



Indian Harm Reduction Network

Bi-monthly Newsletter Volume 1, Issue # 3: Gender & FIDU

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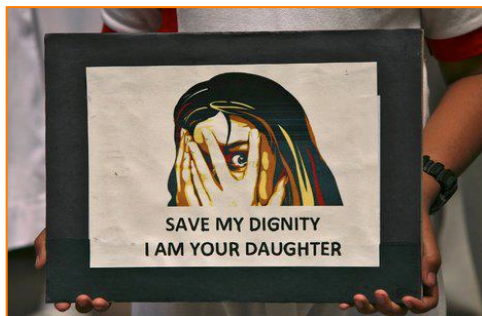
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Editorial

PWID and Gender

We exhaust a huge amount of time and energy spelling out the minutiae of gender discrimination in India, perhaps walk with the fleeing guilt of our advocacy shouts becoming whispers where structural change should supercede discussion, however animated, but we should see reality for what it is! Women are shortchanged in India, and lack of social and economic power only aggravate discrimination. If we are to take steps away from our residual medieval psyche, we have to incorporate uncomfortable change into life situations, and acceptance of women who inject or are spouses of injectors are no exception to the rule.

If we see the key focus on vulnerability of women and children in the HIV and AIDS epidemic, we have also seen that many solutions rest with women in terms of care and support. We have scant knowledge of female specific interventions for people who inject drugs, as programs for both interventions and care and support are insensitively integrated with male interventions. Although we are fully aware of transmission risks with HIV and AIDS for women, and have lobbied for full and equal access, we seem to have a universal sin of omission where female sexual partners and children of men who inject drugs are concerned.

The reason for this glaring gap in program policy and intervention plan is perhaps because our legacy of policies and programs are primarily conceptualised and designed by men-folk, and largely engage needs of men. How many programs are there that have been developed for women, by women and with women in focus? We would then learn from more about the unselfish social concern that is demonstrated by women in consideration of childcare, where people in Sharan learnt that detoxification services were demanded by women as they wanted to take care of children better, but they had to have their children in care with them as they were unable to trust any surrogate mechanism. We would perhaps learn that many women look after their male spouses needs when they are imprisoned, having to deal with shame and childcare, and the tragic downward spiral they are fast tracked to when they (and children) have AIDS and or TB.

We cant just point a finger at the Government without realizing that three point back at us as civil society. Whatever else we configure, we have known about the compromised gender responses to interventions for people who inject drugs, and apart for gendercentric issues, have also have to deal with reduced access to care and support for men that would come with the emotional and social support that family inevitably bring. Our solutions could easily emerge with investment in women for services that are needed for themselves, so we should just be asking the question of ourselves "how, with what and by when"?

Luke Samson and Siddharth Singh
On behalf of Editorial Board

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Report

National Consultation: Gender Challenges in Drug Injecting Populations

IHRN

A national consultation was organised by the Indian Harm Reduction Network (IHRN) on the 31st August 2012 to table out inadequately voiced gender associated challenges faced by PWIDs. Altogether 27 representatives from the multilateral & international organisation, NGOs service-providers, community of affected women participated. Nossal Institute, Australian International Health Institute (AIHI) [Research agencies], India HIV/AIDS Alliance, Emmanuel Hospital Association [EHA], SASO, Sahara [Pune], SPYM, Sharan [leading service-providers], FHI 360 and IHRN staff.

There has been an increasing cognisance of female drug use in India, but there are low levels of intervention, mostly at pilot stage, for this sub-population. This population has never been systematically and adequately mapped therefore the intervention size is considerably lower than for any existing male injecting cohorts.

The objective of the consultation was to arrive at a 'problem statement' that would focus on the most immediate needs for evidence based programming. It sought to identify a pathway to effective gender related size estimation including mapping, assessment and evaluation methodologies, and separate intervention packages for female injecting drug users (FIDUs) and Spouses and Sexual Partners of IDUs.

