Situation Analysis of Basic Education, Vocational Education & Development of Sustainable Livelihoods in Drug Treatment & Rehabilitation Centres of India
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MAP OF INDIA

Source: Survey of India 2005
Composed by: National Informatics Centre
Acronyms

AIDS  Acquired Immunodeficiency Syndrome
EC    European Commission
FGD   Focus Group Discussion
HIV   Human Immunodeficiency Virus
IDUs  Injecting Drug Users
ILO   International Labour Organisation
KI    Key Informants
MoH   Ministry of Health and Family Welfare
MSJE  Ministry for Social Justice and Empowerment
NACO  National AIDS Control Organisation
NDPS  Narcotics Drugs and Psychotropic Substances Act
NGO   Non Government Organisation
NISD  National Institute for Social Defence
RRTCs Regional Resource and Training Centres
SPYM  Society for Promotion of Youth and Masses
UNESCO United Nations Educational Scientific and Cultural Organization
UNODC United Nations Office on Drugs and Crime
Foreword

It is now a commonly accepted fact that education is a crucial factor in the achievement of development goals, and this is especially true in the contexts of those affected by drug use. We know that education is a highly effective, contributing factor for social inclusion and the creation of sustainable livelihoods. It is acknowledged India has experienced widespread drug use and continues to do so, with many of these users also being drug dependent. Many drug users need and seek assistance by being admitted into drug treatment and rehabilitation centres but it is widely acknowledged that relapse following discharge from such facilities is common.

In late 2008, research was undertaken by UNESCO, jointly funded by the European Commission, to improve our understanding of broad ranging educational activities, within the government, non-government and private sectors, with a specific focus on the development of vocational education and the fostering of livelihood skills among drug users, ex-drug users and people vulnerable to drug use. This is the first time a study of this kind has been conducted in India. It is important to note that the various responses received do not represent all the drug treatment and rehabilitation facilities of India. However we do believe that important new insights can be gleaned from the various findings of the key-informants, focus group discussions and questionnaire response.

The research found gaps in basic education, vocational education and development of livelihood skills of drug users within the overall drug treatment and rehabilitation system. Most facilities did not provide regular referrals or linkages with other organisations in their locality to assist with basic education, vocational education and livelihood skills, and only a minor number have formulated any partnership with an outside agency, organisation or institution that may have offered such services.

The release of this report is timely when the social and economic re-integration of drug users into the community at large, requires innovative and pragmatic solutions for the way forward.

We hope you find this report interesting and of use.

Minja Yang
Director and Representative
UNESCO New Delhi Office
A situational analysis of basic education, vocational education and the development of sustainable livelihoods in the drug treatment and rehabilitation centres of India was undertaken from August to November 2008. A key focus was on vocational education and sustainable livelihoods, with drug and HIV awareness running as transversal themes. Research of this type was not known to have previously occurred in India. The aim of this research was to improve our understanding of broad ranging education activities with a focus on the development of vocational education and the fostering of the skills for livelihoods of drug users within the government, non government and private sectors.

India was identified in the literature as a drug using nation. Widespread misuse of alcohol was found and there were an estimated two million opiate users, eight million cannabis users, and up to 164,000 drug injectors. Responses to these issues were broad ranging. Examining the legal framework for rehabilitation of drug users, the Narcotics Drugs and Psychotropic Substances Act (NDPS) introduced in 1985, mentions rehabilitation and social re-integration of “addicts” twice, in Sections 7A (2) and 71(1), but does not provide any specifics of rehabilitation per se. Drug demand reduction programmes rest with the Ministry of Social Justice and Empowerment (MSJE) and were responsible for implementing the Scheme for Prohibition and Drug Abuse Prevention, 1985-1986. The focus of the scheme was the de-addiction and rehabilitation of drug users in a community setting. A partnership between the MSJE and the National Institute of Social Defence (NISD) with other NGOs implements a range of services including drug treatment and rehabilitation. The Ministry of Health and Family Welfare (MoH) were responsible for drug treatment centres within hospital and health institutions.

Eleven key informants (KI) representing eight stakeholder bodies in New Delhi were selected and interviewed as part of the research: MSJE (Government); United Nations Office on Drugs and Crime; MoH (Government); International Labour Organisation; Sharan (NGO); National AIDS Control Organisation (Government); NISD (Government); and the Society for Promotion of Youth and Masses (NGO). Few mentioned the ‘Scheme for Prohibition and Drug Abuse Prevention 1985 – 1986’, as more orientated towards basic education, vocational education and livelihood skills. Delivery of HIV and drug education messages was often described as prescriptive and didactic. Stigma and discrimination towards drug users was mostly described as endemic in the community at large thus hampering social and economic reintegration. Some identified a lack of literacy among some drug users as a barrier and some suggested the critical importance of developing suitable skills among drug users for re-integration. Most believed referrals or linkages with other services were under-developed. Scope for improvement with monitoring and evaluation to improve outcomes for drug users, was highlighted. The lack of formal linkages between Ministries linked with drug use issues was commented upon. Referrals and linkages with those outside the drug sector were considered the way forward. Training was an ongoing process and innovation was something that should be encouraged.

Four focus group discussions with drug users were undertaken in four different cities, comprising of six to eight participants, aged between 20 and 40. All had experienced a treatment programme of more than 30 days. Findings indicated some suggestions. The request for treatment centres to identify skills and aptitudes of clients to assist and guide clients towards employment; counsellors must have an improved and comprehensive understanding of vocational education and livelihood skills; halfway homes for recovering drug users linked with reintegration programmes need consideration; and vocational education training must be practical and oriented towards the reality and demands of the community at large.

A total of 122 drug treatment centres were identified under the responsibility of MoH. Over three weeks, 215
Situation Analysis of Basic Education, Vocational Education & Development of Sustainable Livelihoods in Drug Treatment & Rehabilitation Centres of India

telephone calls and 38 emails were sent to MoH drug treatment centres, of which a total of 24 electronic questionnaire responses were received. Facilities identified under MSJE/NISD and those not linked with this Ministry numbered over 450 sites. Contact information was generally available. Over seven weeks a total of 300 telephone calls were made, 380 emails sent and 80 questionnaires posted. Twenty-two face to face interviews were also undertaken. A total of 95 completed questionnaires were received of which the majority were received electronically.

A summary of the survey was undertaken using descriptive statistics to depict the different characteristics. We then compared the types of organizations participating in the survey for selected variables. The data collected in the survey was coded and entered into Excel sheets.

The research revealed an extensive list of findings and these are found in the full report.

Specific findings of direct relevance for the social and economic reintegration of drug users were as follows:

- 23% of clients inside facilities were identified as illiterate, while 11% had achieved primary school education only
- 61% of facilities did not provide basic education (numeracy and literacy skills) for drug users
- 61% of facilities did not provide vocational education and livelihood skills
- Vocational and livelihood skills offered were commented to be income generation activities like soap, candle, paper bag making, with a few responses commenting on computer skills, printing and TV repairing
- 64% of facilities did not provide regular (1-3 months) referrals or linkages with other organisations in their locality to assist with basic education, vocational education and livelihood skills
- 74% of facilities had formulated no partnership with an outside agency, organisation or institution
- 63% of facilities believed they had the capacity to undertake basic education combined with vocational education and livelihood skills

Some other highlight findings include:

- 119 responses in total: 56 (MSJE/NISD); 24 (MoH); 15 (other NGOs not linked with MSJE/NISD); 20 (Private); and 4 (Others)
- Representation from 25 States and one Union Territory of India
- 96% of facilities provided HIV and drug education to drug users mostly with group sessions (86%) and Mass Media such as radio, TV and film (46%)
- Most popular sources of information about HIV and drug use came from the Government (56%) followed by the Internet (37%) and UN agencies (32%)
- 69% of facilities provided educational materials or used suitable approaches for those who could not read but less so for those under MoH
- 70% of information to those who could not read was by verbal explanation, followed by group discussion (68%)
- 61% of facilities provided educational materials in other languages (excluding the main language of locality) and was higher among those under MSJE/NISD
- 44% of facilities did not test, discuss or access the opinions of drug users about the educational materials provided
- Most facilities reported that their client group had no fixed job with irregular income (57%), followed by unemployment (32%). Only 11% had regular jobs
- Only 21% were aware of any laws, regulations, policies, schemes that comment upon vocational education and livelihood skills for drug users.
Gaps in basic education, vocational education and development of livelihood skills of drug users within the overall drug treatment and rehabilitation system were identified. Within a broad ranging education framework there was a need to move towards an evidence based and practical response. To aid the process of whole person recovery, basic education, provision of appropriate vocational education and skill development compatible with the needs of the society will be necessary. Only then could the social and economic re-integration of drug users into the community at large, be ensured.

The research findings of this report were presented to a broad range of participants attending a UNESCO event in New Delhi, 10 November, 2008, titled ‘National Consultation on Education and Harm Reduction related to drug use, HIV and AIDS in India’. The event not only highlighted the findings, accompanied with participatory discussions about the recommendations, but also provided a platform for various UNESCO funded projects in India that focus on various aspects of HIV and drug use.

Recommendations
A detailed overview of the recommendations, accompanied with suggested responsible agencies and collaborators have been outlined in the full report. Broad-based recommendations were as follows:

1. Advocate and encourage at a national and state level for policies, schemes, and/or laws that incorporate the concept of the ‘whole person recovery’ in order to expand and offer opportunities to recovering drug users to receive basic education (numeracy and literacy skills where applicable and appropriate), vocational education and livelihood skills from all types of drug treatment and rehabilitation services

2. Improve and provide training opportunities and skill building for appropriate staff working at all drug treatment and rehabilitation facilities

3. Encourage drug treatment and rehabilitation facilities to explore more widely the benefits of alternative employment opportunities suited for social and economic reintegration of drug users and ensuring that human and funding resources are made available.

4. Improve the coordination and harmonizing of all the different stakeholders directly or indirectly associated with education, vocational education and livelihood skill development, with those services providing drug treatment to improve the lives of recovering drug users.

5. Undertake further research to address some limitations and gaps identified in the situation analysis.

6. Improve the lives of all recovering drug users (impoverished or not) that may be isolated from supportive networks to gain social and economic reintegration.
Introduction and Background

A global series of country-based consultations, including India, funded jointly by UNESCO with the European Commission, were planned to review the status of drug demand and harm reduction strategies and strengthen the educational dimension and responsiveness of such approaches. Within UNESCO there is an emphasis on universal access to education, (latest figures from UNESCO (2008) show there were an estimated 774 million illiterate adults in the world, of whom about 64% were women), sustainable livelihoods, prevention, treatment, care and support for people vulnerable to drugs and affected by HIV and AIDS. Education is a key to development goals, especially in the contexts of those affected by drug use, through offering effectiveness and dignity in development along with empowerment for the poor and most vulnerable. We know that education provides opportunities directly into people’s hands and is thus an effective, contributing factor to social inclusion and the potential for sustainable livelihood. Additional benefits are evident when education is associated to other services, especially in the relationship to prevention, treatment and care.

In this research study titled ‘Situation analysis of basic education, vocational education and development of sustainable livelihoods in drug treatment and rehabilitation centres of India’ a key focus was on vocational education and sustainable livelihoods, with drug and HIV awareness running as transversal themes. Research of this type was not known to have been undertaken in India. Due to time, budgetary and methodological constraints this research cannot be viewed as a comprehensive overview of what was taking place inside drug prevention, treatment and rehabilitation centres nationwide. But it will be hoped that research of this type will lead to an improvement in our understanding of the holistic needs of drug users, ex-drug users and people vulnerable to drug use within a broad ranging education framework and contribute towards informed, evidence based, practical response.

Aim of research
To improve our understanding of broad ranging education activities, within the government, non-government and private sectors, with a specific focus on the development of vocational education and the fostering of livelihood skills among drug users, ex-drug users and people vulnerable to drug use.

Objectives
1. To increase knowledge, awareness and understanding of various broad ranging education approaches for drug users, ex-drug users and people vulnerable to drug use in India among the various sectors including government, non-government organisations, the private sector and the broader community.
2. To highlight broad ranging education activities which aim to improve the possibilities for social reintegration and the inclusion of drug users, ex-drug users and people vulnerable to drug use into the wider community.
3. To advocate for the prioritisation of the development and fostering of broad ranging education opportunities for drug users and ex-drug users as part of their ongoing treatment and rehabilitation towards community reintegration.
4. To increase government support for broad based education, vocational education and development of livelihood skills among drug users, ex-drug users and people vulnerable to drug use, the evaluation of these schemes and their subsequent scale-up.
5. To promote a multi-sectoral response to the joint issues of broad ranging education, drugs and HIV through greater coordination and collaboration between education, health and social sectors of the government.
Methodology for Survey

A mapping exercise to identify treatment sites commenced in August 2008. Different methods were implemented during the various stages and adapted according to the sector involved in drug treatment. The Ministry of Health and Family Welfare (MoH) provided a document of drug treatment centres under their responsibility that comprised of 122 facilities. The list only provided the facility name and state, but did not list address or contact details. The internet, search engines (primarily Google) and personal contacts were used to identify contact details in different states. Over three weeks a total number of 215 telephone phone calls and 38 emails were sent to MoH facilities. A total of 24 completed questionnaires were received representing 15 States (Annex 2 for more details).

