had sought help from a NGO to get treatment for her husband, "but I lost heart the moment I heard the fee for a month's treatment. It is what we earn in 3-4 months."

Women and drug use

If data on males is scanty it is even more so with female drug users, although there is a long tradition of them using drugs. Women are known to partake of drugs like cannabis during festivals, chew tobacco and beetle nut and have alcohol or the local brew. Historically, women drug users have not found a place in official statistics and studies since they are fewer in number and also because of their "largely subordinate position" in the drug sub-culture. The first indications of women in drug use came only in 1979 when a Government of India Report "suggested that 25-30 per cent of registered opium addicts were women". Consequent to that, reviews of women drug abusers in treatment have revealed both poly-drug use and tranquilizer abuse; studies in the 1990s indicated a increase in opiates, especially heroin and propoxyphene perhaps because of increased availability and accessibility of drugs. Two recent studies- Burden on Women due to Drug Abuse by Family Members, (2002) and Substance Abuse among Women (2002) - and the Rapid Assessment Survey (2001-02) though small in nature also provide indications of emerging trends in drug use and the psycho-social consequences of drugs on women.

[24] Dr. Rajat Ray, Women and Drug Abuse: The problem in India. 2002. UNDCP and the Ministry of Social Justice and Empowerment, Government of India.

Burden of drug abuse on women

The first, based on 179 respondents, found that the drug users in their families were male between the productive years of 16- 30 years and a large number of them had been in drugs since their teens. The heaviest burden faced by these women was economic followed by stigmatization, emotional and relationship problems, the neglect of children and their own needs. They are often blamed for the drug use in the family, causing some of them to turn to alcohol or drugs for solace and almost half of all respondents reported violence in the context of demands for money to sustain their habit. At a detoxification center in Delhi 87 per cent of addicts said that they had been violent with family members. Many of the women (62) said they had been often coerced into giving money and goods because they couldn't tolerate the drug users' condition during withdrawal. The enhanced economic burden had also forced women and children to take to the streets and the sex trade. Some became involved in the cultivation, production and peddling of drugs. Very few approached the police for help out of fear for the drug users and only 8 per cent had sought treatment for them.

The second study, on women in drug use found that the majority were in their 20s and 30s; 30 per cent were single and 20 per cent were married before the age of 16. A majority was employed either full time or part time as laborers, vendors or commercial sex workers. They combined these with begging, stealing or peddling. Of the total sample only 5.5 per cent had received any technical or professional training. Up to 53 per cent reported high levels of drug use in their families and 68 per cent said they had been initiated into drugs between the ages of 11-20. While 48 per cent of the respondents said that friends had introduced them to drug use to relieve stress, 11 per cent were introduced to drugs by their spouse or partner. Apart from alcohol, tobacco and heroin preferred substances for abuse were sedatives, buprenorphine, cannabis, cough syrup, opium, Ecstasy and cocaine. What is very disturbing is that of the 75 respondents 30, largely from Aizwal and Delhi was IDUs.

Growing incidence in numbers of IDUs

Injecting drug use is growing in popularity and with it the incidence of HIV infection among IDUs and their sexual partners. In the state of Manipur, which for over a decade has witnessed an epidemic driven by injecting drug use, HIV prevalence in ante-natal clinics of Imphal and Churachandpur has gone up from 1 per cent to 5 per cent. Many of those testing HIV positive are sex workers who are IDUs - "there are signs that injecting drug use is playing a bigger role in India's epidemic then previously thought."[25] In the Tamil Nadu capital of Chennai, 26 per cent of IDUs tested positive in 2000 and by 2003 they had increased to 64 per cent. Forty six per cent of them had a wife or regular sexual partner[26]. That helps explain why Chennai also has the highest incidence of HIV prevalence among pregnant women in the country.

[25] AIDS epidemic update. December 2004. UNAIDS and WHO.
[26] AIDS epidemic update. December 2004. UNAIDS and WHO

Changing trends

National infection levels continue to be low in India with the latest estimate counting 5.1 million people living with HIV-AIDS. However, surveillance surveys do indicate the movement of the epidemic from high-risk groups to the general population and from urban to rural areas. It may be argued that India is battling not one distinct epidemic but several epidemics that vary in nature, pace and severity from state to state. In Tamil Nadu, HIV prevalence among commercial sex workers is as high as 50 per cent while in Karnataka, Andhra Pradesh, Maharashtra and Nagaland the incidence of HIV among pregnant women has crossed the 1 per cent mark.

Policy initiatives- international and regional

At the policy level, India has been a party to several international, regional and bilateral efforts to reduce drug supply. The most recent initiative is a commitment made with Pakistan, in the "road map to peace" to share information and operational intelligence on drug trafficking. Similarly, operational level strategies have been adopted with Sri Lanka and the Maldives to combat drug smuggling. Regulations to control the imports and exports of internationally controlled substances are also in place but inadequacies continue vis-à-vis the control of licit manufacture and sale of narcotic drugs and psychotropic substances that are easily available. In Goa, Ketamine, which should be sold only with a prescription, is easily available at pharmacists and the abuse of inhalants by slum dwellers and street children is rampant.

National level policies initiatives

At the national level, the Narcotics Drugs and Psychotropic Substances (NDPS) Act of 1985 was amended in October 2001 to bring flexibility to the sentencing structure for narcotic offences and remove the obstacles faced by investigating officers with regard to search and seizures. It also permits the freezing of assets of drug offenders prior to conviction and increases the chances of drug offenders being refused bail.

Service delivery

A year after the NDPS Act of 1985 was promulgated a scheme for the prevention of alcohol and drugs were introduced. Initially, the focus was on awareness and prevention education in schools, colleges and communities but over time this was extended to include counseling and hospice services. Today, the country has 440, 20-60 bedded treatment and rehabilitation centers that are run by select NGOs with government funding. Under the scheme, outreach workers go into communities, identify addicts and take them to the nearest centers for either OPD or IPD treatment. De-addiction camps are also held in communities to create awareness and identify those who need treatment. Relapse rates range between 70-80 percent but as Mr.Sunil Kumar, Deputy Director, National Institute of Social Development (NISD) notes, ``the point is that services are available and they are free. Moreover, they don't relapse immediately. It may happen over time and then they come back for treatment."

Reviewing the response

Besides this, the Ministry of Health also runs 105 de-addiction centers that are attached to the Psychiatric Departments of Government hospitals. They provide in-patient de-toxification services followed by OPD rehabilitation and re-integration services. Though there is no discrimination under the scheme and both men and women can avail of services, the latter are not known to do so. As Satyender Prakash, Director NISD points out, “Looking at the mindset of people you cannot expect women to come forward. Until a few years ago even men were in denial and continue to be so. It will take time for people to get into the acceptance mode and come for treatment. It is doubly difficult to be a women and in drug use.”

Despite this situation, the government is reluctant to provide separate facilities for women. As Prakash says, “It is not economically viable to have hospices just for women. In a 15-bedded center there must be at least 12 patients at a time to make it worthwhile.” The government had asked NGOs to set up centers for women under the NDPS scheme and one NGO had applied but it was unable to provide assurances on the minimum number of clients. Prakash cites the Alp Sankyak Vikas Sangh of Muzaffarpur, which has a separate ward for women. It draws patients from all over the country and even Nepal but there is no regular inflow.

Capacity building

Eight Regional Resource Training Centers have been set up to enhance the technical capabilities of service providers - both NGOs and government - in the area of drug demand reduction. They hold three-month diploma courses and several service providers from SAARC countries have been trained under the Colombo Plan. Besides this, a minimum services standard for alcohol and substance abuse programs has been developed to serve as guidelines for improving the quality of services offered by NGOs.

Policy initiatives to contain HIV-AIDS

Five years after the first case of AIDS was reported from Chennai, the National AIDS Control Program -NACP-I - was launched in 1992 with support from the World Bank. The aim was to launch interventions for HIV prevention so as to slow down the spread of the virus and mitigate the impact of AIDS. The period 1992-99 also saw the setting up of the National AIDS Committee, the National AIDS Control Organization (NACO) as well as state AIDS cells. However, program implementation was uneven at the state level; IEC was limited and community involvement poor. Since a surveillance survey was not conducted across all the states information was inadequate with regard to the progress of the epidemic so issues concerning treatment and care for people living with HIV-AIDS could not be adequately addressed.