Consultation Proceedings

A wide-range of core issues affecting female injecting drug users and spouses of IDUs such as stigma and discrimination, intervention based concerns and parameters for expansion were deliberated in this pre-consultation through presentations covering:

- **Integrating Gender into HIV & AIDS Programs to Address Challenges and Reducing Stigma & Discrimination:** Madhumita Das, ICRW;
- **Targeted Interventions among Female IDUs: Experiences of Project ORCHID:** Melody Lalmuanpuii, Project ORCHID, EHA;
- **SASO FIDU Experience 2012:** Ch. Bangkim, SASO;
- **Introduction to Gender Challenges - focusing on Drug Use and HIV stigma:** Dr. Enisha Sarin
- **Gender Challenges for PWID in India: Where do the women and children go?** : Luke Samson, IHRN
- **Operational Research on Female Injecting Drug Users and Female Sex Partners of Men who Inject Drugs – Assessing Care Needs and Developing Responsive Services:** Debashis Mukherjee, UNODC shared key findings.
- **Bringing Home the Reality of the Challenging Issues Confronting FIDUs:** A representative of the community from Sahara-Pune shared her testimony.

Discussions

The key discussions centered on the following:

- There is no estimation available on the number of female drug users in India. The injecting pattern among female drug users is recorded in only a few sites in some of the northeast states; and there have been no substantial efforts to consolidate the special needs of this group.
- Though the draft of NACP-IV mentions the need to address Female IDUs, an in-depth discussion regarding the specific requirements of this population is not only timely but relevant.
- Female IDUs who are also living with HIV experience multi-pronged stigma: as women and mothers using drugs; as injecting drug users; as women susceptible to Intimate Partner Violence; as mothers to children with emotional, behavioural and academic problems; and as people living with HIV.
- Stigma and discrimination against FIDUs is manifested through evident physical and social isolation, verbal abuse, loss of livelihoods, loss of housing, poor access to health care, judgmental treatment by healthcare providers, rejection by peers, loss of reputation and violence. The consequences of these are: low HIV testing; minimal disclosure, lowered risk perceptions, negligible care and support, low access to treatment and inconsistent adherence to treatment.
- WWIDs are often reluctant to seek antenatal care and are often pressured or coerced to undergo abortion or to give up their children. They have limited access to accurate information about PPTCT or drug use and

Gender Challenges for PWID in India:

There are considerable gaps in the existing corpus of knowledge regarding:

- Estimated number of married PWID s in India;
- The number of spouses of male injectorss tested for HIV;
- HIV sero-prevalence among spouses of male injectorss;
- Estimated number of female injectorss;
- Estimated number of 'FIDUs & spouses' seeking access to health care and social support services;
- Estimated number of PWID who have children and spouses and who are widowed;
- Prevalence of TB, Hepatitis B and C among spouses or sexual partners of male injectorss who are living with HIV and have no access to ART;
- Social stigma and domestic violence faced by spouses;
- Strategies to access this 'hard-to-reach' population.

treatment during pregnancy.

Some of the intervention experiences shared by NGOs working with WWIDs in the Northeast highlighting the following issues:

- Physical and sexual harassment by security personnel;
- Lack of conducive environment for HIV testing at the ICTC centres;
- Absence of alternative livelihood options often leading to relapse even after completion of rehabilitation/treatment programs;
- Inadequate linkages with the OST program for women;
- Limited drug treatment facilities for women, inadequate slots and limited options for child-care. In several instances, admission to treatment programs is refused to those who have undergone repeated relapse or have multiple health complications;
- Poor access to information on reproductive and child health. Late detection of pregnancy owing to irregular menstrual cycles is common among WWID, and often it is too late to seek abortion services. Engagement in sex work to support their drug use continues during pregnancy and even soon after delivery.

Recommendations:

- Existing models of interventions for WWIDs should be continued and scaled up to generate information, assess different approaches, promote access to services and support advocacy;
- The importance of interventions for spouses and sexual partners of male injectors should be acknowledged and services for counselling, testing and treatment for HIV, TB and Hepatitis B and C should be extended to this population on priority;
- Linkage with social protection schemes and initiatives should be enhanced.

It was decided that IHRN would set up a WWID consultation e-group to discuss WWID/gender issues and incorporate suggestions and recommendations. The Pre-consultation report will be posted for feedback. A smaller group would be formed to compile thematic issues that will in turn inform the upcoming National-level Consultation. The Pre-consultation ended with a vote of thanks from IHRN.

“The story of women's struggle for equality belongs to no single feminist nor to any one organization but to the collective efforts of all who care about human rights.”

Gloria Steinem



Face in the crowd: A Female Injecting Drug User in India

This is a case study documented under the Advocacy and Legal AID component of GFATM Round 9 IDU*.