A mapping exercise accessing publicly available sources was undertaken to identify all NGO facilities offering drug treatment and rehabilitation services under responsibility of the Ministry of Social Justice and Empowerment (MSJE) and National Institute of Social Defence (NISD) facilities as well as various agencies not associated with MSJE/NISD. Further consultations with those representing the Regional Resource Training Centres (RRTCs) empowered by the MSJE to support and guide the nation’s drug treatment centres were also undertaken. A combination of in-active emails, difficulty accessing functioning telephone numbers and an overall poor response rate to emails, telephone calls or posted questionnaires (87 questionnaires were sent by post to those agreeing to participate but only six responded) resulted in the data collecting phase extending to just over six weeks from 1 September to 22 October. Twenty-two face to face interviews took place in Mumbai, Pune, Bangalore, Kolkata, Imphal and Aizwal during which period the consultant travelled to access more responses. During the study period 300 telephone calls and 380 emails were sent to treatment facilities (Annex 2 for more details).

We summarised the data of the survey using descriptive statistics to describe the different characteristics. We then compared the types of organisations participating in the survey for selected variables. The data collected in the survey was coded and entered into Excel sheets. The data was analysed using software packages Epi Info (version 6.4b, Centers for Disease Control, Atlanta, GA, in collaboration with World Health Organization, Geneva, Switzerland) for frequency distribution and univariate analyses.
Narrative summary of drug vulnerabilities

A review of poverty in India showed that between 1981 and 2005 India had shifted from having 60 percent of its people living on less than US$ 1.25 a day to the lower figure of 42 percent. Yet the number of poor people living under US$1.25 per day was estimated at 456 million in 2005 (World Bank 2008). In the first decade of the new millennium India has been experiencing substantial economic growth but this has been coupled with an increasing disparity between the rich and the poor: for the poor many still lack food security, experience higher illiteracy, often lack access to health facilities and when they do, it can impact severely on their income (Ma and Sood 2008).

In 2004, of the more than one billion people in India, the median age was 24 years, with 36 percent of the population younger than 15 years (Ma and Sood 2008). The size of the youth population in India can result in several challenges. Currently youth unemployability has been suggested to be a bigger crisis than unemployment with an estimated 57% of Indian youth experiencing some degree of unemployability. This has been largely due to a demand and supply mismatch, a lack of ‘marketable skills’, and an overall absence of vocational skill training to secure employment (Team Lease Services 2007; Papola 2008). These high figures need to be viewed with concern as it has been the youth who often are and were the most vulnerable and likely age group to use drugs. In 2005 it was reported there were over three crore (30,000,000) of educated, unemployed youth registered in India (Tribune News Services 2005). In some parts of the country such as North East India, youth unemployment (15 – 29 years) was high: Nagaland (18.3% among males); Assam (19.6% among males); and Manipur (19.2% among males,) in 2004 -2005 (Hanjabam 2008). While most of the poor were not unemployed or underemployed (the poor cannot afford to remain unemployed), the number of ‘working poor’ was estimated to be 105 million (Papola 2008).

The rate of literacy in India has increased over the years and in 2001 it was reported to be 64.8% (Census 2001). Despite this improvement, in 2006 it was reported that 39% of the Indian workforce of 15 years and above was still illiterate and 23% had studied only to primary level (NSSO, 61st Round 2006).

To add to the social and economic pressures upon the vast majority in India, the nation’s vulnerability to drug use and trafficking has remained a reality. India’s close proximity to Afghanistan, a nation that currently produces 92 per cent of global illicit opium, has potentially contributed to a recent increase in opiate use, linked by a rise in heroin smuggling from Afghanistan, via Pakistan, into India (UNODC 2008; Bureau of International Narcotics 2008). In 2008, police confiscated 54kg of Afghan heroin, worth Rs 50 crore, in Amritsar: total seizures across India in 2007 were around 1000kg, though much was of inferior quality (Times of India 2008). India does have its own licit opium industry and it has been estimated that 20-30 per cent of the opium has been diverted onto the black market (Bureau of International Narcotics 2008). Manipur which borders Myanmar, (the latter with a long history of opium and heroin production, and trafficking) has since the early 1990s been severely impacted by an epidemic of HIV and Hepatitis C co-infection among the drug injecting population (Hangzo et al 1997; Eicher et al 2000).

Background of drug use and drug users

Estimating the number of drug users in India has for many years proved elusive but currently a clearer picture has emerged as a result of various science-based assessments. Various studies show that India has experienced widespread drug use and that many people experienced problems with drug dependency. The largest nationwide collective series of surveys undertaken (combining a National Household
Survey, Drug Abuse Monitoring System and Rapid Assessment of Drug Abuse) released in 2004 indicated that alcohol, cannabis and opiates (such as heroin) were the major drugs misused. Statistically it was reported that an estimated 62.5 million used alcohol, 8.75 million used cannabis, 2 million used opiates, and 0.6 million used pharmaceuticals such as sedatives and hypnotics. Among all drug users an estimated 17 -25 percent were classified as dependent users and an estimated 500,000 were opioid dependants (UNODC and MSJE 2004, Kumar 2004).

A demographic profile of drug users from this study highlighted that most were male, 16 – 49 percent were illiterate, 3 to 27 percent were students, most were aged in their 20s and 30s, and the majority had not gone for treatment. It was suggested that low enrolment in drug treatment programmes and the period of time before seeking assistance was a concern for the authorities (UNODC and MSJE 2004; Kumar 2004). A more recent study enrolling 5,800 drug users showed that half were aged 21-30 years, most were males, 15% were illiterate, 62% were employed, 48% were married, most were sexually active with only seldom use of condoms and among drug injectors syringes were often borrowed and lent (Kumar 2008).

In the early 1990s it was estimated that there were 50,000 injecting drug users (IDUs) (Jain 1994) and this figure had risen substantially by the late 1990s when the figure more than doubled, following a series of assessments (Dorabjee and Samson 2000). In 2006 the estimates had increased to 164,820 (range 106, 518 – 223,121) nationwide (Mathers et al 2008). The drug injecting phenomenon was now spreading to several parts of the country as was shown in a recent study of Punjab, Chandigarh and Haryana (Ambeckar and Tripathi 2008). High risk behaviours (lending and borrowing of syringes, seldom use of condoms and various sexual partners) among IDUs remained a widespread concern but overall HIV prevalence among IDUs in India was reported to be declining from 11.5 percent in 2004 to 6.92 percent in 2008 (Mathers et al 2008; UNAIDS 2008).

Literacy and employment among drug users
In India the common perception about literacy was generally defined according to that used by the Census Department: a person aged 7 and above who can both read and write with understanding in any language (Mathew 2005). In 2008 a nationwide study showed that most drug users surveyed could read and write (85%) with the respondents identifying themselves as literate (Kumar 2008). However, other studies when focused on specific areas of the country did not show such high levels of literacy. In Kolkata a survey among IDUs found that 42 percent could not read or write. This was similar in Delhi but slightly less in Mumbai where it was found to be 35 percent (Panda 2000, Manning 2001). A recent study in Chennai among HIV infected IDUs showed that most had either primary or no formal education (58%) (Solomon et al 2008). In Chandigarh, a survey among general drug users found that 38% were illiterate (Chavan et al 2008), while a study undertaken among juveniles (aged 13 – 17 years) in New Delhi inside an observation home for males showed that 29% were illiterate (Malhota et al 2008). Higher levels of literacy could be found among drug users in North East India where in Nagaland and Manipur only 4.6 percent had not received any education (Kermode et al 2007). Female IDUs in Manipur on the other hand were more disadvantaged according to a recent study which found that 12 per cent had not attended school and that only 20 percent achieved Class 1 – 5 (Oinam 2008). The number of school drop-outs among drug users was also a concern, as shown in a study in North India among a group of adolescents in a de-addiction centre, where they constituted 54 per cent of the group (Saluhja et al 2007).

Examining employment status among drug users, Kumar (2008) found that 66 per cent were employed, but as has been highlighted previously, those living in poverty (drug users or non-drug users) have few options but to be employed: for impoverished people a sense of overall security was mostly absent when incomes were generally low, often irregular and uncertain. Unemployment among drug users in some parts of the country were reported to be much...
India’s close proximity to Afghanistan, a nation that currently produces 92 per cent of global illicit opium, has potentially contributed to a recent increase in opiate use, linked by a rise in heroin smuggling from Afghanistan, via Pakistan, into India.

higher such as in Nagaland (76%) and Manipur (89%) (Kermode et al 2007).

Constitutional, Legal and Policy Framework of Drug Use.

Supply Reduction
Well before the introduction of the Narcotics Drugs and Psychotropic Substances Act (NDPS) 1985 and its following amendments, the Constitution of India incorporates broad public policy directives in Chapter IV. These include commitments towards attaining just working conditions, improving standards of living, and providing livelihood security for everyone. Nothing specific to drug users or about rehabilitation can be found. By contrast alcohol and drug prohibition are explicit objectives under Article 47.

‘The State shall regard the raising of the level of nutrition and the living of its people and the improvement of public health as among its primary duties and in particular, the State shall endeavour to bring about prohibition, except for medical purposes, of the intoxicating drinks and drugs which are injurious to health.’ (Ministry of Law and Justice 2008)

Following the implementation of the NDPS Act 1985 it was discovered that the criminalization of drug use and increasing rate of arrest of low level drug users for possession of small quantities of drugs has resulted in a re-assessment of the legislation by various authorities. The NDPS Act 1985 was amended in 2001 on issues such as length of imprisonment and quantity and type of drugs seized. A further amendment followed in 2002 in which the focus was on what was considered small and commercial quantities, and according to the type of substance seized (Charles et al 2005). In line with the supply reduction approach, India was also a signatory to the Single Convention on Narcotics 1961, the Convention on Psychotropic Substances 1971, and the Convention against Illicit Trafficking of Narcotics and Psychotropic Substances 1988 (UNODC 2008).

It was interesting to note that Section 71 of the NDPS Act 1985 has a relevant portion linked to demand reduction which allows the Central and State Governments a role to establish at their discretion centres for identification, prevention education, treatment, after care, rehabilitation and social interrogation of drug users (National Institute of Social Defence (NISD). The NDPS Act 1985 mentions rehabilitation and social re-integration of “addicts” twice in Sections 7A (2) and 71(1) but does not provide any specifics of rehabilitation per se. The former act recommends the setting up of a fund to support inter alia rehabilitation while the latter proposes establishing centres for drug dependent persons. However there is no commitment towards employment or providing economic opportunities for recovering drug users. Additionally further information about the Fund or the deployment of available resources for drug treatment was not identified (Lawyers Collective HIV/AIDS Unit 2007).

Demand Reduction
The focal point for drug demand reduction programmes in India rests with the Ministry of Social
Justice and Empowerment (MSJE). The MSJE have for over three decades been implementing what was called the Scheme for Prohibition and Drug Abuse Prevention, 1985-1986. The focus of the scheme was the de-addiction and rehabilitation of drug users in a community setting. Through a partnership process various non-government organisations (NGOs) throughout the country receive 90 – 95% of funds from the government to implement a range of services including the following: awareness and prevention education counselling; treatment; and rehabilitation of drug using clients (NISD; MSJE; Goswami 2004). In 2004, it was reported that under the scheme there were a total of 381 de-addiction centres and counselling centres (most were de-addiction centres but some were stand alone counselling centres or both services were included) (Goswami 2004). It is likely that this number has increased since the report was released. It was reported that the MSJE spends around US$5 million to support NGOs in providing such services to drug users (Bureau of International Narcotics 2008).

In 2002 the institution of Regional Resource and Training Centres (RRTCs) was formalised with eight long established NGOs involved in the areas of treatment, rehabilitation, training and research. The RRTCs were found in Chennai, Delhi, Imphal, Kohomia, Pune, Kolkata (x2) and Aizawl and serve different regions of the country. The RRTCs function primarily as outreach centres of the National Centre for Drug Abuse Prevention, which sits within the National Institute of Social Defence, as a part of the MSJE (NISD).

Wider acceptance of drug dependency as a chronic medical condition resulting in high relapse has contributed to treatments which are shifting towards ‘whole person recovery’, including the need for social reintegration and adaptation to work and responsibility. In India it was suggested that a critical component of the whole person recovery was the need to integrate the vocational training within the rehabilitation process, which would also require networking and utilisation of appropriate agencies for economic rehabilitation to occur (NISD).

Giving support to this approach a ‘minimum standards of service’ was also developed in India, with support and endorsement by MSJE, in which NGOs serving drug users need to aim for a service delivery level. To try and ensure that the NGOs can monitor their progress on service delivery, indicators for performance of appraisal were provided for various services, such as after-care and rehabilitation including family, community and vocational rehabilitation. In recent years an evaluation found that drug demand reduction programmes in India had benefitted directly from the RRTCs. However, the report did make various recommendations including the integration of vocational training into the therapeutic community model. It was suggested that demand reduction NGOs should network with other NGOs implementing programmes of such training under the schemes of MSJE or other Government Ministry. Further more recovered drug users may be placed with other NGOs for vocational training but still receive assistance and counselling from a parent drug demand NGO (NISD).

In the latest National AIDS Control Programme Phase III (2006 – 2011) with regard to IDUs, it emerged that there was an identified need for closer collaborative work with the MSJE for providing support for de-addiction and rehabilitation programmes (National AIDS Control Organisation 2006). Specific details of what this may entail were not identified. As reported in the National AIDS Prevention and Control Policy, issues around rehabilitation were not identified but it was documented that the Government would encourage NGOs working in drug de-addiction to take up harm
minimization as a part of the HIV/AIDS control strategy, in areas known to have large numbers of drug users (NACO 2002). As part of this policy approach the link between HIV and AIDS and drug use was understood so consequently education in this area would be offered at drug treatment programmes run by the Government.

**The role of vocational education and livelihood options**

The promotion and implementation of vocational education for drug users in India was documented, but literature was scant. For treatment centres, social integration, occupational stability and ensuring that measures were taken to maintain the recovery period, were often not a primary focus. Programme initiatives in India to address these issues first commenced in the late 1980s and early 1990s and it was deemed that greater success would be attained following encouragement of inter-sectoral partnerships through international agencies, government and NGOs. Emphasis was on enabling recovering drug users to become gainfully employed through income generating programmes, involving revolving loan schemes (Murthy 2002).