With NACP-II (1999-2006) there has been a paradigm shift; the objectives now are the reduction in the growth of HIV through targeted interventions among high risk groups, preventive interventions among the general population and low cost treatment and care. As part of this response, annual surveillance surveys have been stepped up from 55 sites in 1994 to 670 in 2004

and they have also been expanded to include ante-natal clinics, MSM, IDUs and CSW sites. A National Blood Policy has been put in place, anti-retroviral treatment has been extended to people living with HIV-AIDS and grants have been mobilized from international agencies to expand services aimed at preventing HIV transmission to new born children and managing HIV-TB co-infection. It is hoped that NACP-II will be able to keep HIV-sero-prevalence below 5 per cent among adult populations in high prevalence states, 3 per cent in moderate prevalence states and below 1 per cent in low prevalence states.

Government initiatives for women

Growing indications of drug abuse among women have not resulted in any government initiatives for them. No special protocols have been developed taking into account women's needs and concerns because as Dr. Rajat Ray[27] at the All India Institute of Medical Sciences in New Delhi explains, "All these years the numbers of women seeking treatment has been low". He adds that there are plans to set up a "specialty clinic, which will obviously segregate them because their needs are different and provide them with different types of interventions, both medical and psychological." At present the "very few" who come in for treatment are sent to a separate OPD clinic that has "two social workers, nurses, trainee doctors and supervisors who are women. The women themselves requested that we see them separately." A conscious effort is also being made to develop "brief interventions and simplified counseling techniques" that "a BA Social Work graduate can conduct with 7-15 days of training."

At the state of the art National Drug Dependence Treatment Center in Ghaziabad, there are two wards with 24 beds but no ward has been started for women though the facility has been there since 2002. The "very few 8 or 10 of them in the last year"[28] who come in, "most of them are heroin users who have been initiated into it by their spouses". They are being treated in OPD.

Dr. Sunil Kumar, Deputy Director, National Institute of Social Development says that, "though several requests had be made by civil society seeking separate treatment centers for women, nothing concrete had been done so far." He adds that "this was one area that the nodal Ministry was seriously thinking about."

UN Initiatives

The Regional office for South Asia of the United Nations Office on Drugs and Crime has undertaken a number of activities to facilitate and support the integration of a gender perspective into this area. It spreads knowledge about the issue, conducts epidemiological studies, and generates manuals and guidelines to help women's groups or organizations working on prevention activities. The UN agency also supports women-centric interventions in the North East. A pro-active intervention, the Coordinated HIV-AIDS Response through Capacity-Building and Awareness or CHARCA, has been launched in six districts to reduce women's vulnerability to HIV-AIDS. Finally, through the H-13 project it is hoped that all stakeholders

[27] In an interview in New Delhi on July 14, 2004.
[28] Deepak Yadav, Social Welfare Officer, in an interview on 13, July 2004.

would become aware of the urgent need to act from a gender perspective when dealing with drugs and HIV-AIDS.

NGO initiatives for women

The oldest initiative for women addicts is the Women and Child Home run by Sahara in New Delhi. It has a staff of seven and facilities for treating 24 women at a time. The treatment regime comprises of 15-day detoxification followed by a 10-month to year-long rehabilitation program using the therapeutic community model and re-integration. Many women quit before the program is complete. What makes Sahara's program unique is that it is tailored for women and emphasis is placed on the post rehabilitation period, which according to Shantanu Choudhary, Head of Education and Training, "is when they need the most help given the stigma and discrimination they face from society." A mother is allowed to keep her children with her and there is a day care centre for those who can't stay for the entire rehabilitation period. Nicola Chotha, the Director of the Home, describes a "case of a well-to-do lady who was fixing (injecting). She had abscesses and was going from here to there. Her family did not know which would be the right place for her because there is no other place that has rehabilitation the way we do it here. So finally she was referred to us by the police."

More recent is the Arundaya Midway House that was started in August 2000, for women by the Calcutta Samaritans after male drug users who came for treatment spoke of women friends and relatives who also needed treatment. Initially, a small room with a bathroom was kept for the women who sought treatment but since many of them wanted to stay on after the 21-day detoxification period, the home was started in Narenderpur. While the detoxification process is conducted at the center in Calcutta for both men and women, the rehabilitation for women is at the home using the therapeutic community model. During this period the women are counseled and helped to see the turning points in their lives that made them turn to drugs. Self-help groups are also formed and when they leave they are encouraged to attend NA meetings. In fact an all women's group has been formed in Kolkata called Narishta. To quote Dr. Pawamani, the Director of Calcutta Samaritans, "to a large extent the strategies are effective in reaching out to women, their families and community. In our experience about 60 per cent of the strategies have been useful for women."

In Chennai, the T.T. Krishnamurthi(TTK) Centre has since the 80s been synonymous with rehabilitation of alcoholics and drug use. The majority of its clients (90-95 per cent) are alcoholics who come for de-addiction and rehabilitation. However, the Centre also runs a successful de-toxification program for drug addicts at the center itself and in communities. It has needle and syringe outreach program in collaboration with FHI. Its outreach workers have successfully persuaded all the IDUs to come to their outreach units; approximately 25-30 come every day, to get themselves voluntarily tested and the Centre also conducts HIV awareness programs among 20,000 women belonging to SHGs – an initiative supported by funding from UNESCO.

The Centre's experiences with drug use among men clearly indicates that the focus should not be on making them give up something but in bringing about a change in their thinking, attitude and

behavior. Also, that "once the inhibitions that come in the way of seeking help has been broken, they tend to come back and persist with treatment, even in situations of relapse. So they have a short time in-patient service followed by long term out patient sessions that motivate them to keep at it." In fact, at TTK they believe that this is the only way in which the program of drug use can be dealt with in India given the fact that we have huge numbers and 350 centers can treat only 5,000 in a whole year. Given the cultural context, it is not possible to drug users from the family for long periods, especially in the case of women.

Strategy for women in drug use

Dr. Shanti Ranganathan, Founder and Hony. General Secretary of TTK suggests that any strategy to reduce drug use among women must begin with advocacy and awareness programs that will create an enabling environment and the sensitization of public health workers and social workers. This should be followed by outpatient care units manned by counselors and psychiatrists. After the success of its camp organized exclusively for women alcoholics (mostly plantation workers) in Coorg, Dr. Ranganathan is convinced that if the right messages are sent out and sufficient outreach work is done, the women will come in for treatment. Such camps she felt should be organized in hot spots and among communities - they would work well with sex workers.

HIV-AIDS awareness programs

In the North East a few care centers have been set up by NGOs, the best known being the 10-bed care hospice set up in 2001 by the Nagaland Mother's Association in Imphal. Of the 10 beds, four have been set aside for women and according to Enoli Neidonuo Angami, a former president, "there is never a time when all the beds are not occupied."

Drug patterns have substantially changed in Manipur because of the Meira Paibis group of old women who patrol the streets to ward off crime and alcoholism resulting in a decline in riotous behavior and thereby greater safety for women.

The Institute of Social Disease in Manipur has set up three self-help groups - HOPE, WEDA and MANGAL – that consist of over 60 widows to enable them to sustain themselves. The activities of these groups include skill training, vocational training, literacy programs, health check-ups and condom promotion. Mary (name changed), a recovering addict spoke of how "we don't earn a big amount from packaging *masalas* but at least I have some money in my hand." In 2001, the HOPE group brought together seven SHGs of sexual partners of IDUs and formed a union called Women's Joint self-help Group.

Challenges in providing services for women

- **Lack of Community support- Neighborhoods object to treatment homes for women**. Assume they are brothels.
- **Lack of trust in the care and support service. Parents are apprehensive about sending daughters** for long periods of rehabilitation.
- **Many women have children and other domestic responsibilities** so they can't come in for log term treatment.
- **Many women can't afford treatment**. Calcutta Samaritans charge Rs.5,000 for detoxification and Rs. 6,000 per month for rehabilitation.

What needs to be done?