Ms. Emmy M and her family are permanent residents of Meghalaya although they are originally from Mizoram. Emmy was an injector living with HIV and Hepatitis C. She divorced her husband who is also HIV positive because of frequent physical abuse and mental torture from him. After divorced she came back to her parents' house with her daughter and she stopped using drugs and got married again.

On the 10th of June 1998, she was arrested under section 22 of NDPS Act 1985, in Paltan Bazar by Guwahati Police for possession of a box of Spasmo Proxyvon (18 Strips) and sent to the Paltan Bazaar Police Station where she was detained for a night. The next day she was shifted to the district jail Guwahati after a sentence for one month and 12 days. Although she was bailed out for an amount of INR 60,000 paid by her parents, she regularly went for her hearing till 2003.

In 2004, she went back to Mizoram to undergo a treatment, and stopped going for her court hearing anymore. She also did not contact her advocate. Ms. Emmy M and her family assumed that her case was already over. In the year 2011, two policeman came to her house in her absence and handed over an arrest warrant to her father. They also told the father that if he pays INR 2000 to them they will not arrest her and they will close the case. Her father paid the said amount to them. But again on 25th April 2011, Police from the Madanryting Station [Shillong] came to Emmy's house with an arrest warrant that stated that she has to appear at Guwahati Sessions Court on the 9th of May 2011.

On receiving the warrant she wanted to hide and contacted an outreach worker of VHAM who asked her to visit female DIC, where she was introduced to a lawyer from a Legal Forum (Rebina Subba) who guided her on entire legal procedures.

Following this the VHAM FIDU Team with the help of other support organizations including Indian Harm Reduction Network (IHRN) took up the case and started intervening, and the arrest warrant was recalled. Now Emmy is safe and secure, she can go around freely without any problem. Also hopefully the next court hearing will be the last.

Eventually on June 2, 2012, Ms. Emmy M has been acquitted of all the charges levied against her related to suspected possession of illegal pharmaceutical drugs under Section 22 of the NDPS Act 1985.

She was one of the first clients to be registered under the FIDU project supported by UNODC and also under the OST programme in the year 2010. At present she has sincere adherence to both ART and OST. Even her parents have been instrumental with their great support. Emmy comes to the DIC regularly and gets access to services that she needs.

She has been appointed as peer educator for the FIDU project for one year now and since then she has been very active in all the activities that are being organized in the DIC or in the field. She has developed an interest in pickle making and also flower making which is a part of incoming generating activities in the DIC.

This Case study is written by Kh. Jayanta. Kumar with the help of Ms. Atokali H Assumi, Programme Manager (UNODC FIDU Project) of Voluntary Health Association Of Meghalaya, VHAM. She has provided all the data necessary to compile this particular Case study.



Mission Report

A Rapid Assessment: Females Using Drugs in Darjeeling

Ineke Bass, *Public Health Consultant*

A rapid assessment was undertaken in April 2013 for the Society for the Promotion of Youth & Masses (SPYM). The mission sought to engage in:

1. Assessing the health and social problems female drug users face;
2. Exploring the accessibility of Drop-in-Centres (DIC) for female drug users;
3. Exploring the accessibility of rehabilitation centres for female drug users;
4. Informal meetings with female drug users, with community workers and with outreach workers;
5. Formal meetings with different stakeholders participating in the program.

The RAR method with a set of different qualitative tools, included interviews with key informants and drug users: male and female, ethnographic observations, and meetings with local stakeholders and national stakeholders were used.

According to a 2008 study, there are 10,055 to 33,392 female IDUs in India. This number would have only have increased in the past 4 years. With regard to Injecting Drug Use, both males and females who inject drugs experience a significant burden of HIV disease, infection with other blood-borne viruses and also potentially life threatening conditions i.e. Tuberculosis that is HIV linked. However, FIDU face still greater risks. Risk accrues from both unsafe injecting and risky sex practices. Gender inequality, sexual exploitation and economic pressures add to the risk for women. They are also likely to face violence and greater levels of stigma and are more likely to die earlier.

Pattern of drug use among females

Many women who inject drugs begin as non-injectors and rapidly transit into injecting. The patterns of injecting among FIDUs are similar to those of male injectors, and they show a preference for pharmaceutical injecting. High rates of sharing and reusing, involvement in sex work and intoxication with alcohol is common in this group.