By the mid 1990s another major innovative programme commenced involving ILO, UNODC, MSJE and the European Commission and was titled ‘Project 808: Community Based Rehabilitation and Workplace Prevention Programme’. It ran from 1994 – 1999. With the ‘community based rehabilitation’ component, a real focus was on income generating activities, supported employment and the training of recovering drug users to instil them with effective work habits and ensure ‘whole person recovery’. The results of this initiative appear impressive. Highlights include: 25,000 drug users covered within 18 community based drug rehabilitation programmes in nine cities/towns; 411 participants trained in more than 12 training workshops; and 12 enterprises and 110,664 employees covered. This project was declared a success and it was recommended that any gains should be maintained and strengthened (Murthy 2002). However it has not been possible to identify the institutional sustainability of such initiatives through documentation. It was difficult to speculate why such efforts towards ‘whole person recovery’ was not sustained but it was possible that a lack of ongoing funds and securing partnerships with appropriate government schemes and various non-government agencies that focus upon vocational education and skill development had yet to be firmly established. In India, drug use problems and drug user needs have not diminished over time and as such the concept of ‘whole person recovery’ involving vocational education and development of livelihood skills remain just as relevant today. Training programmes to promote such initiatives have not abated and both RRTC and MSJE acknowledge their value (Society for Promotion of Youth and Masses 2008).

Documentation of other initiatives in India to facilitate the mainstreaming of recovering of drug users into the wider community through education and provision of livelihood options were as hard to find. In recent years two studies in India have explored the concept of the need to provide structured occupation and social support to facilitate

**Wider acceptance of drug dependency as a chronic medical condition resulting in high relapse has contributed to treatments which are shifting towards ‘whole person recovery’, including the need for social reintegration and adaptation to work and responsibility**
reintegration back to the community with impressive results. A series of case studies among homeless substance users highlighted that by implementing a holistic treatment approach with some seed money to initiate small business endeavours, coupled with ongoing psycho-social and medical support, this approach could achieve success (Yadav et al 2008).

A more extensive study focusing on a micro-financed based approach among 55 participants, with drug use history (all opioid dependent), showed what impressive results could be achieved. Most participants (of which the majority were on buprenorphine maintenance) received on average 560 rupees to start up a series of small of jobs that suited their skill set and physical condition (candle making, electrical work, plumbing, gardening, fruit selling, tea vending to name but some) with most (74%) repaying the amount taken within one month of taking credit. Up to half the participants had switched over to financially and technically more lucrative employment after a few weeks/months. This initiative showed that occupational rehabilitation could be carried out and the process suggested the feasibility and practicality of this intervention within an Indian setting. It was suggested that this approach was not likely to be equally effective for facilities that only provided detoxification but had no substitution maintenance therapy (Yadav et al). Anecdotally other such initiatives throughout the country were likely to exist but appear to be rarely recorded.

The role of harm reduction
By the late 1990s the dual epidemic of HIV and injecting drug use was acknowledged by the Government of India to be serious and adopting a harm reduction strategy was for consideration. However, at that time most senior level drug and health policy makers across the country appeared to have little understanding of what the concept of harm reduction was and the rationale behind the term (UNAIDS and UNODC 2000). In more recent years the policy environment has changed substantially and harm reduction as a means to address HIV among IDUs has been endorsed with support for needle and syringe programmes, and oral drug substitution treatment. Also endorsed is peer education and wide use of outreach workers to connect with drug users should be encouraged (Lawyers Collective HIV and AIDS Unit 2007; NACO 2007; UNAIDS 2008).

It was estimated that at the end of 2007 around 86,000 IDUs through 122 targeted interventions were receiving a service for their needs (NACO 2007). Acknowledging the large number of IDUs in India it was clear a limited number of this high risk group receive a service. Broadening the scope of harm reduction to reach out and be beneficial for all types of drug users and not just IDUs, ensures that the challenges remain substantial. It can be noted however that in contemporary India there were many more advocates, supporters and implementers of the concept for harm reduction than ever before. It was hoped that the holistic approach to assist those still consuming drugs, and to those in a process of recovery, will continue to grow and be endorsed.

Drug misuse prevention and the impact of education: the role of UNESCO in India
In recent years UNESCO has been strengthening local partners in developing countries towards developing a global response to prevent harm associated with drug use. UNESCO has a general focus on ‘Education for All’ and on non-formal education in particular, and this includes working with vulnerable groups, including drug users. By drugs education UNESCO refers to offering learning opportunities for all to develop the knowledge, skills, competencies, values and attitudes that will limit the extent and degree of drug use as well as reduce the transmission of and impact of the HIV pandemic. In India three projects that UNESCO have continued to support in the addressing issues surrounding substance use and associated harms can be found with the NGOs, The Ishara Puppet Theatre Trust, New Delhi, TT Ranganathan Clinical Research Foundation, Chennai, and Society for Community Intervention and Research, Kolkata. The following case studies provide some brief insight about these three groups.
By drugs education UNESCO refers to offering learning opportunities for all to develop the knowledge, skills, competencies, values and attitudes that will limit the extent and degree of drug use as well as reduce the transmission of and impact of the HIV pandemic.

The Ishara Puppet Theatre Trust (IPTT)
UNESCO collaborated with IPTT to set up a project promoting awareness drug misuse and HIV and AIDS. The plays have been performed in various settings including the street as well as indoor venues. It is the first time that a consistent effort has been made in India to use puppetry for drug misuse awareness, and not just for one-off shows or programmes. It has been shown that puppets were very useful in relaying difficult messages, creating awareness on various public issues and reaching out to various communities where such information was not always easy to access. In the process they have involved young people from the street, who have through time developed vocational skills and have been trained in the art of puppetry and are now trainers themselves. This has allowed them to be independent, to find employment and has led to their own empowerment (UNESCO 2007).

T.T Ranganathan Clinical Research Foundation (TTRCRF)
For a number of years TTRCRF has been dedicating itself to counselling, treatment and rehabilitation services specifically those affected by alcohol and various substances. UNESCO collaborated with TTRCRF to expand its program of activities by raising awareness and increase prevention of alcohol and drug use, HIV and AIDS, and sexually transmitted infections. Targeted efforts have been directed towards those affected by alcohol, and drug misuse, and women and marginalised youth with limited access to education and low literacy skills. Work has been undertaken in rural districts identified as having high HIV prevalence and high alcohol use and has focused on the development of micro credit interventions, non-formal education programmes, and peer education programmes for rural women. The community-based programmes have shown to be successful and were well received with HIV and substance misuse information widely disseminated primarily to rural women but also to community members (UNESCO 2007).

Society for Community Intervention and Research (SCIR)
Society for Community Intervention and Research (SCIR), based in Kolkata, has developed a multi-pronged approach to offer a comprehensive list of services to the community of drug users: needle and syringe programme, primary health care, oral drug substitution therapy, counselling, meals, to name just some of the activities. In late 2008, UNESCO collaborated with SCIR to establish a new project, ‘Mainstreaming of recovering drug users with vocational education and livelihood skills through capacity development programs’. The overall vision of this project is the social and economic reintegration of recovering drug users from an education lens. This breaks new ground because not only is it not based on a general health approach but actively seeks linkages and partnerships among a broad range of stakeholders ranging from various training institutions, educational facilities to those linked with the corporate sector. The project will attempt to address the missed educational opportunities of an often neglected community, namely drug users and in doing so, enabling their social and economic rehabilitation (UNESCO 2009).
Key Informant Interviews

Methodology
Senior key informants based in New Delhi representing stakeholder organisations involved in drug use issues, drug treatment and rehabilitation centres, social welfare, labour and development were identified by UNESCO. Eleven key informants representing eight stakeholder bodies\(^1\) were selected and included the following:

1. Ministry for Social Justice and Empowerment (Government);
2. United Nations Office on Drugs and Crime (UN);
3. Ministry of Health and Family Welfare (which included a senior advisor from the All India Institute of Medical Sciences) (Government);
4. International Labour Organisation (UN);
5. Sharan (NGO);
6. National AIDS Control Organisation (Government);
7. National Institute for Social Defence (Government); and
8. Society for Promotion of Youth and Masses (NGO).

Key informants were provided with an outline of what the research would hope to achieve. They were aware that the data would be useful for two purposes: to contribute towards a questionnaire for those associated with drug use issues at the grass-roots; and to be compiled and incorporated into a UNESCO report examining broad-based education in the drug treatment and rehabilitation centres of India.

Key informants gave verbal consent to be interviewed and understood that they may not be able to answer all the questions if it was not their area of expertise. Interviews were conducted by the UNESCO Regional Programme Specialist (HIV and AIDS) based in New Delhi, who was accompanied by a research assistant. Interviews took from 45 – 60 minutes and were audio recorded, including note taking. The data was then analysed thematically to identify the most commonly recurring issues and topics.

Specific laws, policies, guidelines, schemes linked to basic education, vocational education and livelihood skills associated with drug sector
Half the respondents were aware of laws related to drugs but comments mainly focused upon the legal implications of use, possession and prohibition, not from an overall education and skill development perspective. Half of the respondents referred to the Narcotics Drugs and Psychotropic Act (NDPA) 1985, associated sections and amendments. Others commented upon specific text identified in the Constitution, the source from where the intervention or prevention of alcohol and drug use was derived. No respondent commented about specific guidelines.

‘Article 47 of the constitution clearly mentions that the use of intoxicating drugs substances should not be allowed for any other purpose than that of medicinal use’

(National Institute of Social Defence – NISD)

The NDPS Act 1985…addresses the issue of drug use from the perspective of a user, [and] amendment in NDPS Act 2001 differentiated in the quantity of substance carried…user has the first right to be sent for drug treatment, versus penalized for possession of drugs’

(United Nations Office of Drugs and Crime - UNODC)

Some respondents commented that specifics within the law or the constitution to address

\(^1\) However their position does not reflect necessarily the position of the Organizations they represent.
Half the respondents were aware of laws related to drugs but comments mainly focused upon the legal implications of use, possession and prohibition, not from an overall education and skill development perspective

the broader issue of the rehabilitation of drug users were not provided.

‘…there is a component of rehabilitation in the law, NDPS Act-1985 Section- 74 … it talks about setting up of rehabilitation centres [but] does not go into specifics of rehabilitation per se’

(Ministry of Social Justice and Empowerment – MSJE)

‘NDPS Act section 26, 27 and 64 have direct link with drug users [but] I don’t see any thing which has direct relation with livelihood, vocational training related to drug users’

(Society for Promotion of Youth and Masses – SPYM)

Only three respondents commented upon the ‘Scheme for Prohibition and Drug Abuse Prevention 1985 – 1986’, as being orientated towards basic education, vocational education and livelihood skills.

‘…the scheme itself has tried, from its inception, talked about rehabilitation programs which include making a person much more productive and able to have better adjustment back into their family on their way to recovery’

(UNODC)

Respondents suggested the scheme implied issues of vocational education and livelihood skills will be a part of the rehabilitation process but details were not forthcoming.

‘…a major component in the drug scheme is rehabilitation…the vocational aspect is in-built into that scheme…it is not explicitly stated with any details’

(MSJE)

‘…scheme may not be specifically speaking about vocational training or vocational rehabilitation but certainly the scope of the scheme is the rehabilitation of the recovering person and is based on WHO concept of whole person recovery’

(NISD)

Government respondents not commenting on the MSJE scheme did acknowledge issues surrounding rehabilitation or skill development were on the agenda but specifics were lacking and sometimes discussions on the topic were more informal and in-house.

‘when ministry talks about treatment what is emphasized is treatment beyond detox…part of recovery is rehabilitation and that acceptance exists in the health ministry…though no stated policy exists’

(Ministry of Health – MoH)

‘NACO strategic implementation plan as well as operational guidelines talk of referrals within the existing rehabilitation as well as detoxification-rehab centres’ (National AIDS Control Organisation)

(NACO)
Specific laws, policies, guidelines, schemes linked to basic education, vocational education and livelihood skills associated with the education sector

Most respondents commented that from the education sector perspective they were not aware of laws, policy, schemes on basic education, vocational education or skill development. However a few respondents did remark upon the implementation of preventative drug education and life skills education targeting adolescents within the school curriculum. One respondent spoke of universal primary education, while another commented on vocational schemes for street children.

‘Ministry of Human Resource Development as part of their adolescent education program, has incorporated the issues of drug education as part of overall policy in programmes’

(UNODC)

‘…universal amendment [part of the Constitution] for primary education for children up to the age of 14. The focus is for the child to learn and develop skills and a sense of security. It looks at the rights of the children, and ways to avoid drug use’

(International Labour Organisation – ILO)

‘There are vocational training schemes where we have had drug using children linked up to these schemes. Some are private and easier to link up with. Government ones exist which in most towns are sub-standard and difficult for accessing’

(Sharan)

Relationship between laws, policy, schemes and practice at grass-roots

Respondents were divided about what was documented as a scheme or policy by specific government sectors and then ensuring delivery, ability and capacity for implementation at the grass-roots. As was suggested by a respondent, coordination at the central level does not mean a message was necessarily transferred at the state level. Some respondents however confidently commented about communications and delivery as being sound with appropriate mechanisms in place.

‘…meeting has 25 invitees from 12 states. A person [invitee] is going to travel back and information is carried back. At the local state level this information is then transmitted. There is a consultation process where those from treatment centres, managers are aware of what is required’

(MoH)

Other respondents however suggested the relationship was not free of challenges and there was a need for improvement, sometimes depending on what aspect of the scheme needs to be implemented, such as components related to vocational education and skill development of drug users.