- Greater effort must be made to **understand the vulnerabilities and stigmatization** faced by women so as to evolve programs that are tailored to meet their concerns.
- **Capacity building** needs to be enhanced at all levels- state, district and municipal - for care givers.
- **Treatment literature must be developed in the vernacular on drug abuse and HIV-AIDS.** Mr. Greg, Program Coordinator at the Sharan Yamuna Baazar Drop-in center, says, "Treatment is one thing but treatment literacy is another. And so much of the stigma around HIV is because people feel powerless to do anything. Treatment is one thing that gives people power in their hands at least they can do something if they want to. Tell people where they can go for treatment, which is what people love to do. Now that option is there for people but only for the English-speaking".
- More **community-based initiatives** to create awareness on the links between drugs and HIV-AIDS, especially among high-risk groups.
- **Low cost community –based care** a must.
- **Private sector, civil society and the government need to be further mobilized**.

e. Bhutan

Since Bhutan is also wedged between the Golden Triangle and the Golden Crescent, the possibility of a rapid escalation of drug abuse, drug trafficking and in time, HIV-AIDS is considerable, especially in view of growing cross-border migrations.

Policy response

The government of **Bhutan** has, therefore, undertaken various measures to deal with these issues. At the international level it has signed the UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988. At the domestic level, the government has arrived at a broad consensus with elected representatives on how drug supply and demand should be dealt with. A national committee comprising of all stakeholders has been set up to develop a national strategy for drug control in the country. This will also address gender issues. A Rapid

Assessment Survey is presently being conducted on the basis of which the national strategy will be formulated.

At the center of this response is the Ministry of Health and Education which is presently sensitizing other agencies involved in the control and regulation of drugs like the police, Customs, Excise and the courts.

NGO responses

Other interventions include interactions between Government and NGOs like the Youth Development Fund – an NGO responsible for youth on drug abuse prevention. The National Women's Association, is an NGO dealing with issues related to women.

Interventions for women

While **Bhutan** prides itself on there being no gender disparities, the government has instituted a National Commission on Women and Children which deals with issues related to them. There is also a National Association of Women. The focus is that women's empowerment must be holistic in nature. In the context of women drug users, the government is currently developing linkages and identifying areas of possible collaboration with NGOs and others. However, the design and implementation of specific schemes for women drug users will depend on the inputs received from the Rapid Assessment Survey that is presently underway and the National Strategy for Drug Control which will be evolved after the RAS is complete.

f. Pakistan

Pakistan, which, lies in the Golden Triangle, has for long been battling drug cultivation, trafficking and abuse. In 1989, Pakistan's Narcotics Control Board was set up and in 1995 the Anti-Narcotic Force was established to deal with the growing problem of drug abuse in the country. The Ministry of Health spearheads the campaign against HIV-AIDS. A general consensus has been reached among all stakeholders on the need to eliminate the cultivation of drugs, check supply, impose severe punishment on drug traffickers, stop over the counter sales of psychotropic substances, create awareness and treat drug users as patients rather than criminals.

Policy response

At the international level, Pakistan is a signatory to all the major conventions. This includes the UN Single Convention on Narcotic Drugs 1961, the 1971 Convention on Psychotropic Substances, the UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988. More recently, in 1999 it ratified the 1972 Protocol that amends the 1961 Convention. At the national level there is the Control of Narcotics Substances Act 1998 which covers all aspects of the issue of drugs including treatment and rehabilitation of drug addicts. There is also a Master Plan for Drug Abuse Control (1998-2003) that was arrived at with

assistance from UNODC. It has worked to minimize the health and social consequences of injecting drug use and towards the prevention of HIV. A network of NGOs has also been evolved at the provincial and federal levels.

Interventions for women

The number of female drug addicts is much lower than male; yet, gender figures prominently in the government's agenda on this issue. A series of workshops have been organized across the country on the role of women in drug prevention. Both the enhanced HIV-AIDS program and Master Plan clearly address the issue of women, especially with regard to domestic violence, job losses and financial and emotional pressures. Women drug crisis and counseling centers are being set up along with home-based detoxification programs. The help lines set up in Lahore have been very effective already.

NGO response

The Dost Welfare Foundation has been working extensively with women in Pakistani prisons and in Afghan refugee camps where there is extensive drug use and misuse among women. According to Muhammed Ayub, Program Manager of the HIV-AIDS Program, "60-80 per cent of the women in jails are facing drug-related charges mainly related to drug trafficking, as they are being used by the drug dealer. These women are from less-privileged economic backgrounds and from dysfunctional families. We are providing prison-based as well as after release rehabilitation and social reintegration services." He adds, "There are Afghan women living in refugee camps in Pakistan who eat raw opium. This is a traditional cure to heal body aches caused by heavy workload at homes and to counter psychological problems caused by deprivation, frustration, substandard life, war trauma, etc. These women also use pharmaceutical drugs, mainly tranquilizers. We are providing these women various drug demand reduction, income generation and aftercare services."

Regarding women family members of a drug user, he says, "It is vital to ensure their regular participation in the treatment process in a centre-based program. In case of home-based program their participation is automatic. In some cases where female family members cannot attend the treatment centre, arrangement should be made for the treatment counselor to visit the women at least 2- 3 times during the process of client rehabilitation in the centre and in aftercare."

Asked if former female drug users could be involved in services and outreach, Mr. Ayub says, "From the experience of former male drug users involved in counseling and care of male drug users, we can say with confidence that involving former drug users works a lot. A former female drug user can work as a female community counselor not only for the treatment of female drug users but also with the families of male drug users. We have experience of involving former opium eaters in the our program for Afghan refugees, where these women do general community work, conduct drug abuse prevention sessions with other women, identify and motivate new opium users in the camps, visit female clients in follow-up, etc."

The focus at DOST is on community participation. Could this be applied to women in other vulnerable situations like alcohol abuse? Mr Ayub feels that "the principle base of our strategy is community participation and community ownership of the problem and of the program. The male community is the key decision-maker in our society and community leaders (especially religious leaders) play a vital role in shaping the future course of action. For any women specific program community (especially male) participation should be encouraged and through female community volunteers (usually health workers) the initial sensitization can be done among female community. Women-friendly outreach centres can be established." Mr.Ayub also feels that "women could be given information and the space to evolve their own perspectives of the issues in hand and the need to cope and deal with them. This could be done at women friendly community outreach centers where women community workers facilitate dialogues and discussions on women-related issues to encourage general women participation in the program". Vis-à-vis HIV-AIDS, "More community sensitization and sense of problem ownership will be required because of the high stigma and discrimination attached with HIV-AIDS. One effective means could be if an HIV infected client or a drug addict is considered as an 'ill person', who need care and cure."

On the subject of women-centric services, Mr. Ayub says an initiative made a few years ago to "establish a separate residential center for women drug addicts. After one year of operation, we had close it down because we found that in our culture, due to the high stigma attached to women addiction, women are not sent or taken to any treatment center. Presently, we have home-based treatment program under our community based demand reduction program for Afghan female drug users. We are planning to establish similar program for Pakistani population too if we could get donor support."

Assessing the response

There are an estimated 60,000-100,000 IDUs in Pakistan. However, this figure is not entirely reliable: no treatment centers have been set up in the provinces, so there has been no registration of drug users in these areas. Policies do appear to be in place, but there is urgent need for the training and sensitization of the bureaucracy whose attitude appears to be hampering public-private partnerships. NGOs implementing government programs complain of getting no support or encouragement from the bureaucrats who show a marked preference for doing such programs on their own.

During the implementation of a government supported project for the rehabilitation of drug addicts (male and female), Mr.Ayub found officials associated with departments such as social welfare uncomfortable with public-private partnership: ``It's very difficult to get full support from the government when you are working with groups like SWs, MSM, etc. Though the national health policy and recent policy developments support and encourage the work, the government machinery has not been trained and sensitized on these developments and new stands". On the question of supportive policy and legislative measures to help design and delivery women-friendly services, Mr.Ayub agrees that it would help "but it also needs training and sensitization of the concerned government authorities on these polices and effective procedures."

Challenges in providing services to women

The major problem is reaching out to housewives. There is an urgent need for female health workers who can access them in their homes. Referring to DOST's own experience, Mr Ayub says they had found that "women drug users respond very well to a home-based program because it is very confidential, not disturbing her daily life, not taking her away from her children and home and not very expensive." However, "women drug peddlers need an intervention in which their economic, family relationship and shelter issues are addressed while Afghan refugee female drug users need a comprehensive program for their rehabilitation. He adds that, "in refugee communities or in Afghan communities (which are conservative) community-based program for demand reduction, work very well and that community elders, especially religious leaders need to be first sensitized and involved in the development and implementation of any such program".