Sex Work

'Many female injecting drug users sell sex to procure money for buying drugs which makes it even more difficult for them to negotiate safer sex whilst increasing needle sharing.'¹ Studies show that women drug users



are more likely to take risks in sex work and are less likely to work in brothels.'²

Male Dominance in Relationships

'Many of the social factors influencing HIV transmission among women injecting drugs relate to gender dynamics and the imbalance of power structures between men and women.'³

- Female (injecting) drug users often have a male sexual partner who also uses drugs. Their male partners' drug (injecting) habit very often promotes the onset of using drugs.
- Due to an unequal power balance in many of these relationships, females have greater difficulties abstaining from drug use, particularly if their male drug-using/ injecting partner continues and supports injecting.
- The male partner may even discourage the female from seeking prevention and treatment services. These relationships are highly stressful, particularly for the female partner.
- Condom usage with regular partners is low, and they have no access to female condoms.

Fear of Social Stigma

Females who use drugs and who inject drugs are more likely to be stigmatized by society than male injecting drug users because their activities are considered to be doubly deviant: It is generally considered that drug injecting violates social norms of behaviour, and many feel that drug injecting by females is even worse, as it diverges from the traditional expectations of women as wives, mothers, daughters and nurturers of families.

Compared to their male counterparts, female injecting drug users face exceptionally intense stigma

¹ Desk Review Report: Female injecting drug users and drug users in South Asia: Concerns, responses, achievements and challenges.

² www.aidsalliance.org in Desk Review Report: Female injecting drug users and drug users in South Asia: Concerns, responses, achievements and challenges.

³ Ibid.

and discrimination that keeps them from assessing key health and education services. Combined with severe social stigma and discrimination, women suffer more because of the intensity of stigma and discrimination often associated with drug use; because of wider social implications that affect women such as domestic violence, rape and abuse, lower social status and educational attainments, human trafficking; and especially because of expectations related to traditional roles of women's drug use.⁴

Health Problems

- Mental stress is high, a significant number of female (injecting) drug users face isolation and report suicide attempts.
- Many female (injecting) drug users have a history of physical and sexual abuse. Females who have been abused are more likely to use drugs and have multiple sex partners.
- Sexual and reproductive health problems, particularly abortions are frequent.

Lack of Comprehensive Services

While (injecting) drug use among females is being increasingly recognised in India, it is clear that services are not gender responsive in terms of meeting the need of FIDUs. Female drug users encounter lack of access to gender specified care for drop in centres and rehabilitation facilities, treatment of OST, counselling (VCT), prevention and treatment of HIV and STI. The major concerns are:

- Female (injecting) drug users are a hidden population in the community;
- They do not seek treatment in a male-centred treatment environment;
- Female (injecting) drug users with children may also not seek services because of fear of hostility or of having their children taken away from them;
- Females may also encounter barriers in accessing services because of household responsibilities, lack of family support, lack of social networks and lack of financial resources;
- Drug treatment options are also extremely limited for this group; Restrictive treatment policies range from the lack of gender-segregated care, lack of childcare facilities, lack of drug treatment and rehabilitation facilities (In Darjeeling at a women rehabilitation facility of at least 50 treatment places is needed).
- Unhelpful attitude of service providers to several barriers to help seeking;
- A major barrier is lack of privacy and confidentiality, leading to fear of being identified and stigmatize

Situational Context: Drugs & HIV

There are approximately 96,463 to 1,89,729 male IDUs and 10,055 to 33,392 female IDUs in India⁵. A study in 5 northeastern states highlighted significant presence of female IDUs in all the IDU groups studied. Further, evidence of sex work in some locations added a new facet in the transmission dynamics of HIV infection.

Female IDUs may often sell sex for drugs and for their livelihood in the region. The dual risks of sexual and drug injecting practices put female IDUs in this region at greater risk of the acquisition and transmission of HIV infections. A study in Manipur reported a high prevalence of HIV (57%) among female IDUs. The study further showed that female IDUs also acting as sex workers in the region may facilitate transmission of HIV infections to a wider general population through their non-IDU sexual partners⁶.

Gender shapes the experience of drug use and its associated risks. There is a growing body of literature on gender differences with respect to risks and harms associated with injecting drug use, including HIV transmission. These differences relate to the way in which women inject (or are injected), to levels of high-risk sexual behavior, such as commercial sex work, transactional sex, and to other factors such as stigma and discrimination.