‘Every sector can tell you about the policies for this and that…inter-linkages are being talked about at the ground level [but] not much is there when we see that drug user demands or needs are changing from one state to another state’

(NACO)

‘Most may not be fully aware of all facilities in the schemes…it’s a colossal task to make them aware….but we have started to reach out and make organisations aware of what is available…’

(NISD)

As suggested by one respondent the issue about the relationship with the schemes or policy and the grass-roots was not uniform and can vary from one state to another state as a result of multiple factors.

‘Schemes work generally on a state wise basis. Some states are better performing in certain areas than other states. Often people in Manipur have a high literacy rate, perhaps less hierarchy, better informed about schemes, and how to access some of them’

(Sharan)
**Situation Analysis of Basic Education, Vocational Education & Development of Sustainable Livelihoods in Drug Treatment & Rehabilitation Centres of India**

**HIV, drug education and delivery method**

There was a general consensus that general HIV and drug education was provided and delivered inside drug treatment or rehabilitation centres but also in the field to current drug users and to those at risk. Information about HIV and drugs had been developed from various sources and education was imparted from specially trained counsellors, outreach workers and peer educators. Delivery of the message varied but was more often described as prescriptive and didactic.

‘Counsellors are trained and receive training by NISD and through the Regional Resource Training Centres. The NISD has training modules on aspects related to education awareness, counselling…[and] how to deliver the messages. NACO supports (MSJE) to assist the NGOs in our centres and to engage peer educators on HIV issues’

(MSJE)

‘The education is overall, didactic in nature, provided on a one to one basis by the counsellors. [Sometimes] there would be group discussions or by peer educators. The information provided is a general overview of HIV issues that covers many areas…also includes information about harm reduction’

(NACO)

A couple of respondents commented that while no known official assessment on delivery of education or quality of education imparted had been undertaken, scope for improvement should be examined. Another respondent commented that HIV and drug education can be selective and from a Ministry of Health perspective, almost exclusively focused on injecting drug users, despite those with alcoholism engaged in high risk sexual behaviours and consequently also at risk of HIV infection.

‘...if we were to undertake a national appraisal overview we would not be looking at high quality on either front [drugs or HIV]… people from different sectors of society don’t get good, accurate information about drugs…likely to be reflected in treatment centres as well’

(Sharan)

‘…need to look more closely at IEC materials about delivery and context…it is more than is information understood, [but] also is information completely factual’

(NACO)

**Challenges or barriers for social and economic reintegration of drug users into the community**

**Misunderstood - Stigma, Discrimination**

Most respondents agreed that an underlying sense of stigma and discrimination – real or perceived - towards and experienced amongst drug users, active or recovering was mostly endemic in the community and consequently reintegration was considered a difficult process. Non-acceptance of drug users by the community was widespread and this had also impacted upon drug users within
schools, which according to some respondents, had meant that such students were requested to leave the school.

‘...often seen as criminals...not in demand by the organized sector. A person in need of rehabilitation is referred to an organised sector, by virtue of being a drug user, they are often rejected ...It is the history of the various stigmas that is attached to drug use. A criminal can be viewed as always remaining a criminal and over time be distrusted’

(NACO)

‘...attitude of service providers...they are not familiar with this behaviour....stigma and discrimination even for the person that is recovering’

(UNODC)

‘General understanding is the addict is a lost case and you can not do much about it....difficult to access [education] institutions and resources. The social stigma can be high. If he is recovered then the situation could be somehow different’

(MSJE)

Levels of Education, Access to Education, Skill Development and Employability

The level of literacy identified among drug users, whether functional or non-functional was considered a barrier by some respondents. It was more widely agreed that institutional structures for accessing education can prove a challenge for various reasons, including age, stigma, and issues related to personal motivation.

‘Education is primarily pitched at the underage population [school age]. For our clients we are dealing with an illiteracy rate of about 40%. Our clients are all over the age of 18 years. ...how are we imparting HIV and drug education to illiterate people? This has not been resolved at all’

(Sharan)

‘...biggest challenge is how you motivate a person to pick up the threads of life especially in education field. From the time the person decided to drop out and then helping them to connect with continuing education programmes, distance education programmes...this is a barrier’

(UNODC)

Accessing appropriate education can be challenging but ensuring that the development of a suitable skill will follow was just as critical as part of mainstreaming the recovering drug user back into society.

‘Skill development in general in India is a huge challenge, reaching out to people numerically and improving the quality. Applies to the general population [but] to reach out to particular disadvantaged groups [such as drug users] requires far more of an enormous effort. Have to pay special focus and attention to meet specific needs of a certain group’

(ILO)

Capacity and expertise to respond

Organisations having the capacity to assist in the process of the social and economic reintegration of drugs users back into the community received mixed comments. Some respondents were adamant that the capacity did not exist, others commented that the potential was there, or the capacity was variable among the organisations around the country. One respondent commented that most centres had been sensitized about social re-integration and that this had become an integral part of their work as a result of skill training for staff.

‘The skills are not there to look at the holistic picture of a drug user. There can sometimes be a feeling that the detox is over but the next stage is not always considered or the capacity is not there to respond to the other needs of drug users’

(SPYM)

Some organisations might have capacity...[but] imparting education with vocational education might be a big task... It is a totally different
The level of literacy identified among drug users, whether functional or non-functional was considered a barrier by some respondents. It was more widely agreed that institutional structures for accessing education can prove a challenge for various reasons, including age, stigma, and issues related to personal motivation.

specialisation for imparting education, vocational education, is not at all connected with skills required for treatment, counselling or de addiction’
(MSJE)

‘Few centres can impart good learning and have technical capacity to increase skills for social re-integration [of drug users]…this also requires aptitude and ability and I would say they are certainly not up to mark’
(NACO)

‘Capacity varies nation wide…based on my experience I say almost 1 in 5 of organisations supported by MSJE have capacity…1 in 5 is very generous…with social integration the challenges will be immense’
(UNODC)

‘Most people inside treatment centres are focusing on successful treatment outcome and not necessarily looking at other factors. I do not think they could do adult education unless you had the training and skilling building from someone like the National Literacy Mission’
(Sharan)

Most respondents agreed that staff inside the treatment and rehabilitation centres were aware of the link between drug use and unemployment but how to respond could be thwarted when resources were limited. Capacity to deliver was not always linked with a shortage of skilled human resources, though this does occur as suggested by some respondents. Issues of funding restrictions could not be ignored when there were many competing needs to address disadvantaged communities in a country like India.

‘…sometimes they are not mandated to deliver…this can come from resource allocation and availability. If the organisation is given 15 lakhs they say with 15 lakhs we can only do so much’
(MoH)

Referral process and linkages
It was widely accepted that services for drug users could not address all their needs and consequently referrals or linkages with others to assist should be sought. Most respondents commented that referrals or linkages with others were underdeveloped, not easy, and many services did not really have the know-how to undertake the practice or did not know where to refer to in their vicinity.

‘They don’t understand referral…even if they want to refer they do not know where to refer. They may refer but then again they are not sure if the drug user will be taken by the organization they have been referred to’
(SPYM)

‘...lack of understanding of referral process is very much a challenge. Informal meetings do happen between organizations but a single forum does not exist when it comes to knowing what other services can assist treatment centres to direct to different services such as vocational education’
(NACO)
‘…you need to have good communication skills, should have knowledge about their programme, need to collect information and maintain indexes per institution. It is not an easy task’

(MSJE)

It was also suggested that the ability to form linkages with others came with experience and know-how within certain NGOs, highlighting that it was possible but generally would not come automatically for all. The holistic coordination of different NGOs working to address some of these difficulties had not yet generally emerged.

‘…not all NGOs are strong in the area of referral and linkages. Some stronger NGOs certainly do [but] not many NGOs are not aware about what other opportunities or services could be better utilized’

(ILO)

Others held more optimistic views declaring networks were already established and many implemented linkages.

‘…there are lots of linkages and referral with vocational training centres with private institutes for placement recovering users…they invite people for training programs and get better employability for recovering users’

(UNODC)

Monitoring and Evaluation

Generally, but not exclusively, respondents agreed that while monitoring and evaluation (M&E) has more recently been identified as a priority area, there was still a need to strengthen this mechanism for improved outcomes. This issue was not just confined to the drug sector but more broadly. While it was commented that M & E of overall drug treatment centres under the care of National Institute of Social Defence had a half yearly reporting system in place, a component about livelihood options was not included; it was hoped in time this would be brought into the overall scheme.

‘People are not talking about responsible reporting. People who even have the good programmes may not have the capacity to monitor. Very few are absolutely delivering this’

(Sharan)

‘Sometimes we do monitoring but that it is more ad hoc. It is not from the concept of developing a programme, integrating and upgrading’

(NACO)

‘Generally there has been a lack of monitoring and evaluation… but it seems only in the last couple of years that there is a sort of paradigm shift taking place in the government sector, to some extent’

(ILO)

Cost of rehabilitation and type of client group

Fees associated with entering treatment or rehabilitation centres were described as a barrier for specific groups of drug users. Consequently this potentially impacted upon what could be offered to service users in the area of social and economic reintegration. It was commented that addressing the needs of less affluent drug users had its own set of challenges and this required consideration.

‘…we are getting fewer non–literate clients into rehab centres. If you are going to be that much of problem why would people take you on board…most rehabs are not free. Only paying clients, slightly better off clients, get access to treatment’

(Sharan)

‘Government sector are likely to be serving more socially disadvantaged [as] they [treatment centres] are cheap, inexpensive… With literacy and some times lack of psychological sophistication, certain messages are not understood well by our clients. Staff do not always have the know how to articulate the information in a manner to be digested by this group’

(MoH)

Multi-sectoral involvement

It was suggested by a couple of respondents that
While there was no uniform comment or enquiry about linkages or policies between the Ministries, the lack of formal linkages or the need to expand dialogue exchange between Ministries was raised by a few respondents as a barrier that required attention.

When examining HIV issues, multi-sectoral participation was required, in order to have an impact upon the HIV epidemic. As was described by some respondents there was no single department or government ministry which was responsible for all aspects of drug use issues. Drug treatment was taken care of by Ministry of Health, whereas harm reduction and issues of HIV prevention among drug users fall under National AIDS Control Organisation (which falls under the MoH), rehabilitation and psycho-social aspects were under the domain of the Ministry of Social Justice and Empowerment (MSJE), and the Ministry of Human Resources Development co-partnered with MSJE in drug prevention programmes.

While there was no uniform comment or enquiry about linkages or policies between the Ministries, the lack of formal linkages or the need to expand dialogue exchange between Ministries was raised by a few respondents as a barrier that required attention.

‘We don’t have definite linkages or inter-sectoral coordination between the three Ministries [and] do not know what the other three Ministries are doing. Multi-sectoral [response] means right from the beginning - harm reduction to oral substitution, detoxification, rehabilitation and finally social integration. This is addressed by different Government sectors... need to have some common platform to share the programme’

(NACO)

Others did not hold such similar views.

‘Lot of people will work in vertical...easier to manage...[but] there is a sea change and a lot of people are looking at inter-sectoral cooperation...there are different sets of committees, inter-ministry committees, cabinet committees... all expertise from various lines of streams’

(UNODC)

Multi-sector involvement was not just confined to ministerial levels but also where there can be differing attitudinal approaches between the demand and harm reduction sector as commented by a stakeholder.

‘harm reduction is one sector and the second sector is about detoxification and rehab...both can be untouchable with each other. [one sector] don’t agree with the model of harm reduction...or harm reduction people not agree with model of detoxification and rehab...mental barrier has happened [but] there is a movement to bring them together under one platform’

(NACO)

Matching skill potential with individual need

Many respondents agreed that matching the compatibility of drug user skills with the vocational options was a challenge. A further barrier to economic rehabilitation was the changing employment landscape in India and the need to acknowledge the value of investing in appropriate skills.
‘…lot of people who are educated may not have enough options of employment with current skills because it is a competitive world…if you do not invest in core skills you will not get much in return’

(UNODC)

Matching skill with individual need can also vary with age and the geographical location of the treatment centre, which added another dimension in knowing what was considered a requirement in the holistic part of treatment.

‘…majority of users coming to our centres are 30 plus and they are working on some livelihood. But young person in Srinagar who is 18 or 20 is totally different…need of person who is in Srinagar is totally different to Delhi. Priorities of centres are different…might not be thinking of developing new skills to those in recovery is required, don’t think its part of the recovery process

(SPYM)

Connecting with corporate world
The corporate world was viewed as an important partner to assist drug users in the development process of gaining social and economic reintegration. It was acknowledged that some NGOs were successful in creating linkages with this sector, particularly among those with a sound reputation. Overall however barriers and lack of skill remained and undertaking this type of partnership was under-developed.

‘…there are unfortunate stories about the corporate sector in general… engagement is pretty low, poor and not really effective

(NACO)

‘Some rehab centres do have the linkages [but] currently very few organisations have the skill to link with the corporate world’

(MSJE)

‘…they want to do it but really they have not developed the kind of confidence or the skills’

(NISD)

Peer involvement
Overall there was an acknowledgement that the role of peer educators while previously under-developed, had gained ground for improved outcomes among drug users in the area of drug education. However, how peers can play a role in the social and economic reintegration of drug users was less developed. Some respondents suggested that there was always the potential for distrust by some service providers (non peers) towards the full acceptance of the role of peer educators as to what they could contribute. But it was apparent that overall an increasing acceptance and peer inclusion was underway in the country.