VI. Regional Strategy

Since the thrust of the Project is on "preventing the spread of HIV-AIDS among drug users in the SAARC countries and reducing the consequences of drug use", any gender strategy would have to focus on making gender a cross-cutting concern. Policy-makers, planners must be sensitized; the capacity of service providers working in this field needs to be enhanced so as to implement strategies that are effective in addressing gender differences and in responding to the special needs of women.

It is clear from the country-specific responses that while there is universal recognition of the centrality of gender, even some nascent and vital efforts to address gender concerns, the major challenge is systematically integrate gender into the programmatic response - that too on a regional scale. Within the region some beginnings have been made, with the technical support and guidance of UNODC to catalyze a response that is gender-inclusive and sensitive. This has resulted in a set of experiences that reveal, "what works" in "local settings".

Despite, these significant gains, stakeholders admit they face many systemic and societal barriers, that include a lack of technical capacity to sustain and scale up the response, the inability to motivate women to access services and create among service-providers a greater sensitivity and acceptance of the special needs and concerns of women.

Some guiding principles:

- The recognition that while addressing the issue of drug use and HIV prevention, gender must be centrally addressed, must be, as far as possible, universal.
- This recognition must go beyond knowledge and theoretical understanding of the issue. The stakeholders should know how to programmatically respond to the day-to-day challenges women face, particularly women who are living in difficult circumstances.
- Such a programmatic response must factor in the different needs of women and men as far as services are concerned. Among women, there are the more complex needs of

marginal communities such as adolescents or women who live far away from health care services, etc.

- Since stakeholders know that drug demand reduction and HIV prevention interventions for women are made more difficult by the twin factors of gender discrimination and rigid cultural norms, it is essential that any strategy focuses on building an enabling environment for women drug- users.
- Any women-centered intervention must be based on human rights. It must reach out to as many women as possible and reduce the constraints that women experience in accessing services such as information, counselling, health etc.

It is important to ensure that implementers and service providers have the capacity to understand gender in its specifics. The specifics are;

- Emphasize women's personal and social vulnerability to drug use, assess from where the self-denial in women stems and its links to risk factors related to HIV infection.

- Make the implementers sensitive to the inhibiting role played by the discriminatory gender norms in the lives of women. Impress upon them the fact that this often results in women waiting for long periods, with many of them reaching an advanced stage of addiction and illness before they seek services and treatment for drug use and HIV.

- In the context of HIV-AIDS, sensitize the implementers to the differential roles that women and men play as caregivers and different expectations they have as receivers of care. This is, to a great extent, shaped by the differential experiences they have with service providers, specifically in relation to treatment services for STI-RTI and opportunistic infections. In many instances, women do not use the services because of the discriminatory attitude of the service providers towards injecting drug users and sex workers.

Drawing on the experiences of a number of organizations working with women on addressing their vulnerability to drug use and HIV-AIDS the following can be done:

- Learn strategies, which have proven effective from a gender perspective and especially those, which have attempted and strengthened multi-sector partnership, community involvement and gender mainstreaming.
- Ensure that critical stakeholders are sensitized to the needs, experiences and insights of women.
- Expand the target group/reach of interventions, to attain the required critical mass to push forward the program on integrating gender into an HIV prevention, care and support and drug demand reduction.
- Strengthen multi-sector linkages to achieve rights-based developmental response.
- Sensitize the service providers to ensure more inclusive services for women in relation to HIV prevention, care and support and drug demand reduction.

Sensitizing Stakeholders, Building Capacity of Service Providers

It is clear from the above that given the issue that the Project is seeking to address, the "primary target group has to be the policy makers, planners, academicians, services providers and NGOs working in the field of drugs and HIV-AIDS".

It has been realized that "during the fast track" phase of the program implementation, a "regional sensitization workshop would have to be conducted to ensure that gender concerns are reflected in every project-related activity including capacity building and policy advocacy". It is also imperative that we harness knowledge about women's vulnerability to drug use and HIV-AIDS.

UNIFEM, South Asia, collaborates with leading women's organizations and gender training institutions of the government and NGOs across the region. It is essential to bring together all the existing knowledge and the learning from the practices related to this issue that have emerged in these collaborations. We need to focus on women's concerns on drug use, sexual violence, trafficking, gender disparity and the community-centered processes in order to promote women's health-seeking behavior particularly in the area of reproductive and sexual health. We need to have a common understanding of women's insights into survival and safety and their experience in the formation of collectives to establish platforms for self-expression and to raise their self-confidence and self-esteem.

Women's Empowerment: Learning from Practices

In many parts of the region, there are large-scale social mobilization and movements against alcoholism. These movements have challenged the state as well as powerful commercial and other interests. Laws have been framed giving women the democratic space and right to fight against commercial practices that are prejudicial to the interests of women, such as setting up liquor shops within the radius of a village or a residential settlement.

Nascent women-centered initiatives, the emergence of HIV positive women's organisations, the formation of women's collectives and self-help groups, are initiatives that can inform drug demand reduction interventions.

We need to enhance the right to economic **survival**. Efforts are being made to mainstream and formalize women's work, since much of it is in the informal and unorganized sector. It is a well-known fact that poverty adds to the environment of risk. It not only aggravates the lack of access to education, health services and increases food-insecurity at the household level but also increases dislocations due to forced migration, engagement in risk-occupation and even sex-work that is poverty driven.

Concerns related to women's **safety** stem from the realities that confront women on a regular and every day basis. Subject to all manner of violence, ranging from domestic to public forms of oppression and subordination, women's ability to negotiate safe sex is not only undermined but she also experiences a feeling of "neglect" and disempowerment. Women find it extremely difficult to access timely information in a user-friendly manner. Combined with their poor

literacy and educational standards, this makes it difficult for them to counter the social pressures that keep women and girls ignorant about gender, safe sex, sexuality and HIV-AIDS. Hence, struggles or campaigns and interventions which address issues of safety are a prerequisite for the implementation of drug-demand reduction and a HIV prevention strategy.

Strengthen women-centered outreach initiatives to address drug use

Across strata and community, most stakeholders base their approach on the fact that given the strong culture of silence and self-denial, no institutional processes targeting women has thus far worked to the necessary and essential extent. This could be in the soft area of information and communication or in the more specialized area of treatment, care and support.

The experience of organizations working in this sector in accessing and sustaining their relationship with women vulnerable to drug use and HIV-AIDS has been a mixed one. Therefore, the Project faces the major challenge of effectively integrating gender into a meaningful but time-bound response.
We need to create responses based on the principles of gender equity; to mainstream these and integrate them with a national and regional HIV reduction programme that reflects a continuum of approaches and processes. These responses must resonate with women and ensure high levels of participation and involvement.

In terms of strategy, it is essential we build on past or existing community-centered outreach interventions that target women vulnerable to HIV-AIDS and drug use. Civil society organizations such as APON in Bangladesh, FASHON and SHE in Maldives or large government-partnered program such as CHARCA in India have developed - or, are in the process of developing - rapport with the community of women, even gained their support.

In many such endeavors, the organizations have followed innovative approaches to reach out to women living in different circumstances. Most have found that it is essential to motivate female peer educators to gain the confidence of women, motivate them to be part of larger processes that aim to reduce their vulnerability to a host of predicaments, including HIV-AIDS and drug dependence.

However, most stakeholders have major concerns related to scaling-up efforts, forging effective partnerships with government and professionals and being able to create interventions that are more sustainable and responsive to complex ground realities.

We recommend that with women “more affected by the stigmatization associated with drug use” and “more likely to hide their use of drugs to avoid the disapproval of society and even the health authorities”**,** any intervention must be based on situational assessment studies that emerge from the community. The community must be involved in mapping the women’s “context of drug use and any overlap into other HIV risk behavior”. The Project must demonstrate the recognition of a gender perspective by “involving women and girls affected by substance use in the planning and development” of the intervention.

An outreach intervention must be multi-pronged. Since, the core objective is to "win the trust" of women and girls, there is a need to do everything from starting a drop-in-centre and providing them a confidential space to speak-up, to creating support groups/ networks and income-generation skill training programme. The community outreach program must be informed by a broad perspective and strive for greater empowerment along with a more focused approach in dealing with drug use and HIV prevention.