In India, experts point out that there is no one single epidemic. Instead there are numerous sub-epidemics, which are localized in geography reflecting the diverse socio-cultural reality of the country. Some significant structural and socio-economic factors serve to exacerbate the existing vulnerabilities to HIV infection⁷:

- High poverty levels, with more than 35 percent of the population living below the poverty line;
- Skewed gender relations
- Large scale migration
- Low levels of literacy;
- Unsafe mobility
- Lack of awareness
- Cultural myths, misconceptions, silence and resulting stigma regarding sex, sexuality and HIV;
- Commercial sex and unprotected sex with multiple concurrent partners;
- Male resistance to condom use;
- High prevalence of sexually transmitted infections; and
- Low status of women, resulting in inability to negotiate safer sex;
- Women's limited control over and access to economic resources;

⁵ Position Statement Injecting Drug Users and Access to HIV Treatment The Global Network of People living with HIV/AIDS (GNP+) And The International Community of Women Living with HIV and AIDS (ICW) And The International Community of Women Living with HIV and AIDS (ICW)
13 Harm Reduction and Human Rights The Global Response to Injection-Driven HIV Epidemics Sub

⁶ Medhi Gajendra Kumar; Mahanta Jagadish et al; Spatial distribution and characteristics of injecting drug users (IDU) in five Northeastern states of India; BMC Public Health

⁷ Mainstreaming HIV and AIDS for Women's Empowerment, NATIONAL AIDS CONTROL ORGANISATION, Government of India 2008

⁴ Desk review report: Female Injecting drug users and drug users in South Asia: Concerns, responses, achievements and challenges.

Drug Policy & Harm Reduction Policy: Darjeeling Context

As far as the legal environment in Darjeeling specific is concerned, (male/female) drug users may be arrested and prosecuted on charges of possession of and /or consumption of a small quantity of classified drugs under The Narcotic Drugs and Psychotropic Substances Act 1985. The offense is punishable with imprisonment for 6-12 months, depending on the quantity and type of drug⁸. Those convicted for possession and/or consumption of a small quantity may be diverted into treatment under certain conditions and drug users undergoing treatment may seek immunity from prosecution.

Although possession of injecting equipment per se is not illegal, provision of sterile injecting equipment for drug users may be viewed as amounting to —aiding and abetting offence of unlawful consumption of drugs⁹. This includes both male and female injection drug users.

Discussion and Recommendations

In this rapid assessment a few numbers of female drug users have been interviewed. The small number is very likely due to fear and social impact of disclosing. This study relies primarily on a focus group discussion, interviews with women and meeting with staff members and as well comments of male drug users.

In addition to the nine interventions for responding to HIV among IDUs, interventions addressing other important morbidities (such as overdose and mental health problems) should not be overlooked, and should form part of a comprehensive response to injecting drug use.

WHO, UNODC and UNAIDS have endorsed a comprehensive set of nine interventions for responding to HIV among IDUs, including:

1. Needle and syringe programmes (NSPs) 16
2. Opioid substitution therapy (OST) and other drug dependence treatment
3. HIV testing and counselling (T&C)
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programmes for IDUs and their sexual partners
7. Targeted information, education and communication (IEC) for IDUs and their sexual partners
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis (TB).

Source: Female Drug Use, Sex Work and the Need for Harm Reduction, fact Sheet

Harm reduction program

- Although programmes and services have been available for men many years in Darjeeling, it is evident that coverage of availability and accessibility for women is an issue. Harm reduction programmes need to be expanded and should include women who use drugs.
- Women who use drugs and wives of men who use (inject) drugs must be included in HIV prevention, (OST) treatment, care and support programmes for people who use/inject drugs.
- Consider in the current situation *OST treatment for women by mobile OST with provision on certain days, times and places known to the female clients*.
- VCT and testing promoted through a safe, culturally appropriate mechanism for women who use drugs must be scaled up for women.
- Provision of training and skill building on harm reduction, including prevention, outreach, counseling and policy. Involvement of (strategic) partners to strengthen durable harm reduction programs.
- Training on using guidelines in a proper way. According guidelines on the one hand OST is provided while on the other hand the OST in the same situation with the same guidelines has been refused. A tailor made manual for staff might be beneficiary here.

Gender sensitivity

- Programmes need to extensively increase information on sexual and vertical transmission of HIV, as well as condom promotion and distribution among (injecting) drug users.

Community engagement

- Integrate prevention and care services with existing health and social institutions to jointly combat HIV/AIDS and Hep. B and C among drug users, including mobile teams, outreach works and drop in centres accessible for women*.
- Address the need of a self-support group
- Develop early age prevention programmes, for schools, sports facilities etc.
- Develop awareness programs.