‘…we stress immensely the involvement of peers. This is not always found in other Ministries…there is a need to further strengthen peer involvement…approaches with the use of peers are still not systematized or articulated as yet in many responses’

(NACO)

‘…new scheme provides peer educator in each centre…. he is better equipped to empathize and lead them through the recovery process’

(MSJE)

‘… training steps have not been taken apart from drug education. They do not consider this as part of their tasks, educate people, assist them to access employment etc. Nobody is paying them to do this anyway. They could be overwhelmed with extra responsibilities as resources can be thin on the ground’

(Sharan)

Lack of documentation and information
Only a couple of respondents commented on the insufficient documentation of what was taking place at the grass-roots, sometimes in broad terms but also related to the drug sector. A lack of documentation it was suggested was linked to a lack of time but also because success stories were not so widespread thus not recorded.
The corporate world was viewed as an important partner to assist drug users in the development process of gaining social and economic reintegration. It was acknowledged that some NGOs were successful in creating linkages with this sector, particularly among those with a sound reputation.

“We hear occasionally about what institute is doing what and its great work. But it is on an ad hoc basis. Still we do not have a comprehensive picture and so the information is a bit scattered”

(ILO)

…why there is no documentation is because they have no time…many are overworked, burn out is there. We need to document the failures as they will give us a real road map’

(SPYM)

Solutions for social and economic reintegration of drug users into community

Undertake mapping for various resources and enhance linkages and referrals

Respondents widely agreed that referrals and linkages with those outside the drug sector was the way forward to address the needs of drug users as part of social and economic reintegration. Directly depending upon the Central Government or a specific Ministry to help out was not advised as they were not in a position to provide all the necessary resources. Initiatives undertaken by those working at state and grass-roots level was recommended.

‘Check on national linkages at state level with various departments that exist, social welfare department, women and child welfare department. Various sectors at state level need to interact because they are all state subjects’

(UNODC)

‘Map local resources of an existing resource as its unlikely the Government will be in a position to create new structure. Mark the local resource possibility they can go to them and talk to them we will be sending X number of drug users to your centre, engage with them, provide them opportunity and see if linkages can be created with others like JSS.”

(SPYM)

‘First you have to know what sources are available and then you only can move to next step! A type of resource mapping would be good and not too difficult. First you need to know what resources are out there and then you know how to move forward. That is planning’

(MSJE)

For some respondents it is not just about referral for social and economic benefits but acknowledging what is also going to be beneficial to a drug user’s health.

‘You may have an impossible client, does not wish to quit. Send them to the methadone [or buprenorphine] programme, they can deal with them. If they are not interested in rehab then they are not your client anymore’

(Sharan)

It was suggested by a few respondents that as drug users overall were considered to be disadvantaged it was necessary to explore how linkages with other government schemes may be able to assist with social and economic reintegration.
There is an agency Rashtriya Mahila Kosh (RMK) which provides seed money to self help groups... [it is] supported by Ministry of Women and Child Development and Ministry of Human Resource Development. The director of RMK attended our advisory committee... out of 114, there were 16 SHGs she committed to adopt and ensure they receive resources for running their own enterprises and provide them training... you have to step out to interact with different sectors and agencies’

UNODC

Skill building, training, education leading to increased capacity

It was acknowledged that the creation of the Regional Resource Training Centres (RRTC) in various parts of the country had accelerated training programmes to build capacity in order to address the multiple needs of drug users. Many agreed that the drug sector in India had changed substantially over recent years with an ever increasing number of institutions dealing with drug use issues. A high degree of optimism about recent operations was commented by some respondents.

‘We have 8 RRTCs and also minimum standards of care and practice that evolved by NGOs themselves. The continuing capacity enhancement process from 2000-2008 is the best journey ever for the drug sector... you have institution mechanisms for the delivery of capacity enhancement in the country’

UNODC

However, as respondents suggested the need for further training was an ongoing process and innovation in training should be encouraged. Training was not something to be confined to staff working at the drug treatment and rehabilitation centres but also to the client group who required the skills in order to be engaged with the mainstream of society. To ensure a more successful outcome some respondents also placed emphasis on the need for increased funding to deliver the full package of treatment options.

‘Pull out the modules that exist for vocational training, a reintegration [created by UNODC and ILO in recent year]. Find approaches that have worked, create a type of inventory. Investment in training on the basic principles of rehab needs to happen’

UNODC

‘Increase the technical capacity of organizations in order to institutionalize the realities process. We need to look for low cost rehabilitation process linked in with vocational skill building’

NACO

In the area of vocational skills and the development of livelihood skills, there was a need to know more about the process of guiding potential candidates to be employable - appropriate career or job guidance - and awareness of the employment market for skill matching.

‘...we design a skill development programme for the training process... have to know what are the opportunities available before the skill training occur so that the employer can maximize the employability of the graduate. What is wanted by the institution and what is wanted by employer and we know there is a discrepancy. We need to reduce this... need to ensure the skills that are developed are based on demand and are looked at accordingly’

ILO

Issues about basic education were rarely commented upon by the respondents but when it was, the focus was on basic life education skills and implementing a literacy type movement specifically for drug users.
Drug users’ needs are complex and simple solutions would not resolve their multiple problems. However most respondents suggested that the way forward was by looking at drug users from a human rights lens and from a more holistic perspective.

‘…there is a need for education for work conditioning, education for reality, how to prepare yourself for an interview, organising your time, you need these basic things rather than looking at numeracy and literacy education’

(UNODC)

‘There are literate people who can help set forward a national literacy mission. We could start encouraging that in our treatment centres’

(Sharan)

Greater utilisation of the peer model
Half the respondents agreed that the use of peers was beneficial, held broad value and appeal and overall should be encouraged to expand with its contribution to address the complex needs of drug users. Expansion of the peer model should however, as suggested by one respondent, be scaled up on the proviso that peers were fully recognised for their role and should receive appropriate financial support.

‘[peers] have become the backbone of our intervention, it improves their self esteem, motivation, they consider themselves useful…clients become the staff. They have benefited hugely on this model. We would put this out as something that could fit the national guidelines. One of the strengths of therapeutic communities or residential care programmes is that by default they are managed by drug users. This is nation wide’

(Sharan)

‘there is a need to further strengthen peer involvement. Peer processes are much better and productive… needs further upgrading. We need more of an introduction of the peer model, building capacity of peers, being involved in the training and decision making process of programme. Approaches with the use of peers are still not systematized or articulated as yet in many responses’

(NACO)

‘…awareness exists among the doctors, nurses, counsellors that they [peers] are important, this is another resource that needs to be tapped’

(MoH)

Holistic care and human rights
Drug users’ needs are complex and simple solutions would not resolve their multiple problems. However most respondents suggested that the way forward was by looking at drug users from a human rights lens and from a more holistic perspective.

‘…quality of life is more important than treatment per se and treatment will improve if the quality of life improves… promoting a drug user as a human being, a citizen of the country and with all the rights that are fundamental to our constitution’

(Sharan)

‘Social inclusion will only come when you start thinking of the humanistic perspective. They [drug users] have human rights, and they need to be included. Service providers need to understand that these are people who also need education’

(SPYM)
‘We need to view drug users more in the light that the person is, more than just a drug user…we really need to come up with a comprehensive programme starting from de-addiction, harm reduction, rehabilitation, and social integration and linking them all into a productive life’

(NACO)

Self help groups and micro-credit

Half of the respondents agreed that success stories linked to self help groups, not necessarily associated with drug users, required more exploration. Micro credit programmes were increasingly documented in India and such programmes exist among recovering drug users. This specific area was considered by a few respondents as a way forward.

‘…self help groups (SHGs) by providing small finance [seed capital] to purchase books or take up skill development. They engage another person who can teach them skills. These kinds of things happen regarding small micro credit societies… the person [outsider] remains with the group say for two months, they will pay them. That person will be imparting skills’. As a group it can work. If an individual in the group wishes to pull out, other group members usually encourage the person to remain. Everyone has invested equally and wishes to see it succeed’.

(MSJE)

‘Every organisation should link up with one or two schemes of Government which can offer them revolving funds or micro credits. [NGOs] can aim to harmonize between the two or three schemes [and] through the process to direct transfer to the organisation to get better access to the financial resources’

(UNODC)

‘We are doing micro-credit schemes already and trying to engage micro-credit schemes and we are also trying to promote self help groups to take charge of needle exchange delivery, HIV counselling etc. All of these employments and skilling means furthering their capacity’

(Sharan)

Training programmes to better grasp and seek solutions in the area of livelihood skill building and issues of micro-credit took place and required greater expansion.

‘We organized two workshops on livelihood for drug users. We developed some sort of understanding of the issues to build the capacity of NGOs, particularly RRTCs. With the help of NISD we completed 8 trainings last year and specifically on micro-credit options, and specifically for drug users and their spouses’

(SPYM)

Increasing multi-sectoral involvement

Successful multi-sectoral collaboration and involvement with those examining issues related to drug use, do take place. This was recently reflected in the proposals for scaling up oral substitution therapy where drafts and committee meetings were held. It was also noted that leading experts from some larger NGOs involved in drug use issues (either linked with MSJE or not) were active participants with NACO on harm reduction programmes. But it was suggested that similar models of involvement across government sectors, appropriate United Nations agencies, and key non-government stakeholders – both from demand and harm reduction perspective- should be encouraged to enhance harmonized agendas in the area of vocational education and skill development of drug users.

‘…bring all [relevant] sectors together and have a single platform to understand the whole issues related to drug use. Also include Labour Department for the vocational perspective [and] education sectors. Somebody has to take the lead and drive the process and that should be MSJE’

(NACO)

‘…increase the interaction of experts, mixed groups and other stakeholders… resources like ILO or labour industry might do work interventions…help from State Government is required. We should sit together with different sectors and develop a national policy and strategy’

(MoH)
A model used in Sri Lanka that examines addressing the needs of vulnerable groups was suggested by a respondent for its applicability in moving from policy development to actual implementation, through a process of consultation and dialogue.

‘They are setting up 5 – 6 working groups to develop specific implementation strategies for different target groups. Working groups consist of government and other institutions plus NGOs and societal research institutes addressing specific groups such as those working on HIV and AIDS. Once policy is formulated, an implementation committee is set up and within this there are specific working groups looking after vulnerable groups. There is a national consultation in skill development for vulnerable groups’

(ILO)

Advocacy to raise the profile of drug users and of responses

Many respondents agreed that drug users were widely misunderstood and discriminated against, and for various reasons could be considered less a priority issue for the Government to address.

‘We need to organize campaigns, media events in order to de-stigmatize the drug user. They can be rehabilitated; they can be integrated into the social mainstream’

(NACO)

‘Talking to business houses, talking to chambers of commerce, start opening the ways just like the HIV sector has done. It’s about advocacy and also descriptions of success stories… media advocacy is needed because the media has also highly stigmatized the whole drug sector’

(SPYM)

As suggested by one respondent community acceptance of treatment centres can be low and the reasons for this were varied. Greater efforts were needed to connect with the community through advocacy, in order to reduce the barriers.

‘…acceptance of NGOs running the centres is not very high by the community…we need to make these service providers more community oriented. They need to reach out more [and] some kind of advocacy should be done at frequent levels involving Panchayat heads, school teachers…[need] constant interaction with these organizations at local level with rehab centres’

(NISD)
Beneficiaries from treatment centres involved in broad-based education interventions and value given to participatory approaches

Respondents could not provide specifics as to what extent the beneficiaries (drug users) had an involvement in education interventions. However there was an agreement that in the area of peer education many drug users had benefited particularly in the intervention area of HIV and drug education. The involvement of beneficiaries in other areas of education was reported to occur but was rarely, if ever, documented. Comments were based on personal observations and experiences.

’Some of them do work as peer educators…one of the ways they actually give value back to the institution or in the field of education. Specifics I am not aware of due to lack of documentation’

(MSJE)

‘…absorbing recovering users is done by drug treatment centres themselves…train recovering user to become peer educators…identify users, help them network and improve access to services for users. Recovering users also undertake research. People who are putting in the best energy are recovered users themselves in the drug sector. It is a case of mutual interdependence which helps and works’

(UNESCO)

It was noteworthy to observe the association with participatory approaches and development as was referred to by one stakeholder.

‘A lot of value is given to the participatory approach but the skills do not exist to deliver. We started as a development organization not as a drug treatment organization, so we took a participatory approach to drug treatment. By default we are listening to clients and helping them to move along’

(Sharan)

Surveys of the marketability of specific entrepreneur skills or products within the local context

Respondents were not aware of any official surveys but suggestions of feasibility or case studies did indicate successes took place but such programmes were either disbanded due to non-availability of ongoing funds or long term monitoring to examine sustainability had not really occurred.

‘In Mizoram we know of groups of recovered female drug users, sex workers and HIV+ people where they started small enterprises as income generating, such as selling flowers in the market’

(UNODC)

‘…computer education is much sought after and much in demand by drug users themselves…we had to disband our process because we were not getting enough money for it…we did not measure marketability of computer training …[but] we know it works and have seen that in terms of outcomes. Seen people go through this process and many are working for us now’

(Sharan)

Research upon basic education and livelihood skills as a therapeutic activity to assist drug users in reducing relapse

Generally respondents commented that, to their knowledge, this was an area that had not been researched in India. Case studies were reported to have been documented and personal anecdotes were available on drug recovery websites but this would not be classified as research based. There was a general assumption that if this area was researched, the findings would prove positive, based on personal observations and experiences.

‘I observed when in Bangladesh they created some skills for IDU linked to their projects…they were given the abscess management job, opening and maintaining clinics. We had twenty such people in the drop-in-centres. Their relapse rate is extremely low compared with other drug users that had recovered’

(NACO)
Focus Group Discussions with Drug Users

Themes and questions explored and considered appropriate and most useful for the research were as follows:
1. What can services do to assist with employment opportunities?
2. What kind of work skills provided in treatment (including those through Income Generating Programmes), were useful in finding work?
3. What do you think could be a link between employment status and drug use?
4. What were the challenges faced to get back into mainstream society?
5. What were practical solutions for social reintegration to take place?