Developing Gender Sensitive Sites, Demonstrating Practical Approaches to Gender Integration on Drug Demand Reduction Intervention

Across the region, efforts made by organizations working on drug demand reduction focus on vulnerable populations such as street children, under-trial women prisoners, caregivers, women and family members of drug users.

In India, organizations such as Sahara in Delhi and Calcutta Samaritans in Kolkata work with women drug users. Both provide women treatment and a residential rehabilitation program. The Women's Unit of the Arunoday Midway Home run by Calcutta Samaritans, which started in 2000, claim that it is the "first and the only one in Eastern India". One woman drug user revealed that, after being addicted to drugs for two years, she had found support and succour in Calcutta Samaritan. "For the first time," she stated, "I learnt about the addiction". She realized that she was suffering from a "disease" and was the sole member of the family who acquired it. Her biggest achievement has been her self-empowerment: "I recall that when I came here I could not speak properly, I was full of self-pity, but today I can do an unbiased, self-analysis."

In Delhi, Sahara had started the women's rehabilitation center as early as 1978. By 1997, it had become a much larger rehabilitation initiative. Much of the success of a women-centered rehabilitation program, Sahara feels, depended on the institutional sensitivity to gender. This sensitivity includes the principle of involving ex-drug users to spearhead and manage the response. When Nicola Chotha, Manager of Woman and Child Home, Sahara, was asked why there are few women–specific programs, she said: "I think it is because of the outside world, the way they stamp on them, suppress them that women don't have a chance to come out, open up and know exactly what are their rights". She made it clear that much of female addiction is due to highly entrenched realities such as "extreme poverty", which in many instances led to "forced prostitution in order to support the family".

In other parts of the country and region, leading organizations provide comprehensive community-based de-addiction and rehabilitation programs to drug-users and their families. This includes Shakti in Bangladesh, Dost Foundation and Nai Zindagi, Pakistan, Sharan, Kripa Foundation, India and Naulo Ghumti, Nepal. Some institutions like the Vivekananda Education Society, Kolkata, Galaxy Club, Imphal, and Manipur also run special programs for women (and children) as caregivers of those affected by addiction. An organization like Galaxy claims to have addressed substance use inter-linked with sexual health related problem of drug-users.

The organizations are also evolving different approaches to enhance coping skills of drug users. Specific life-skill educational methods and techniques are being used to ensure that different sections do not engage in risky behavior.

In the case of women prisoners, Dost Foundation found it essential to build a **"conducive"** environment. This has involved an integrated intervention that brings together a supportive family structure, behavioural changes and economic empowerment. The emphasis is to provide a continuum of service.

Oganizations like Nai Zindagi have developed an innovative project for street children. They decided to "move away from conventional orphanages, juvenile detention centers and realistically deal with children on the streets, improve their quality of life and reduce risks related to living on the streets". Young people living on the streets and, in particular young women are vulnerable to sexual exploitation. In the context of HIV-AIDS, this issue requires a concerted and decisive response

CHARCA would give this Project the maximum opportunity to scale up and mainstream gender into HIV-AIDS. Its three-year program at the district and community level intends to bring together five distinct components: better service-delivery, awareness-raising and social mobilization, capacity building, strengthening support structures and building a supportive environment. In the case of interventions, such as this one that have a behavioral change component, communication, research and impact assessment will facilitate organized learning and sharing.

Learning from these nascent endeavors could be extremely relevant for institutions across the region. At select sites, the Project must focus on qualitatively scaling up these initiatives. It should work to ensure that the community's concerns are mainstreamed, services are provided and the concerned people are able to leverage on-going welfare and development program which target women in difficult circumstances.

OBJECTIVES AND CORE STRATEGIES

Objective 1

In support of the regional goal to reduce women's vulnerability to drug use and HIV-AIDS, empower women and girls and especially those living in marginal and difficult circumstances with information about drugs and HIV-AIDS

Strategies

- Empower women and girls living in difficult circumstances- trafficked sites, families where drug use is prevalent, prisons, slums, in conflict zones-with a personalized understanding about their vulnerability to drug use and HIV-AIDS.
- Ensure that they engage with the information, deal with the self-denial, low self-esteem in a non-discriminatory manner, create women-friendly spaces and processes such as drop-in-centre and peer sharing.
- Enable them to translate this information into personal action, facilitate them to seek services for counseling, treatment and care.
- Inform and educate them on how to protect one self by being aware of the causes of HIV-AIDS and the ways to prevent their transmission, likewise to be able to negotiate safer sex.
- Support programmes and processes that strengthen girls access to all forms of education, in particular life skill education, legal information and support and livelihood opportunities.

Objective 2

In support of the regional goal on care, support and treatment, the programme aims to increase the proportion of women receiving care, support and treatment.

Strategies

- Consistently sensitize service-providers to deal with the deep-seated gender bias and discrimination against women drug users and women vulnerable to HIV-AIDS.
- Facilitate the sensitization of service providers in treatment and care settings by using peer educators or community guides to interface between them and the client.
- Ensure that peer educators and community workers are trained to motivate women to engage with information on health; access services such as counseling, home-based care and support.
- Ensure that in each country in the specific demo-sites earmarked to provide home and community-based services for treatment- therapeutic community care and detoxification-women are given equal importance as care receivers.
- Ensure that safe spaces are provided for women drug users within existing rehab services for improved access.

- Ensure that standardized treatment protocols and gender sensitive norms are established.
- Strengthen the counseling outreach especially for women in distress, with referral system, that links up community-care with clinical support.

Objective 3

In support of the regional goal on capacity-building, the programme aims to intensify gender mainstreaming through multi-sector partnerships involving government, non-government, community-based and donor, through technical assistance and through training of policy-makers and service providers.

Strategies

- Strengthen gender training for staff/service providers associated with the Project H 13.
- Build capacities of staffs/service providers associated with project H 13 to provide beneficiaries with information related to livelihood options.
- Mobilize support of and strengthen the capacity of policy makers/focal points to advocate on the experience and process of integrating gender as a cross cutting concern.
- Document emerging practices relating to outreach, formation of women's collectives and tracking health-seeking behavioural changes by women.
- Facilitate exchange of experiences, encourage site visits and share process-centered information with each other across the region.
- Actively partner with local media and opinion makers to build a more enabling and supportive environment for women affected by drug use and HIV-AIDS.

Objective 4

In support of the Regional goal, the programme aims to ensure gender perspective at every step of national planning, monitoring and evaluation system.

Strategies

- Develop women-specific knowledge and expertise on the patterns of drug use, its intersection with other deprivations and circumstantial challenges.
- Consistently, conduct community-centered, action research on the strategies that women respond to.
- Use the research to strengthen evidence-based planning, implementation and monitoring of the programme.
- Ensure that women's documented experiences with different institutions are effectively disseminated to influence the responsiveness of different stakeholders.
- Strengthen collectives and networks of women affected by and living with drug use and HIV-AIDS to ensure that community-based leadership is built.
- Include gender-specific indicators to assess and monitor the quality of gender integration in every process and level of intervention.

VII. Developing Gender Sensitive Indicators on Drug use and HIV-AIDS

Concerns- Lack of Health Seeking Behavior/Consciousness because of;

- Culture of silence.
- Stigma and discrimination against women drug users and women living with HIV-AIDS.
- Lack access to information/low awareness.
- Burden of care/ parenting/housekeeping.
- Virtual non-existent drug demand reduction services for women.
- Gender-insensitive health-care systems-not sensitive to needs such as-timings, privacy, women as health care providers, affordability.
- Lack of women-specific knowledge and expertise on patterns and trends of drug use, its intersection with other circumstantial challenges.
- Inadequate participation of women in planning, designing and implementing the programmes.
- Lack of ownership.

Programme Components

Objective 1

In support of the regional goal to reduce women's vulnerability to drug use and HIV-AIDS, empower women and girls and especially those living in marginal and difficult circumstances with information about drugs and HIV-AIDS

Input Indicators

These refer to the **resources dedicated** to implement the programme.

- Design and plan varied outreach interventions, in the form of campaigns, educational activities, group counseling targeting women in different milieus-slums, sex work sites and conflict areas.
- Partner with community-based groups catering to these women in different circumstances.
- Build a team of committed outreach workers, preferably women who are ex-drug users and sensitive to women's experiences.