Human rights

- To advocate for human rights of female drug users on local, national level and global level, to address stigma and discrimination, accessibility to information and services: rehab, OST, VCT, NSP for women.
- Poverty reduction

Program approach

Programmes aimed at women using drugs need to look beyond HIV prevention, harm reduction and drug treatment options and improve linkages and networking skills training and employment opportunities in Darjeeling to help reduce poverty among women using drugs.

⁸ The Voices of Injecting Drug Users: Harm Minimization in Nepal By Dr. Chandra Kant Jha and Jeanne Madison 1

⁹ Position Statement Injecting Drug Users and Access to HIV Treatment The Global Network of People living with HIV/AIDS (GNP +)

Just A Handful of Life: Female Drug User

SASO

Manipur is a small state in the northeastern side of India. It is located at Indian-Myanmar border and links both countries with a border-town Moreh also an entry point for heroin to different parts of state. There was a time when drug use was primarily a male dominated behavior. However in the last 2 decades we are witnessing an increase in the number of women using drugs. Perhaps they start using drug from peer pressure, sheer curiosity or when they have family problems or their husband happens to be an injector.

When drug use is initiated, then it is difficult to stay away from drugs and they soon look for more. This vicious cycle leads to a situation when they are seen or labeled as drug addicts. Then their miseries start with several traumatic experiences such as their family disowns them, they are forced to leave their home and start a life on street as 'no-one' who belongs to 'nowhere'. Often at night while living on streets they are physically and sexually abused, raped and brutally tortured. The bitter reality is that they are not able to share such traumatic experiences and seek justice for what they have gone through. Female drug users are highly discriminated against and stigmatized by community and society. Wherever they go they receive harassment, filthy remarks and demeaning names. When they very urgently need healthcare services or any form of treatment, they make all possible attempts to avoid this because either they are afraid or ashamed. Some remain painfully untreated while some pass away.

In order to arrange their daily substance demand most of them engage in sex-work as it is the easiest means for earning money, while others try to get money by doing petty drug related crimes. Due to their dual risk behavior they are highly vulnerable to HIV, HCV and STI, etc. and their health condition deteriorates very fast. The magnitude of transmission of HIV/AIDS and HCV through them is high.

Most of the female drug users had been to the residential rehabilitation centres several times. Except for a few, most of them fail to recover. The probable reason is that they are not able to adapt to the environment at home as they feel uncomfortable. A majority of them are from the hilly areas and they do not want to stay at their native places as they have to work

hard to earn money for their livelihood. So they land up at their original workplace where they can earn easy money doing sex work. And that is why as soon as they come out from the rehabilitation and relapse.

A case study

Kim was a 23 years old unmarried injector as well as a sex worker. She was conceived but due to her drug using habit she did not realize that she was pregnant as she had irregular menstruation. She did not go for routine check-ups and continued her sex work and drug injecting. At the time of her labor pain, one of her injector friends took her to a hospital. Soon after the delivery of a baby boy she was discharged from the hospital.



To support her daily drug use, she got involved in all sorts of petty crimes such as snatching mobiles, stealing things from relatives' houses, cheating others. One of her friends took care of the baby. In 2 or 3 instances she was beaten 'black and blue' by the local people for stealing. One day Kim was caught by a local women group red handed while she was stealing mobiles in a shop. The women group handed her over to the All Manipur Anti Drug Association who contacted a Female IDU DIC staff at North A.O.C. (a hotspot for drugs and sex-work in the middle of Imphal). From there she was referred along with the newly born baby to a rehabilitation centre for drugs but she ran out after 3 days.

After coming out of the centre as Kim was still not able to earn through sex work, she had to get money somehow or the other. She sold her baby for Rs.500/- to buy drugs. Her health condition deteriorated day by day due to her multiple sexual reproductive health related complications and she passed away just after 5 months of the child delivery. It was a very pathetic situation at her end time also as there was no one from her family side to carry out the burial ceremony. The local Student Group of her tribal community took up that responsibility at last.

This kind of thing is a very common occurrence among the female drug users. Something needs to be done for them. They need to unite together and strengthen their stance, to voice their grievances to the authority and make known the problems they are facing. Female drug users are human beings and they are entitled to all the rights, especially the right to life.