The theme of the connection between education level and drug use among the participants was not examined. Those from Imphal were believed to be the most educated. Participants in all focus group discussions were those that had previously been in some form of treatment with MSJE, MoH and Private NGOs.

Methodology

Four focus group discussions (FGD) were undertaken during the research period: One in Mumbai and Kolkata and one each in the cities of Imphal and Aizawl in the North East States of India where drug use was considered a major concern. At each site 6 - 8 drug users were recruited and participants were aged 20 to 40 years. All had been through treatment centres for a minimum duration of 30 days. Participants had attended a NGO or Government operated de-addiction centre or a rehabilitation centre. Participants had either recovered or had relapsed. All participants were male. Inclusion of females to the FGD was not able to be fulfilled for the purpose of this study. It is important to note that in India most NGOs under MSJE are overall male treatment centres where as in some MoH centres an estimated 5% were female, and mainly as a result of alcoholism. The purpose of the FGD was outlined before the proceedings. Each participant introduced themselves before the group discussion. Each FGD lasted 60 to 70 minutes. Notes were taken of the discussions. Each participant was encouraged to contribute with their comments. Data collected were analysed and assessed to determine the commonality and differences between the different sites.

1. What can services do to assist with employment opportunities?
The response to this question was varied with drug users from Mumbai and Imphal making concrete suggestions. Drug users in Kolkata tended to focus their answers upon programmes which they had been exposed to. A common remark from those of the North East India centres was of boredom and a lack of constructive activities while experiencing treatment. Some suggestions by the participants included the following:
- Treatment centres should identify the skills and aptitudes of the clients and help build on them rather than involve everyone in occupational therapy like making paper bags and candles
- There was a need for vocational training programmes to have a focus upon typing and computer skills, as was raised from groups in North East India, who have a large percentage of educated drug users
- Drug users from the North East commented that learning English was an important educational tool for gaining employment
- Drug users in the North East commented that counsellors were very ‘fresh’ (most were working at the end of their own drug treatment) and consequently personal comprehension of relapse was lacking. Under these circumstances the participants felt that discharge planning was only a formality, that it was not given importance, was rarely followed up and was really only a routine task
to permit the discharge to occur.

- Drug users in Mumbai felt that special sessions should be orientated to help them face the challenges of working with employers (who may lack sensitivity and empathy) and who do not necessarily need to know about past drug use.

- A common suggestion from the North East was for all clients to be given the opportunity to be trained as counsellors so that the option of working in a de-addiction centre after treatment could be a potential job.

- Some drug users commented that it would be useful for services to offer opportunities to assist with employment and home re-integration, including education on anger management, time management, practicing honesty and giving back to the home environment that they have destroyed.

2. What kind of work skills were provided in treatment (including those through the Income Generation Programme), that were useful in finding work?

Responses were limited among all FGDs. In the North East they emphasised that no skills were offered to them of any value. In Imphal it was remarked by an all male FGD that females based at one specific all women’s treatment centre were provided with the skills of sewing and weaving: focus on vocational education was lacking in all other male treatment centres of Imphal according to this focus group. Drug users from Mumbai and Kolkata commented that they had learnt professional cooking skills and other kitchen work which was previously unknown to them. Such skills do have the potential to be utilised as employable skills but determining if this was case could not be confirmed. Some drug users learnt about planning and store keeping which was also a task which drug users could be more confident about when applying for storekeeper jobs. It cannot be confirmed if such outcomes were realised, however. A common skill users acquired was in painting the treatment facility and this inspired some to think of doing such tasks upon discharge. Some drug users in Mumbai believed gardening and manual labour skills were valid as well as basic primary health care skills such as wound dressing which it was assumed, had been learnt when working in drop-in centres, serving the needs of drug users.

3. What do you think could be a link between employment status and drug use?

Drug users in Aizawl found no link between drug use and employment status. In other sites a different view was presented. In Kolkata and Imphal the cycle rickshaw drivers were considered prone to drug use because it was perceived that they felt stronger following the consumption of drugs and as a result managed to do a whole day’s work. A more striking comment was made in Imphal.

‘Many people among security forces had become drug users. This was because they can use their uniform to apprehend the drug user and to get free drugs for themselves’

In Mumbai some drug users held the view that working at call centres, and doing night shift was a strong case for drug use. Some commented that lowly paid work, often working in difficult circumstances such as working on the sewage system with the municipality could only be done with the assistance of alcohol. Those from Mumbai believed that long distance drivers required opium to drive through the night, and that sex workers often misused substances in order to tolerate the job. Drug users of Kolkata and Mumbai remarked that a substantial amount of daily earnings by those living on the streets (including some rag pickers in Kolkata) were used for drugs in the absence of other entertainment options.

4. What were the challenges faced in returning to mainstream society?

Comments mainly focused upon what had been learnt during the treatment phase which included regaining trust from family members, building new relationships, healing of the wounds in old relationships and living up to the expectations of the family. One drug user from Mizoram made the comment
Situation Analysis of Basic Education, Vocational Education & Development of Sustainable Livelihoods in Drug Treatment & Rehabilitation Centres of India

‘My parents expect me to continue my studies from the point at which I had dropped out due to drug use, but I do not have the ability to concentrate like before. They also expect me to go to church every day and live up to their religious ideology’

Many drug users remarked that they believed that stigma was a major barrier and that a negative attitude towards recovery of drug users was pervasive in the community. As a result this contributed significantly towards the difficulty encountered in seeking employment. Compounding the challenge was the societal attitude towards those with personal histories of drug use which was considered ‘bad’ behaviour. Obvious gaps with an employment resume proved difficult to explain unless the truth of prior drug use was provided which was considered problematic. Addressing difficulties with former friends was considered a challenge during the process of social integration. Many drug users with a long history of drug use commented that they felt that they lagged behind others of their age group (status, achieving goals, education and job attainment) and had developed an inferiority complex with members of the general community. For those working with outreach programmes the challenge could sometimes surface when they had to resist the urge to use drugs when spreading the message of abstinence.

5. What are practical solutions enabling social reintegration to take place?
For drug users from the North East focus was more related to family and friends rather than work. They felt strongly about the home environment needing to be improved and this could be helped with counselling and awareness sessions. During this process they believed that they could work towards meeting some of their family’s expectations. Comments were made that the family should also be exposed to the kind of programmes being conducted at the treatment centre which would provide new insights and increase their understanding of the type of ongoing family support required to address drug dependency.

A large number of drug users believed that working at the treatment centre for a certain period of time was important and that the facility could help with job placement as part of a discharge plan. There was no comment on formal recognition of vocational training but anecdotally in India experience has shown formal recognition does boost self worth of the individual. Drug users from the large cities remarked upon the need for halfway homes as an important component of recovery. Such ‘homes’ would require additional supervision and support during the initial stages of social and economic reintegration. Some suggestions for vocational training programmes included painting (Kolkata), piggery and poultry keeping (Aizawl). In Imphal drug users commented on their frustration about the payment of ‘fees’ to get a job which acted as an obstacle and financial burden.

Treatment centres should identify the skills and aptitudes of the clients and help build on them rather than involve everyone in occupational therapy like making paper bags and candles
**Mapping Exercise - Key Findings**

**Types of organisation**

Out of a total of 119 organisations responding as many as 56 were NGO’s affiliated with Ministry of Social Justice and Empowerment/National Institute of Social Defence (MSJE/NISD). There were 15 organisations not associated with MSJE/NISD, 24 organisations associated with the Ministry of Health (MOH), 20 from private agencies, and others (N=4).

<table>
<thead>
<tr>
<th>Type of organization</th>
<th>Frequency</th>
<th>Percent</th>
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<tbody>
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<td>NGO – affiliated with MSJE/NISD</td>
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<tr>
<td>NGO not affiliated with MSJE/NISD</td>
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<tr>
<td>MoH</td>
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<tr>
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</table>

Responses were received from a total of 25 States and one Union Territory (India has 28 States and 7 Union Territories). It was likely this was the first time that responses of treatment facilities from a diverse range of States, examining these types of issues, had been achieved. Among the States, Maharashtra had the largest contribution of 19 facilities responding, amounting to 16% of the sample. This was followed by New Delhi where 13 facilities responded contributing to 10.9% of the sample. Tamil Nadu and Kerala contributed nine responses each and Mizoram eight. The larger percentage from Maharashtra could be attributed to the fact that some survey forms were face to face interviews undertaken by the research consultant. All other States were completely dependent upon electronic responses.

<table>
<thead>
<tr>
<th>State</th>
<th>Frequency</th>
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<tr>
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<tr>
<td>West Bengal</td>
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<td><strong>Total</strong></td>
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The questionnaire consisted of 30 questions (See Annex 1), most of which were answered by all 119 organisations.
Situation Analysis of Basic Education, Vocational Education & Development of Sustainable Livelihoods in Drug Treatment & Rehabilitation Centres of India

Over half the respondents did not provide basic education for drug users (60.5%). Reasons could vary but it can be suggested that many facilities surveyed catered towards the more affluent, literate client group with payment a prerequisite for treatment service.

1. Provide basic education (numeracy and literacy skills) for drug users

<table>
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<th>Frequency</th>
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<td>119</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Over half the respondents did not provide basic education for drug users (60.5%, N= 72). Reasons could vary but it can be suggested that many facilities surveyed catered towards the more affluent, literate client group with payment a prerequisite for treatment service. 

2. Provide HIV and Drug education for Drug users

<table>
<thead>
<tr>
<th>HIV &amp; Drug Education</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>114</td>
<td>95.8%</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>4.2%</td>
</tr>
<tr>
<td>Total</td>
<td>119</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

A total of 114 agencies responded that HIV and drug education was offered to drug users. Those that did not offer this service were evenly distributed among MSJE, MoH, Private and others. It was likely that four out of five respondents incorrectly marked ‘NO’ as they responded to the following question on the type of HIV and drug education that they provided.

3. Type of HIV and Drug education provided.

A total of 118 organisations responded, of which

![Basic Education by Organisations](image1)

![HIV & Drug Education by Organisations](image2)

![Type of HIV and Drug Education by Organisations](image3)

Among the 56 agencies affiliated to MSJE/NISD, 50% answered ‘YES’ to providing basic education. This constituted 59.5% of all respondents that answered ‘YES’. Among agencies dealing with harm reduction, 75% answered ‘YES’: this higher than average figure may reflect that such agencies were in close proximity and regular contact with street drug users in need of basic education.
102 (86.4%) mentioned group session as the main mode of providing education. Interestingly 54 (45.8%) were using the mass media as an educational approach. Of the 32 responses mentioning ‘others’, some referred to programmes like community awareness, or jail visits whereas others confused this answer with delivery formats like IEC and verbal explanation.

Interestingly outreach and peer education was not rated highly. This may be because most responses were likely to be from residential centres accommodating 15 persons. In such facilities outreach was not a common tool perhaps because this approach would result in pressure or demand for new admissions from a population who were most likely to be unable to pay for treatment.

4. The delivery formats/ mediums for HIV and drug education provided.

<table>
<thead>
<tr>
<th>Delivery Formats/mediums</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brochure</td>
<td>77</td>
<td>65.3%</td>
</tr>
<tr>
<td>Films</td>
<td>59</td>
<td>49.6%</td>
</tr>
<tr>
<td>Flip charts</td>
<td>60</td>
<td>50.4%</td>
</tr>
<tr>
<td>Group discussions</td>
<td>98</td>
<td>82.4%</td>
</tr>
<tr>
<td>Poster</td>
<td>77</td>
<td>64.7%</td>
</tr>
<tr>
<td>Verbal</td>
<td>102</td>
<td>85.7%</td>
</tr>
</tbody>
</table>

A total of 118 organisations responded to this question and usually indicated more than one format or medium for education delivery. Verbal and group discussion rated highly, with brochures, posters, flip charts, and films shown to be utilised widely.

5. Age Group of beneficiaries of HIV and Drug education provided

<table>
<thead>
<tr>
<th>Age (in years)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 16</td>
<td>3</td>
<td>2.6%</td>
</tr>
<tr>
<td>16-30</td>
<td>75</td>
<td>64.1%</td>
</tr>
<tr>
<td>31-45</td>
<td>36</td>
<td>30.8%</td>
</tr>
<tr>
<td>46 and older</td>
<td>3</td>
<td>2.6%</td>
</tr>
<tr>
<td>Total</td>
<td>117</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Agencies were asked to select only one age group. Majority (64.1%) of the clients were aged 16 to 30 years. This finding indicates most fell within the youth or young adult category and the education provided had the potential for substantial impact upon those that were taught such topics, and to lessen the adverse health consequences of personal risk behaviours. The second most predominant age group were aged 31 to 45 years (30.8%). Most were likely to comprise of chronic drug users, including alcoholics.

6. Most common drugs that are being consumed among the beneficiaries.

<table>
<thead>
<tr>
<th>Most Common Drug</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>97</td>
<td>81.5%</td>
</tr>
<tr>
<td>Brown Sugar</td>
<td>58</td>
<td>48.7%</td>
</tr>
</tbody>
</table>

Respondents were allowed to select from a choice of drugs consumed. The two most common drugs used were alcohol (81.5%) and brown sugar (48.7%). Solvents, benzodiazepines, and spasmoproxyvon were used alone or in combination with other drugs by 15%, 14% and 12% of the clients respectively.