Process Indicators

This reflects the delivery of resources that helps to implement the programme

Based on a strategic plan to identify the following;

- Use of innovative methods and processes to reach out to women.
- Use of effective methods of behavioural change.

- Assess the role of inter-personal communication and the number of household visited per month in different project sites.
- Creating appropriate and representative feedback mechanisms.

Output Indicators

To measure results concerning specific components of the programme-it could be service delivery, knowledge, behavior and practice.

- Percentage of women who benefited from the awareness building.
- Specific groups of women been qualitatively impacted by specific information on drug use and vulnerability to HIV-AIDS.
- Percentage of women who have made an attitudinal shift, making an effort to adopt new practices relating to drug use from visiting drop-in-centers, seeking counseling and services and being more comfortable with talking about safe sex practices including condom use.

Objective 2

In support of the regional goal on care, support and treatment, the programme aims to increase the proportion of women receiving care, support and treatment.

Input Indicators

These refer to the **resources dedicated** to implement the programme

- Establish clear service rules and norms for peer educators and outreach workers in relation to sensitivity and understanding of gender.
- Build their capacity to listen to, engage with many personal dimensions of women's lives.
- Plan locally evolved supportive activities to facilitate behavior change.
- Formulate a package of services targeting women.
- Establish clear criteria on what constitutes gender-inclusive and women friendly service.
- Partner with community-based groups that have experience in providing services for women and other marginal sections.

Process Indicators
This reflects the delivery of resources that helps to implement the programme

Based on a strategic plan to identify the following;

- Enlist peer educators, outreach workers with a track record in gender sensitive programmes, personally experienced the journey of combating drugs and living with HIV-AIDS.
- Use innovative activities to stimulate, motivate and facilitate women to seek services and cope with their vulnerability and behavioural transition.
- Based on exchange and dialogue, establish agreed upon indicators to measure women-friendly services.

Create feedback mechanisms to assess the issue of access to and comfort with the service as much from a "people-centered" as a "clinical" and "technical" standpoint.

Output Indicators

To measure results concerning specific components of the programme-it could be service delivery, knowledge, behavior and practice.

- Quantify percentage of women seeking the first level of services due to the facilitation of peer educators and outreach workers.
- Identify specific collectives of women that have been more decisively impacted due to innovative activities and are seeking more expanded services.
- Asses client satisfaction in terms of timing, attitude of personnel, location, and affordability with package of services designed for women users.

Objective 3

In support of the regional goal on capacity-building, the programme aims to intensify gender mainstreaming through multi-sector partnerships involving government, non-government, community-based and donor, through technical assistance and through sensitization and training of policy-makers and service providers.

Input Indicators

These refer to the **resources dedicated** to implement the programme

- Develop training modules that sensitize personnel to complex ground realities and build skills.
- Develop sensitization methodology that is not 'problem-centered" but builds an ownership and active engagement with it.
- Consistently document sharing from the ground to create process sensitivity.
- Organize regional consultations, interactions and exposure visits to each other's project sites to facilitate transfer of know-how and evolve standardized approach to the issue.
- Disseminate the small gains and strides made by the community to address and cope with the problem.

Process Indicators

This reflects the delivery of resources that helps to implement the programme

Based on a strategic plan to identify the following;

- Making training modules worker-centered to enhance their confidence and capacity.
- Develop pro-active and community-centered sensitization processes by using the on-going documentation, live sharing and perspective building on gender.
- Conduct learning and knowledge sharing events at the national and regional level.
- Work with professional media outlets such as NGO newsletter and institutional web sites as well as mass media to disseminate the processes and learning from the Project.
- Consistently track the impact of the sensitization on different stakeholders.

Output Indicators

To measure results concerning specific components of the programme-it could be service delivery, knowledge, behavior and practice

- Establish qualitatively what worked with the community in terms of building gender sensitive human resources.
- Demonstrate among different stakeholders more inclusive and less judgmental and stigmatized attitude to women drug users and women living with HIV-AIDS.
- Create a wider association with drug demand reduction interventions that are gender friendly.
- Establish some benchmarks and quality control indicators on what do we consider as gender sensitive response.

Objective 4

In support of the Regional goal, the programme aims to ensure gender perspective at every step of national planning, monitoring and evaluation system.

Input Indicators

These refer to the **resources dedicated** to implement the programme

- Build into the Project, the required technical and research support to conduct research, documentation and community-centered monitoring, evaluation and impact assessment.
- Along with the technical inputs, constantly facilitate the involvement of the community in documenting their experiences and qualitatively assess the impact of the intervention.
- Disseminate the findings and experiences of women in a systematic manner using all forms of communication and media.
- Centre-stage the community and their experience with building the leadership.

Process Indicators

This reflects the delivery of resources that helps to implement the programme

- Build partnerships with groups that can provide technical support and facilitate the documentation, monitoring and evaluation in a community-sensitive and inclusive manner.
- Build the capacity in the community for documentation and self-assessment.
- Develop a dissemination plan at the local, national and regional level.
- Involve all the stakeholders in consistently advocating the efforts being made to address drug demand reduction in a systematic, standardized manner with multi-stakeholder partnership and support

Output Indicators

To measure results concerning specific components of the programme-it could be service delivery, knowledge, behavior and practice

- Ensure that gender sensitive indicators made part of the monitoring and evaluation framework, actively used to strengthen knowledge and expertise on women as target audience.
- Strategically document the experiences of women to capture their insight and understanding of the project.
- Conduct regional level impact studies focusing on women.
- Actively disseminate the learning and sharing from these studies.
- Strengthen the role of policy makers in conducting programmatic advocacy.

ESSENTIAL STEPS TO TAKE THE PROCESS FORWARD

The thrust of the immediate **Plan of Action** will be guided by the following priorities:

- Firstly, break the silence on the issue and draw attention to its many complex and invisible dimensions to the issue.
- Secondly, work towards strengthening public-private partnerships at all levels and in particular on the ground with non-governmental organizations, regional networks etc.
- Thirdly, reach out to a large number of service providers working in mainstream health care, women's development and drug-rehab and counseling institutions, sensitize them to the gender-dimensions of the issue and build capacity.
- Lastly, support community-led response, peer-based model by encouraging community-centered processes including collectivization of women in and families affected by drug-use.

How do we go about implementing it?

Firstly, with the help of key women's organizations across the region and gender-sensitive institutions (*Lists appended*) working with drug use population, let us begin with a preliminary effort at strategic documentation-document the voices of women living and affected by drug-use. Since objective of this documentation would be to recognize the critical factors that are preventing a rights-based and inclusive approach to women in and affected by drug use, ensure that women from the community are made part of the process, encouraged to identify their different vulnerabilities to drug use and help policy makers and programme managers to do a community-centered mapping of the problem.

Secondly we should focus on gender-sensitizing service providers, especially those working on drug-use, HIV prevention, care and support as well as in health care institutions as counselors and doctors and in the administration managing women-centered programmes and schemes. The large-scale sensitization must be done especially in States that have high prevalence in terms of drug use.

The ***Gender Sensitization Workshop*** could be a 4 to 6 hours programme where the focus will be on the following:

1. Unpack the social construct of gender; take the participants through the difference between sociological (gender) and biological (sex) construct

2. Familiarize them with the framework of rights as guaranteed in the Constitution, the law makers' contribution to gender sensitive legislations both past and present and the obligations and duties imposed on different stakeholders by International and National Conventions and Codes such as CEDAW, CRC, Beijing Platform of Action, National Policy on Women, etc.

3. Share the ground realities and the day to day experiences that women have in gender insensitive settings, be it with health care service providers or elected representatives or

people managing civic amenities – the purpose of this sharing will be to show how a stigmatized milieu will only aggravate and compound the problem.

4. Focus on the difference that innovative practice, gender sensitive service providers can make on this issue.

This Orientation can be facilitated by using live presentation to disseminate information, affected people's testimonies to strengthen the women's rights perspective as well as through exercises to bring about conceptual and programmatic clarity on gender and human rights and its impact on addressing concerns related to women drug users and their care givers.