ICCAP 11

Asia/Pacific Reaching Triple Zero Investing in Innovation



11th International Congress on AIDS in Asia and the Pacific (ICAAP 11)

17-23 November 2013

Bangkok, Thailand

The International Congress on AIDS in Asia and the Pacific (ICAAP) is the largest forum on HIV/AIDS in the region. Now in its 11th edition, this year's Congress is coming to the vibrant city of Bangkok in Thailand.

Approximately 4,000 delegates from 22 countries across Asia and the Pacific are expected to participate in this five-day long forum. The Congress will offer delegates dynamic learning experience, and great networking opportunities through a variety of programmes and activities.

Registration for ICAAP11 is now open.

Don't miss this once-in-two-year opportunity. Sign up now and register.

Survival guide for Community members

This guide will assist Community members on how to register for ICAAP, to apply scholarship, to submit abstract and to apply for an activity in the Asia-Pacific Village.



Apologies

The Indian Harm Reduction Network (IHRN) Editorial Board expresses its concerns over one month delay of Issue 1: Volume 3. We will try to ensure timely release of next issue.

This newsletter is unsupported efforts from IHRN to set up a platform for sharing information, experiences and expertise with its membes.

If you wish to share your experiences with the IHRN membership please write to us.

Editorial Board

2nd Regional Conference on Harm Reduction s



Middle East & North Africa Harm Reduction Association (MENAHR)
12-15 November 2013

Beirut-Lebanon

Harm Reduction in MENA: Break The Barriers...Build the Future

The Conference is organised by MENAHR - Middle East and North Africa Harm Reduction Association.

Hayek Roundabout, BBAC Building
Second Floor

+9611 493 211/2/3

Sin el Fil, El Metn

Lebanon

<http://www.menahra.org>

The International Drug Policy Reform Conference 2013



Students for Sensible Drug Policy » Upcoming Events » The International Drug Policy Reform Conference 2013

SSDP is proud to be a co-host of The International Drug Policy Reform Conference hosted by the Drug Policy Alliance. The conference will take place Oct. 23-26 at the Sheraton Downtown Denver.
www.drugpolicy.org/2013scholarships

International Overdose Awareness Day

International Overdose Awareness Day

International Overdose Awareness Day is held on August 31st each year.

Commemorating those who have met with death or permanent injury as a result of [drug overdose](#), it also acknowledges the grief felt by their families and friends.

Celebrated around the world, International Overdose Awareness Day aims to raise awareness of overdose and reduce the stigma of a drug-related death, especially for those mourning the loss of family and friends. It also spreads the message that the tragedy of overdose death is preventable.



An inspired idea

International Overdose Awareness Day originated in Melbourne, Australia in 2001. Sally Finn, manager of a Salvation Army needle and syringe program, was touched by the sorrow she observed among the friends and families of those who had overdosed. She witnessed their inability to express that sorrow because of the stigma surrounding people who use drugs.

Sally decided to organise an event of remembrance. To commemorate those who had died from overdose, Sally hit upon the idea of distributing ribbons. She thought she'd need 500, she gave out 6,000.

More than a decade on, that one event in the back yard of a suburban crisis centre has evolved into *International Overdose Awareness Day*, which is now celebrated around the world. Its global significance reflects the universality of the human emotions triggered by the tragedy of overdose – a tragedy that's preventable.

The organisation

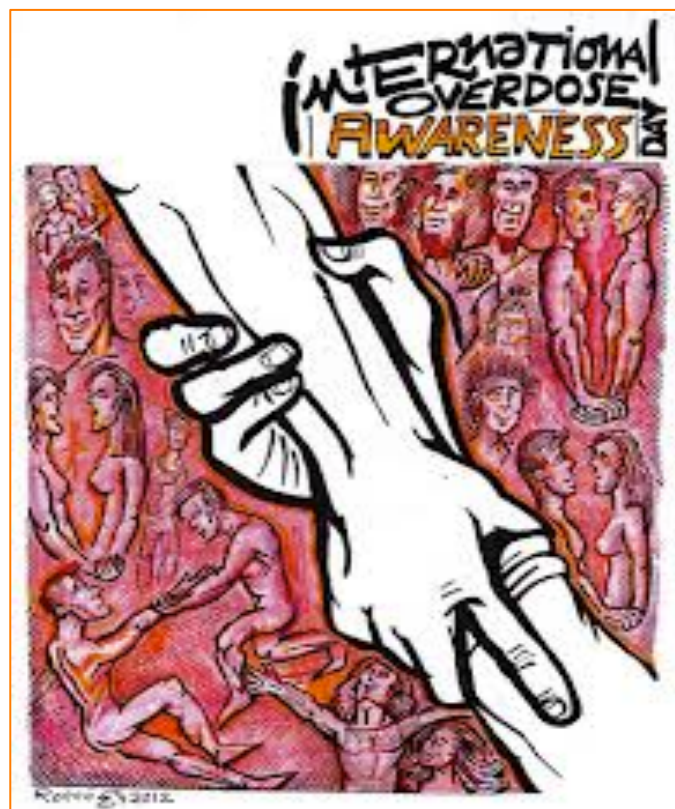
Beginning in 2012 International Overdose Awareness Day is being organised by the non-profit Australian public health body [Anex](#) after Salvation Army Crisis Services transferred responsibility. Its theme is Prevention and Remembrance.