Most common drugs used by beneficiaries

<table>
<thead>
<tr>
<th>Most Common Drug</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>97</td>
<td>81.5%</td>
</tr>
<tr>
<td>Brown Sugar alone or in combination with other drugs</td>
<td>58</td>
<td>48.7%</td>
</tr>
<tr>
<td>Solvents alone or in combination with other drugs</td>
<td>18</td>
<td>15.1%</td>
</tr>
<tr>
<td>Benzodiazepines alone or in combination with other drugs</td>
<td>17</td>
<td>14.3%</td>
</tr>
<tr>
<td>Spasmoproxyvon alone or in combination with other drugs</td>
<td>14</td>
<td>11.8%</td>
</tr>
</tbody>
</table>

7. Main mode of administration of drugs that is most prevalent among the beneficiaries.

The two main modes of administration were swallowing (54.2%) and injecting (28.8%), both reflecting and associated with the two main substances consumed that of alcohol and heroin/brown sugar.
Only a minor number of clients (10.5%) in treatment were reported to have a regular job. A substantial number were unemployed (31.6%), while a majority had no fixed job with irregular income; it can be suggested that many lived a life of financial insecurity, uncertainty, and were overall generally impoverished.

Close examination of injecting behaviour across the various organisations identified that there were statistically significant differences. Among NGOs facilities not linked with MSJE/NISD, injecting among beneficiaries was 40%, while among the MSJE/NISD sites it was 32%. For respondents representing MoH the figure was 16%, and for Private facilities it was 25%. The fact that injecting behaviour was identified across all facilities, highlights the necessity for ongoing and increasing education efforts to address this problem.

8. Sources of information about HIV and Drug use.
Information was sought from various sources, with more than half accessed from the Government. The Internet was commonly used but discernment of the type of information accessed from this source cannot always be guaranteed, nor can the information always be considered factual and current. UN agencies, followed by Technical agencies were also accessed by respondents.

A high percentage (68.9%) of agencies stated they had educational materials suited for those identified as illiterate. This type of information was most commonly found in MSJE/NISD facilities (44%). During the face to face interviews the consultant identified that when agencies displayed their educational materials most showed flip charts only, developed by NACO and State AIDS Control Society (SACS) which primarily focused on Sexual Transmitted Infections (STI) and HIV. Materials that focused on drug use issues were lacking suggestive of the need for education information related to drug use to be developed in a pictorial form, if not yet available.
10. Delivery of information for those who cannot read

Delivery of Information | Frequency | Percent
--- | --- | ---
Verbal Explanation | 82 | 70.1%
Group Discussion | 79 | 67.5%
Picture books | 45 | 38.5%
Film | 39 | 33.3%
Others | 23 | 19.5%

Most education for those who cannot read was done through verbal education and group discussion. More Information Education Communication (IEC) materials with picture books utilised specifically for illiterate clients were likely to be required, and could be expanded. For respondent who answered ‘other’ delivery forms, posters (N = 22), pamphlets (N = 8), flipcharts (N = 4), role play (N= 5), exhibition (N= 2) including art therapy and practical demonstrations were cited.

11. Educational materials available in any other languages, excluding the main languages.

<table>
<thead>
<tr>
<th>Education Material</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>73</td>
<td>61.3%</td>
</tr>
<tr>
<td>No</td>
<td>44</td>
<td>37%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>1.7%</td>
</tr>
<tr>
<td>Total</td>
<td>119</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Sixty one percent of agencies answered ‘yes’, with many having materials in English or Hindi, besides the local State language.

12. Focus group discussion/testing of education materials

<table>
<thead>
<tr>
<th>Material</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>67</td>
<td>56.3%</td>
</tr>
<tr>
<td>No</td>
<td>52</td>
<td>43.7%</td>
</tr>
<tr>
<td>Total</td>
<td>119</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Over half the respondents (56.3%) tested education materials amongst their client group. During face to face interviews it was identified that educational materials developed by others was not tested. Testing would only occur if it was developed by the organisation itself.

13. Provide HIV and Drug education for alcohol dependents

Majority of agencies (95%) did provide HIV and Drug education to alcohol dependents. Interestingly from the KI interviews it was identified that provision of HIV and drug education for
Majority of facilities (61%) do not provide any vocational education and livelihood skills for drug users. Among the facilities that provided this service (38%) most answered that what was offered often resembled occupational therapy for income generation.

alcoholics within MoH facilities was not a requirement, yet most still provided this service. It was shown however that of the six facilities not providing this service, four were from MoH.

<table>
<thead>
<tr>
<th>Education for Alcohol Dependents</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>113</td>
<td>95%</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>5%</td>
</tr>
<tr>
<td>Total</td>
<td>119</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Provide Education for Alcohol Dependents by Organisations

14. Conduct monitoring & evaluation

<table>
<thead>
<tr>
<th>Monitoring and Evaluation</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>91</td>
<td>76.5%</td>
</tr>
<tr>
<td>No</td>
<td>26</td>
<td>21.8%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>1.7%</td>
</tr>
<tr>
<td>Total</td>
<td>119</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Majority of agencies (76.5%) stated they conducted monitoring and evaluation (M & E) to assess the success of their education programmes and if it had changed the behaviours of their client group. However, in the face to face interviews just under 50 percent changed their opinion when enquires were made about the process involved [this was explored in the following question, number 15]. It was highly probable that the M & E undertaken by respondents was not as high as shown among the responses.

15. Describe Monitoring and Evaluation Process

For those that did undertake M & E respondents were requested to describe the process. Unfortunately despite a request for descriptive answers of the process, most responses were extremely short and overall inadequate to understand the method that was utilised. Responses comprised of the following: follow up visits; feedback sheets (sometimes termed ‘confidential’); and observing behaviour change. Such responses were commonly found among all the facilities. Only two NGOs spoke of a ‘base and end line survey’ to compare knowledge gained from the M & E process. With insufficient insight of the processes involved and aware of how opinions can alter when questioned face to face, we suggest there were significant gaps in understanding and implementing M & E processes at the various facilities.

16. Employment Status of persons attending the centre

In the past 12 months only a minor number of clients (10.5%) in treatment were reported to
have a regular job. A substantial number were unemployed (31.6%), while a majority had no fixed job with irregular income; it can be suggested that many lived a life of financial insecurity, uncertainty, and were overall generally impoverished. It can be claimed that most drug users in treatment were accessing some form of work but as highlighted in the literature those that live in poverty have few options but to seek out whatever jobs exist no matter how poorly paid or with few rewards for advancement of a livelihood. This finding indicates that a high number of likely unskilled clients were in need of livelihood skill training, and treatment facilities need to examine this issue closely to ensure ‘whole person recovery’ can be achieved.

17. Provide vocational education and livelihood skills for drug users inside your centre.

Majority of facilities (61%) do not provide any vocational education and livelihood skills for drug users. Among the facilities that provided this service (38%) most answered that what was offered often resembled occupational therapy for income generation.

The provision of vocational education and livelihood skills was found among nearly half the organisations associated with MSJE/NISD facilities, and other NGOs not associated with MSJE/NISD. Only a minor number from MoH offered this service and it may be because this was an unexplored area within the agency or was not considered a part of what they offer directly to those accepting treatment. This does not mean necessarily that they do not refer beneficiaries to other organisations providing these services (see question 18)

18. Describe different types of vocational education and livelihood skill courses offered.

For those that did provide vocational and livelihood skill courses it was shown that many offered what could be called occupational programmes. It can be suggested that a large number of such programmes were unlikely to match the skill set or provide employment opportunities required by the overall employment market. The response list was extensive and included the following: soap making; candle making; paper bag making; creating lanterns and greeting cards; making chalk; lotion, vinegar, disinfectants; book binding; worm culture; dairy and poultry; housekeeping; catering; pottery; umbrella making; basic computer course; music classes; yoga; T.V - VCR Repair; electrician; vocal and instrumental music training; printing; and making leather bags and shoes.

19. Provide regular (every 1-3 months) referrals or linkages with other organizations for basic education, vocational education and livelihood skills.

Majority of agencies (64.4%) do not provide
Situation Analysis of Basic Education, Vocational Education & Development of Sustainable Livelihoods in Drug Treatment & Rehabilitation Centres of India

Majority of agencies (64.4%) do not provide regular referrals or linkages with other organizations and majority of agencies (74%) had not created a partnership with any other outside agency, organisation or institution. The complexity of the drug users’ needs and the various issues associated with social and economic reintegration will require partnerships.

<table>
<thead>
<tr>
<th>Referral to Vocation Related Services</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>40</td>
<td>33.9%</td>
</tr>
<tr>
<td>No</td>
<td>76</td>
<td>64.4%</td>
</tr>
<tr>
<td>Do not know</td>
<td>2</td>
<td>1.7%</td>
</tr>
<tr>
<td>Total</td>
<td>118</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Majority of agencies (64.4%) do not provide regular referrals or linkages with other organisations. A substantial number of clients were identified as illiterate or had received minimal education, coupled with a mostly unemployed, unskilled or in positions of irregular, insecure employment. It was in this context that the lack of linkages or referrals undertaken by the various agencies warranted further examination. Within MSJE/NISD facilities just over half of respondents claimed to offer referral and linkages (54%), but those NGOs not associated with MSJE/NISD and responses from MoH show a markedly lower rate of 31% and 21% respectively.

Linkages to Vocation Related Services by Organisations

<table>
<thead>
<tr>
<th>Type of Agencies</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vocational education training centres or schemes</td>
<td>31</td>
<td>26.1%</td>
</tr>
<tr>
<td>No partnership</td>
<td>88</td>
<td>73.9%</td>
</tr>
<tr>
<td>Total</td>
<td>119</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Majority of agencies (74%) had not created a partnership with any other outside agency, organisation or institution. Those that had formed partnerships had done so with vocational education training centres or schemes. No respondent mentioned partnerships with corporate – private companies, community groups (business and employment orientation), private or public schools, technical institutes, or any partnerships with UN agencies. The complexity of the drug users’ needs and the various issues associated with social and economic reintegration will require partnerships and this will need more examination to ensure it can happen.

21. Alternate employment approaches for drug users

<table>
<thead>
<tr>
<th>Type of Agencies</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Micro credit schemes</td>
<td>16</td>
<td>13.7%</td>
</tr>
<tr>
<td>Self help groups</td>
<td>56</td>
<td>47.9%</td>
</tr>
<tr>
<td>Self employment</td>
<td>42</td>
<td>36.2%</td>
</tr>
<tr>
<td>Supported work schemes</td>
<td>22</td>
<td>19.0%</td>
</tr>
<tr>
<td>Apprenticeships</td>
<td>9</td>
<td>7.8%</td>
</tr>
<tr>
<td>Others</td>
<td>7</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

Almost half the respondents mentioned ‘self help
groups’ as an alternative employment approach. Yet this term among many drug treatment centres in India can and has been interpreted to mean ‘Narcotic Anonymous’ and ‘Alcoholic Anonymous’. Such groups however have no connection with alternative employment. Self employment and supported work schemes appear to be relatively popular. It was interesting to note that 13.7% of agencies had been involved with micro credit schemes. As shown in the literature this was one area that had potential for further examination and implementation in treatment facilities of India.

22. The academic – educational achievement of most drug users served by your organisation

<table>
<thead>
<tr>
<th>Educational Achievements</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dropped out of school</td>
<td>27</td>
<td>23.1%</td>
</tr>
<tr>
<td>Primary school</td>
<td>13</td>
<td>11.1%</td>
</tr>
<tr>
<td>Middle school</td>
<td>33</td>
<td>28.2%</td>
</tr>
<tr>
<td>Secondary school</td>
<td>30</td>
<td>25.6%</td>
</tr>
<tr>
<td>College/University</td>
<td>4</td>
<td>3.4%</td>
</tr>
<tr>
<td>Do not know</td>
<td>10</td>
<td>8.5%</td>
</tr>
<tr>
<td>Total</td>
<td>117</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

A third of drug users in treatment facilities were described as illiterate or had achieved primary school only. It can be suggested that illiterate drug users were potentially greater in number since the definition of literacy by the respondents may vary, and not always be reflective of the true scenario. However, what can be suggested from the responses was nil to poor educational achievements will result in increased social and economic vulnerability and exclusion. Drug users without the fundamentals of basic education will surely encounter barriers to reintegration.

23. Capacity to undertake basic education combined with vocational education

<table>
<thead>
<tr>
<th>Capacity</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>75</td>
<td>63.0%</td>
</tr>
<tr>
<td>No</td>
<td>33</td>
<td>27.7%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>11</td>
<td>9.2%</td>
</tr>
<tr>
<td>Total</td>
<td>119</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

A surprisingly high percentage (63%) of agencies claimed to have the capacity to undertake basic education, combined with vocational education and livelihood skills for drug users. Interestingly most agencies (61%) do not provide vocational education and livelihood skills for the drug users, majority provide no basic education (61.5%), nor regular referrals or linkages with other organisations that could offer such services (64%). It was with this background and the fact that half the KI believe that the agencies do not have the capacity that a high degree of scepticism exists about the capacity of treatment facilities to deliver in this area. Interestingly facilities linked with MSJE/NISD were most confident about their capacity to deliver such services.

24. Overall contribution by civil society towards the drug use and demand reduction response.

<table>
<thead>
<tr>
<th>Civil Soc Demand Reduction</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make a vital contribution</td>
<td>22</td>
<td>18.6%</td>
</tr>
<tr>
<td>Make an Important Contribution</td>
<td>27</td>
<td>22.9%</td>
</tr>
<tr>
<td>Make a moderate contribution</td>
<td>28</td>
<td>23.7%</td>
</tr>
<tr>
<td>Make a small contribution</td>
<td>33</td>
<td>28.0%</td>
</tr>
<tr>
<td>Do not make a contribution</td>
<td>8</td>
<td>6.8%</td>
</tr>
<tr>
<td>Total</td>
<td>118</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Majority of respondents believed that civil society’s contribution towards drug use and demand reduction response ranged from vital to
A third of drug users in treatment facilities were described as illiterate or had achieved primary school only. It can be suggested that illiterate drug users were potentially greater in number since the definition of literacy by the respondents may vary, and not always be reflective of the true scenario.

moderate contribution. These figures may reflect the fact that the majority of respondents were linked to the area of demand reduction. Only a minor number responded that the contribution was minor (6.8%)

25. Overall contribution by civil society towards the drug use and harm reduction response

<table>
<thead>
<tr>
<th>Civil Soc Harm Reduction</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make a vital contribution</td>
<td>18</td>
<td>15.5%</td>
</tr>
<tr>
<td>Make a Important Contribution</td>
<td>26</td>
<td>22.4%</td>
</tr>
<tr>
<td>Make a moderate contribution</td>
<td>27</td>
<td>23.3%</td>
</tr>
<tr>
<td>Make a small contribution</td>
<td>30</td>
<td>25.9%</td>
</tr>
<tr>
<td>Do not make a contribution</td>
<td>15</td>
<td>12.9%</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Civil society contribution towards the harm reduction response was a little more evenly distributed. Harm reduction was a more recent addition to the response to drug use issues but it was still interesting to see a large number of respondents collectively acknowledged that civil society was aware of this movement and made a contribution.