Thirdly, based on the existing practices, that CFAR has documented in this report we should zero in on some project sites where innovative work and efforts have been made in reaching out to women in drug use, providing them confidential and friendly spaces to unwind, seek services and develop community-centered peer educators and outreach workers. It is essential that some of these organizations begin to systematically pass on their learning and experiences to others.

South Asia: Institutes with expertise in addressing drug use problem – Outreach, Counseling, Detoxification, Rehabilitation and Training.

	Institutions/Organizations	Country	Contact person
1	**Kripa Foundation** Drug Awareness, Counseling, Assistance & Rehabilitation Centre Mumbai, India	**India**	Mt. Carmel Church, 81/A Chapel Road, Bandra (W), Mumbai - 400 050 Tel: 022 - 26405411 / 26433027 Fax: 00-91-22-6439296 E mail: kripal@shakti,ncst.emet.in kripabandra@vsnl.net
2	**Arunoday Midway Home** Therapeutic Healing Centre for Substance Abusers The Calcutta Samaritans Kolkatta, India	**India**	**Dr. Vijay Pavmani** Honorary Director **Mridula Bose** Warden, Ladies Unit The Calcutta Samaritan 48, Ripon Street, Kolkata – 700016 Tel: 033- 2229 5920/2229 9731 Fax-033-2217 8097 E mail: emcal@vsnl.com
3	**APON** Addiction Rehabilitation Residence Dhaka, Bangladesh	**Bangladesh**	**Bro. Ronald Drahozel** Director, APON Addiction Rehabilitation Residence 4/10 – Iqbal Road Block –D, Mohammadpur Dhaka – 1207, Bangladesh Phone – 9126297 Email: apon@citechco.net
4	**Mithuru Mithuro Movement** Colombo, Sri Lanka	**Sri Lanka**	**Rev. Kuppiyawatte Bodhananda Thero** Director Mithuru Mithuro Movement Rilhena, Pelmadulla Colombo, Sri Lanka
5	**Mel Medura** The Sumithrayo Drug Demand Reduction Programme Colombo, Sri Lanka	**Sri Lanka**	**Dr. Manoj Fernando** Director Mel Medura 60, Mel Medura, Horton Place Colombo 07 Tel: 694665 / 693460 Fax: 075 339794 E mail: melmedur@sri.lnka.net

6	**INF Naulo Ghumti** Pokhara, Nepal	**Nepal**	**Som Lal Ojha** Programme Officer INF Naulo Ghumti INF Post Box No 28 Pokhara, Nepal **Phone:** (977-61) 24515, 23350 **Fax:** (977-61) 30940 **E-mail:** naulo_ghumti@inf.org.np
7	**Dost Foundation** Peshawar, Pakistan	**Pakistan**	**Ms. Yasmeen Mazhar,** Dost Foundation House 8, Sector B-2, Phase 5, Hayatabad, Peshawar, Pakistan Tel: (92-91) 814181-812218 Fax: (92-91) 814181 Email: dost@netzone.net.pk dost@iqranet.net
8	**Nai Zindagi Drop In Centre** Lahore, Pakistan	**Pakistan**	Nai Zindagi Drop in Centre Opposite PTCL Customer Service Near Ali Park Fort Road, Lahore Pakistan Telephone:+ 92 (42) 7634234 Email::nzdiclhr@hotmail.com
9	**Drug Rehabilitation Centre** Male	**Maldives**	**Kaafu Himmafushi** Drug Rehabilitation Centre Republic of Maldives Phone: 960 440240 Fax: 960 440150 Email: drc@nncb.gov.mv

South Asia: List of institutes/organizations that can conduct gender sensitization training

1	**India**	**Centre for Advocacy and Research** F-19, IIIrd Floor, Kalkaji, New Delhi – 110019, India Telefax : cfarasam@ndf.vsnl.net.in Website: www.cfaronline.org
2	**India**	**Positive Women Network (PWN+)** 9/5, Shanthi Apartments, Avenue Road, Nungambakkam, Chennai – 600034 Tamilnadu. India Tel: 91-044 – 28270204, 28203959. Email: poswonet@hotmail.com poswonet@hotmail.com
3	**India**	**Sanhita** 89 B, Basanta Roy Road Calcutta – 700029, West Bengal, India Tel: 22845525, 22161471
4	**Sri Lanka**	**Centre for Women's Research (CENWOR)** 225/4 Kirula Road, Colombo-5, Sri Lanka. Tele/Fax : 94-11-2369530 / 94-11-2502153 E-mail: cen_info@sltnet.lk cenwor@slt.lk
5	**Sri Lanka**	**Women and Media Collective** 20/1, Eighth Lane, Nawala, Sri Lanka Tel: + 94 - 11 - 2805127 / 2805579 Fax: + 94 - 11 – 2805580 Email: womedia@sltnet.lk

6	**Sri Lanka**	**Pro Public** P.O. Box 14307, Gautam Buddha Marg, Anam Nagar, Kathmandu
7	**Sri Lanka**	**Saathi** Baluwater P.O.Box - 7770 Kathmandu, Nepal **Tel:** +977 (1) 4411078 **Fax**: +977 (1) 4220390 **E-mail:** contact@saathi.org.np
8	**Bangladesh**	**Women for Women** A research and Study Group 1/2 Sukrabad, Dhaka 12077 Bangladesh
9	**Bangladesh**	**Ain o Salish Kendra** (**ASK**) 26/3 Purana Paltan Line, Dhaka - 1000 Bangladesh, Tel: 8802 831 5851 E mail: ask@citechco.net.
10	**Pakistan**	**Aurat Foundation** 8-B LDA Garden View Apartments Lawrence Road Lahore - 54000 Pakistan
11	**Pakistan**	**Rozan** 4-A, Street 34, F-8/1 P.O.Box - 2237 Islamabad-44000 Pakistan Tel: 92 51 2851886, 2851887 Fax: 92 51 2856730 Email: rozan@comsats.net.pk

Annexure - I

Questionnaire: Focal Points

1. Policy consensus and strategizing:

1.1 Has a consensus been reached among policy makers- Government and elected representatives-on how to deal with the issues of drug supply and drug reduction in your country?
1.2 Have the different sectors (government-NGO-private) in your country agreed upon a broad and common agenda on how to deal with the issues of drug supply and drug reduction?
1.3 Does gender find a place in this agenda?

1.4 What kinds of partnerships and collaborations have been forged between NGOs and government departments dealing with:
- Health
- Education
- Women's empowerment
- Related issues

1.5 Is the Government actively assisting NGO to build their capacity in the area of awareness raising, treatment and care of drug-users?
1.6 Are the different stakeholders associated with the government, non-government, media and medical profession-be it as policy makers or as service providers-being sensitised on the specific needs of women as drug-users or affected by drug-use? Have they initiated any women friendly and women centric interventions?

2. Schemes and initiatives:

1.1 Do the developmental schemes initiated by the government in your country address the issue of empowering women from marginalised communities and those that are vulnerable to drug use and HIV-AIDS
1.2 Since many countries in the South Asian region are trying to address the disparities that prevail in gender how does the government of your country view the issue of women affected by drug use?

1.3 Should women's empowerment be through life skill education, livelihood and micro credit schemes, health, laws or political empowerment? In what order would you prioritize them and what sort of linkages would you build?

1.4 If you have attempted to address even on micro-scale, gender disparity particularly in the area of drug abuse, what has been your experience in this regard? What learning and lessons emerged?

1.5 What are the linkages that you would like the different government departments or Ministry to establish?

1.6 What sort of schemes have you put in place or would like to put in place to simultaneously address the reduction of drug supply and demand among youth, women and mobile populations?

1.7 Are you building on on-going interventions and do they include the needs of hitherto marginalized groups like women?

3. Best/Good Emerging Practices:

3.1 What is being done to strengthen existing practices in the area of spreading awareness and reaching out to women, rehabilitation, care and support of women as drug users or affected by drug use? Please indicate any best practices relating to women in the area of drug use that you would like to share with those working in this region.

3.2 Also do you have a dedicated project site that demonstrates the processes that have been evolved to provide gender sensitive outreach and services?

i. Has any supportive legislative and policy framework that been developed and put in place, proved especially useful to in implementing the intervention?
ii. Have you developed monitoring and evaluation indicators to track the process and level of gender integration?
iii. Are you documenting innovative interventions and developing on common learning and strategies? Are there modules you could share?