Anex works to increase understanding of – and improve responses to – the problems arising from the use of illicit drugs, pharmaceuticals and alcohol.

A number of committed individuals and a range of organisations involved in drugs and alcohol and emergency services make up this year's committee.

Everyone from governments, councils, health services, police, families and individuals are encouraged to get involved and show their support.

Organisations and individuals are encouraged to [develop](#) and register their own local events or ceremonies.



**"Words are, of course,
the most powerful drug
used by mankind"**
Rudyard Kipling

On Aug 28, 2013, SAMHSA has come up with a series of tools:

How To Prevent Opioid Overdose and Overdose-Related Death

The Opioid Overdose Toolkit educates first responders, physicians, patients, family members, and community members on ways to prevent opioid overdose. The toolkit also explains how to use a drug called naloxone to prevent overdose-related deaths.

Anyone who uses opioids for long-term management of cancer pain or noncancer pain is at risk for overdose, as are those who use heroin. The good news is we now know that the drug naloxone can be used as an antidote to opioid overdose and can prevent opioid-related deaths when naloxone is administered in a timely manner.

Inside the toolkit are five separate booklets, each designed for a specific audience.

- **Patients** can learn how to minimize the risk of opioid overdose.
- **Prescribers** can understand the risks of opioid overdose, as well as clinically sound strategies for prescribing opioids, and educating and monitoring patients.
- **First responders** will find five steps to use in responding to an overdose, including how to use naloxone and provide other life-saving assistance.
- **Community members** can view facts about opioid overdose that can help local governments, community organizations, and private citizens develop policies and practices to prevent overdoses and deaths.

Survivors and family members can gain information and support through the information provided in this booklet.



Indian Harm Reduction Network

IHRN was established in February 2007 and is composed of a network of organizations and professionals working in the field of drug treatment & HIV prevention, treatment and care.

IHRN: Mission & Goals

To secure access to quality health services for drug users within a rights-based framework and to support the participation of drug users/primary stakeholders in service delivery and in policy development.

IHRN: Activities

Capacity building of members; Policy advocacy; Networking; Information sharing; Research; Collective actions.

IHRN: Members

Members of the network include key grassroots organizations like Sharan, SAHARA, Indian Network of Positive People (INP+), Delhi Network of HIV Positive People (DNP+), SASO, along with other technical support and advocacy organizations like HIV/AIDS Alliance India, Emmanuel Health Association (EHA), Lawyers Collective, Population Services International (PSI), and other technical experts in the field of injection drug use, HIV and drug treatment.

IHRN: Progress

Since its inception in 2007, IHRN has been able to influence and achieve recognition and endorsement from the Government of India in relation to the National AIDS Control Programme Phase III (NACP-III). This was accomplished through the membership of key IHRN members in the IDU Technical Resource Group of the National AIDS Control Organization (NACO) and the UN Task Force on HIV & IDU in Asia and the Pacific, as well as through informal advocacy initiatives and technical support activities.

IHRN is one of the sub-recipients of the GFATM: Round 9 grant for HIV with the primary focus of strengthening the capacity of service-providers in delivering harm reduction services for injecting drug users and ensuring the development and implementation of quality programming for harm reduction services.

In order to effectively accomplish its objectives, IHRN has established network with key stakeholders in the field of IDU programming in India, primarily to identify current gaps in program implementation, client-matching service provisions and develop strategies to effectively scale-up and strengthen the national IDU programs and responses.



Forthcoming issues

Issue 4: Capacity Building
Issue 5: Children

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