*** Focal points:** This includes Government representatives at the decision-making level- policy makers as well as administrative heads associated with youth and health education and services / drug demand/ reduction/ gender, trafficking, law, CSW.

Questionnaire
for
(Implementing agencies, grassroots groups and networks)

1. What has been your experience with reaching out to women in difficult circumstances including drug addicts? This hidden population could comprise of single women, war widows, women prisoners and migrant women.

2. Since stigma and discrimination is preventing women from seeking treatment, care and support what can be done to
   i. Build their confidence,
   ii. Motivate them to seek counseling and treatment and
   iii. Enable them to overcome the feeling of stigma in particular?
   iv. And what is being done to reintegrate women addicts in society?

3. Given the experience of each country in working with people affected by drug use is it possible to involve the community and the families of the affected. If yes, can you share your experience in this regard?

4. Can women affected by substance abuse including alcohol be involved in the development of women-centric service and outreach? Have you any experience of either. Can you share it?

5. To what extent can the strategies you used to reach out to these women, their families and communities applied to women in other vulnerable situations like alcohol abuse?

6. How can they be given information and the space to evolve their own perspectives of the issues on hand and the need to cope and deal with them?

7. Can these experiences be applied to drug users affected by HIV-AIDS?

8. What has been your experience of the governments of your working with women involved in sex-work or those that have got involved in sex-work due to trafficking of women and girls, within the country and across the countries

9. What kind of outreach techniques did you use in the above projects/programmes? Could we replicate these techniques and methods to service the poor, rural women and those living in remote and difficult terrain?

10. If you have rehabilitation programs for women, both residential and non-residential please give details as to what extent are they women-friendly and women-centered.

11. Have you participated in welfare programs and schemes launched by the government for those affected by drug and alcohol abuse, especially those that address women and youth? If yes, what has been your experience?

12. In the formulation of a programme, for women affected by drug-use would a strategy be required to assure continuum of services?

13. Do you have any experience of how we can tailor the programme to meet the needs of marginalized communities such as women affected by drug use?

14. Can supportive policy and legislative help in the design and delivery of women-friendly services?

***For implementing agencies, grassroots groups and networks like:** Charca, Calcutta Samaritans, Sahara, Dost in Pakistan, Shakti in Bangladesh, Naulo Ghumti in Nepal and others working with alcohol abuse, etc.

Annexure -II

List of Interviews

S.No	Name of In-depth Interviewees	Designation	Country	Tool
I. Decision Makers				
1	Ms. Rajwant Sandhu	Joint Secretary National Institute of Social Defense Ministry of Social Justice and Women Empowerment, Govt. of India.	India	In-depth Interview
2	Mr. Satyendra Prakash	Director National Institute of Social Defense Ministry of Social Justice and Women Empowerment, Govt. of India.	India	In-depth Interview
3	Mr. Sushil Kumar	Deputy Director National Institute of Social Defense Ministry of Social Justice and Women Empowerment, Govt. of India.	India	In-depth Interview
4	Mr. Sonam Dorji	Joint Director Ministry of Health Government of Bhutan, Thimpu Bhutan	Bhutan	In-depth Interview
5	Mr. Kamaluddin Ahmed	Director General, Department of Narcotics Control Bangladesh	Bangladesh	In-depth Interview
6	Dr. Tasnim Azim	International Centre for Diarroheal Disease GPO Box – 128, Dhaka – 1000,	Bangladesh	In-depth Interview
7	Ms. Razeena Tutu Didi	Asst. Director General National Narcotics Control Bureau 1st Floor Ghazee Building Ameer Ahmed Magu Male	Maldives	In-depth Interview
8	Ms. Dharshinie Guniyan	Director Srilanka Anti Narcotics Association 121, Kynesy Road Colombo	Sri Lanka	In-depth Interview

9	Mr. Ismail Hassan Niaz	Acting Secretary, Ministry of Narcotics Control Government of Pakistan Shan Plaza, Blue Area Islamabad	Pakistan	In-depth Interview

II. Programme Implementers/Professionals

1	Prof. Rajat Ray, M.D.	Chief Center for Behavioural Sciences Department of Psychiatry & National Drug Dependence Treatment Centre All India Institute of Medical Sciences New Delhi	India	In-depth Interview
2	Dr.Vijay Pavmani,	Advisor, FADAA & Head, MSJE RRTC East II, & Director The Calcutta Samaritans 48, Ripon Street, Kolkata – 700016	India	In-depth Interview
3	Ms.Mridula Bose	Warden Arunadyaya Midway Home The Calcutta Samaritans 48, Ripon Street, Kolkata – 700016	India	In-depth Interview
4	Ms. Jaba Guha	Director Kripa Rehabilitation Center 139 B Rash Bihari Avenue Kolkata - 24643836	India	In-depth Interview
5	Ms. Santhi Ranganathan	Honorary Secretary T T Ranganathan Clinical Research Foundation TTK Hospital, IV Main Road Indira Nagar, Chennai.	India	In-depth interview
6	Shantanu Chowdhury	Head of Education & Training Sahara Center for Residential Care & Rehabilitation E-453, Greater Kailash-II New Delhi	India	In-depth Interview
7	Mr. Rajesh Kumar	Executive Director Society for Promotion of Youth & Masses B4 –3054 Vasant Kunj, New Delhi – 110070	India	In-depth Interview
8	Nicola Chotha & other Inmates	Women and Child Home Sahara, Neb Sarai. New Delhi	India	Focus Group Discussion

9	Deepak Yadav	Social Welfare Officer National Drug Dependence Treatment Center, AIIMS, Ghaziabad Uttar Pradesh	India	In-depth Interview
10	Mr. Greg	Project Coordinator SHARAN Nigam Bodh Ghat, Yamuna Bazar Delhi	India	In-depth Interview
11	Bro. Ronald Drahozel	Director, APON Addiction Rehabilitation Residence 9/7 Iqbal Rd, Mohammadpur, Dhaka-1207,	Bangladesh	In-depth Interview
12	Humayun Kabir	Project Coordinator APON Addiction Rehabilitation Residence 9/7 Iqbal Rd, Mohammadpur, Dhaka-1207,	Bangladesh	In-depth Interview
13	Md. Harun- or- Rasid	Executive Director Light House Jahurul Nagar, Bogra-5800	Bangladesh	In-depth Interview
14	Nr. Tarun Ranti Gay	Chief Executive CREA 9/7, Iqbal Road, Mohammadpur, Dhaka- 1207	Bangladesh	In-depth Interview
15	Frank Boroen	CARE Bangladesh	Bangladesh	In-depth Interview
16	Mr. Vaidyanathan	CARE Bangladesh	Bangladesh	In-depth Interview
17	Muhammad Ayub.	Program Manager, DOST Welfare Foundation, Peshawar, Pakistan	Pakistan	In-depth Interview
18	Mr. Mohammad Zahid	Execitive Secretary 2nd Floor, G. Rasthari Dhoohimeri Magu Male	Maldives	In-depth Interview
19	Mr. Mohammad Zuhar	Chief Executive Officer Society for Health Education Kulunuvehi, Buruzu Magu, Maafannu, Male – 20318	Maldives	In-depth Interview
20	Mr. Karunadasa	SL FONGOADA 380/7, Sarana Road Bauddhaloka Mawatha Colombo	Sri Lanka	In-depth Interview

21	Rev. Kuppiyawatte Bodhananda Thero	Director Mithuru Mithuro Movement Rilhena, Pelmadulla	Sri Lanka	In-depth Interview
22	Mrs. Padmodinee Wijaya	Executive Director Alcohol and Drug Information Centre 40/18, Park Road, Colombo – 5	Sri Lanka	In-depth Interview
23	Mr. Pubudu Sumanasekhara	SL FONGOADA 380/7, Sarana Road Bauddhaloka Mawatha Colombo – 07	Sri Lanka	In-depth Interview
24	Dr. Manoj Fernando	Executive Director The Mel Medura Modality No. 60 Horton Place, Colombo –07	Sri Lanka	In-depth Interview
25	Rumi Mazak	Commissioner of Prison Police Head Quarter Base Line Road Colombo	Sri Lanka	In-depth Interview
26	Kaminee Happugola	Director Community Development Service No. 3 Castle Avenue Clolombo –08	Sri Lanka	In-depth Interview

Annexure – III

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