26. Overall contribution by government towards the drug use and demand reduction response.

Just less than half the respondents considered government contribution towards drug use and demand reduction response as an important to moderate contribution (48%). Most agencies receiving grants from MSJE/NISD, and then those that fall under the responsibility of the MOH, also consider themselves as part of the government response. This may explain these figures.

<table>
<thead>
<tr>
<th>Govt Demand Reduction</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make a vital contribution</td>
<td>19</td>
<td>16.4%</td>
</tr>
<tr>
<td>Make a Important Contribution</td>
<td>31</td>
<td>26.7%</td>
</tr>
<tr>
<td>Make a moderate contribution</td>
<td>25</td>
<td>21.6%</td>
</tr>
<tr>
<td>Make a small contribution</td>
<td>25</td>
<td>21.6%</td>
</tr>
<tr>
<td>Do not make a contribution</td>
<td>16</td>
<td>13.8%</td>
</tr>
<tr>
<td>Total</td>
<td>116</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Harm reduction was a relatively new concept (compared to demand reduction) and despite the approach not always proving agreeable to all it was interesting to note that just over 40% of respondents believed the contribution by government ranged from vital to important. A small to non-existent contribution among the respondents was found to be 29%.

<table>
<thead>
<tr>
<th>Govt Harm Reduction</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make a vital contribution</td>
<td>20</td>
<td>17.1%</td>
</tr>
<tr>
<td>Make a Important Contribution</td>
<td>30</td>
<td>25.6%</td>
</tr>
<tr>
<td>Make a moderate contribution</td>
<td>33</td>
<td>28.2%</td>
</tr>
<tr>
<td>Make a small contribution</td>
<td>19</td>
<td>16.2%</td>
</tr>
<tr>
<td>Do not make a contribution</td>
<td>15</td>
<td>12.8%</td>
</tr>
<tr>
<td>Total</td>
<td>117</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
28. Aware of any laws, regulations, policies, or schemes in India that comment upon broad based education and/or vocational education and livelihood skills for drug users.

<table>
<thead>
<tr>
<th>Policy/awareness</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>25</td>
<td>21.0%</td>
</tr>
<tr>
<td>No</td>
<td>73</td>
<td>61.3%</td>
</tr>
<tr>
<td>Do not know</td>
<td>21</td>
<td>17.6%</td>
</tr>
<tr>
<td>Total</td>
<td>119</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Only 21% of respondents were aware of laws, regulations, policies or schemes that commented upon basic education, vocational education and livelihood skills. During face to face interviews many of the respondents altered their opinion to ‘No’ when they could not specify any scheme.

29. Name the laws, regulations, policies or schemes.

Almost 50% of the respondents when requested to provide the name of a law, regulation, policy or scheme referred to the NDPS Act, Tobacco Prevention Law and the Mental Health Act. A few respondents provided the names of the following: Rashtriya Mahila Kosh; Rajiv Gandhi Yuva Rojgar; Abkari Rules and Schemes; and Tribal Welfare Schemes. The information provided for both question 28 and 29, indicates that the majority of the respondents representing treatment agencies had little knowledge and understanding of the schemes that existed, and how recovering drug users may be able to benefit, access or utilise them.

30. Need for government improvement for policies and practices in the area of broad based education and/or vocational education and livelihood skills for drug users.

<table>
<thead>
<tr>
<th>Need for Government Improvement</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination &amp; harmonizing all different stakeholders in the field</td>
<td>86</td>
<td>73.5%</td>
</tr>
<tr>
<td>Stimulating basic human rights by ensuring drug users have access to basic services</td>
<td>84</td>
<td>71.8%</td>
</tr>
<tr>
<td>Mainstreaming drug use prevention in educational programs</td>
<td>96</td>
<td>82.1%</td>
</tr>
<tr>
<td>Creating/enhancing networks with different agencies to ensure comprehensive response</td>
<td>89</td>
<td>76.1%</td>
</tr>
<tr>
<td>Promotion of peer education model among drug users</td>
<td>91</td>
<td>77.8%</td>
</tr>
<tr>
<td>Design research strategy to plan, monitor and evaluate policies/programs/activities</td>
<td>84</td>
<td>71.8%</td>
</tr>
<tr>
<td>Ensuring livelihood training for drug users as a means for social inclusion</td>
<td>93</td>
<td>79.5%</td>
</tr>
<tr>
<td>Others</td>
<td>24</td>
<td>20.5%</td>
</tr>
</tbody>
</table>

There was overwhelming support among respondents for government improvement for policies and practice with basic education, vocational education and livelihood skills for drug users, ex-drug users and people vulnerable to drug use. These were all areas that require considerable thought as to how may the government put into place some of these policies and practice to facilitate a meaningful and practical approach for the social and economic reintegration of drug users. A fifth of respondents added some suggestions of which some overlapped with other areas for consideration. These included the following:

- Assistance for small rehabilitation centres;
- To promote the aspect that the drug abuse is a disease;
- Network of NGOs for comprehensive response to drug use;
- Treatment education, adherence support, dissemination of information;
- Deglamorise drug use;
- Supply reduction, strengthening of community based organisations like mahila mandals (women’s organisations);
- Generate policy to facilitate treatment and rehabilitation;
- All educational programmes should be oriented towards personality development;
- Life skill training from middle school level; and
- Vocational training and employment opportunities
Discussion

Research of this type, has to our knowledge, not been undertaken in India. This research proved labour intensive: over 500 telephone calls, 400 emails, and 87 postal questionnaires sent to staff working at drug treatment facilities around India. Despite the many obstacles and the extent of the geographical land mass, a total of 25 States and one Union Territory participated in this mapping exercise. An important caveat to this research report was that the various responses received do not represent all the drug treatment and rehabilitation facilities of India. However we do believe that important new insights can be gleaned from the various findings of the key-informants, focus group discussions and questionnaire response.

The literature identified the ‘whole person recovery’ model as part of the rehabilitation process and focus should not just be on clinical management of treating drug dependency. Issues of basic education (numeracy and literacy), vocational education and the move towards developing livelihood skills for drug users was acknowledged to be important but overall implementation of such interventions was lacking. As identified in the survey, 61% of facilities did not provide opportunities for basic education. It can be suggested that many of the agencies surveyed catered to the literate client group as payment was most often a requirement for treatment. Yet the results show 23% identified as illiterate with an additional 11% achieving primary school only. It was plausible that the figures of illiteracy could be higher as defining of literacy can be open to interpretation. With a third identifying as illiterate or of primary education level only, emphasis on the need for more basic education among this group needs encouragement. Further more it is important to note that from a human rights approach, the Universal Declaration of Human Rights adopted by the United Nations General Assembly in 1948, in which India is a signatory, states in Article 26 (1). Everyone has the right to education (United Nations 2009). It is within this context that drug users should be offered the opportunity for education which would contribute towards social inclusion and the creation of sustainable livelihood.

HIV and drug education was undertaken by virtually all facilities and a group session discussion with verbal explanations was the most common mode of imparting education in the various settings. Quality assurance of how the information was imparted to drug users cannot be provided but it was an important area to examine as a number of key informants suggested the delivery of messages was often prescriptive and didactic.

As far as the responses are concerned some limitations are that a gender breakdown was not undertaken and that it has not been possible to determine an assessment of the needs of children substance users from this study sample. The lack of gender assessment in the study was a regrettable oversight as the position of women as drug users and partners of users, particularly within the Asian context, are often overlooked. In the main much of the research and programmatic response lacks focus when addressing the needs of women vulnerable to drugs, directly or indirectly, (largely it can be assumed because the vast majority of drug users are male) and further research into this area should be encouraged. The majority of clients (64%) were aged 16 to 30 years. The survey shows that various drugs were consumed, and responses suggest poly drug use was widespread. While it was true swallowing was the main mode of administration, the degree of injecting was substantial (29%), and sufficiently widespread among the various facilities.
The majority of agencies (69%) responded positively to having material for those who cannot read. Yet it was observed that few facilities were involved in developing materials for this target group and it can be suggested that most existing material available was related to HIV. Preliminary observations suggest that there was a need for materials related to drug use in a pictorial form. Exploring the need for information other than Hindi and English was an area for consideration. Many facilities (56%) tested education materials amongst their clients but the consultant observed during face to face interviews that of those testing, few had produced their own materials to address specific gaps in the information.

It was interesting to note the widespread undertaking of monitoring and evaluation (77%) to assess the success of education programmes by the facilities. However, during the face to face interviews, almost 50% withdrew their affirmative answer when enquiries were made about their process. Respondents were requested to describe monitoring and evaluation processes. Majority of responses produced inadequate text to provide meaningful answers: it can be suggested gaps in thorough understanding of the processes involved were likely. Only a couple of NGOs stated issues linked to a base line collection of data which could then be compared to follow up surveys to compare knowledge gained from a programme conducted. Most key informants suggested scope for improvement with monitoring and evaluation and further research into this area should be undertaken.

Responses indicated that 89% of clients were either unemployed or involved in casual work with an irregular income. Despite many facilities stating that they had the capacity to offer broad based education and livelihood skills, 61% of facilities did not provide any skills for drug users and half the key informants considered that lack of capacity was a reality. Of the 38% who do provide a skill building service, it was most often occupational therapy for income generation and not always suited for long term employment opportunities upon completion of drug treatment. Focus group discussions with drug users show an improved preparation for employment was highly desirable. Many facilities were likely to be overburdened with many tasks and cannot provide all services.

Research found 64% do not provide regular referrals or linkages with other organisations for vocational training, and 74% had not formulated a partnership with outside agencies and institutions to assist in the process of social and economic re-integration of drug users. These findings suggest that treatment facilities should form partnerships with those that were best equipped to provide vocational education and livelihood skill training. Potential partnerships should be broad ranging and can include those from the Government, NGO and the corporate sector. For example one such government scheme was the Jan Shikshan Sansthan (JSS) which offer quality vocational skills and technical knowledge, at low cost, not only focusing on those in the urban areas but to the numerous neo-literates and unskilled and unemployed youth throughout the country. Today there are 223 JSSs established throughout India offering over 300 different types of vocational courses.

Alternative employment approaches for drug users were considered, such as self-help groups but it can be suggested that this term among treatment facilities could be misinterpreted as ‘Narcotics Anonymous’ and ‘Alcoholics Anonymous’ as some had suggested in face to face interviews. Despite only a small number of agencies responding positively to micro credit schemes (14%) and apprenticeships (8%) this was an area worthy of greater expansion as the literature review highlighted some positive outcomes within an Indian setting.

Many respondents believe the degree of
Despite many facilities stating that they had the capacity to offer broad based education and livelihood skills, 61% of facilities did not provide any skills for drug users and half the key informants considered that lack of capacity was a reality

contribution by civil society towards the drug use and demand reduction response was substantially important but many (39%) did not think civil society contributed as much importance to harm reduction. Increased advocacy efforts would be required with the community for them to better understand the merit of harm reduction. Many respondents stated the overall contribution (vital, important, and moderate) by the government towards the drug use and demand and harm reduction response was similar (75% and 71% respectively) indicating an acknowledgment that harms reduction as a concept and approach was taken seriously by the government.

Most respondents were not aware of any laws, regulations, policies, or schemes that comment upon broad based education and/or vocational education and livelihood skills for drug users. Some respondents provided suggested answers but most referred to the NDPS Act, which as indicated in the literature review does not provide any specifics on rehabilitation per se. It appears that no mention was made of the ‘Scheme for Prohibition and Drug Abuse Prevention 1985 – 1986’, which was more orientated towards the whole person recovery.

The majority of responses felt the need for government improvement in policies and practices in the area of broad based education and/or vocational education and livelihood skills for drug users through a series of suggested interventions. These ranged from the development of livelihood skills training for drug users to the mainstreaming of drug use prevention/education programmes. The processes involved in undertaking the various interventions would require greater exploration and would require ongoing advocacy efforts encouraging government participation in the way forward.

In conclusion, gaps in basic education, vocational education and development of livelihood skills of drug users within the overall drug treatment and rehabilitation system were identified. Within a broad ranging education framework there was a need to move towards an evidence based and practical response. To aid the process of whole person recovery, basic education, provision of appropriate vocational education and skill development compatible with the needs of the society will be necessary. Only then could the social and economic re-integration of drug users into the community at large, be ensured.

The research findings of this report were presented to a broad range of participants attending a UNESCO event in New Delhi, 10 November, 2008, titled ‘National Consultation on Education and Harm Reduction related to drug use, HIV and AIDS in India’. The event not only highlighted the findings, accompanied with participatory discussions about the recommendations, but also provided a platform for various UNESCO funded projects in India that focus on various aspects of HIV and drug use (see Annex 6).
Recommendations

1. Advocate and encourage at a national and state level for policies, schemes, and/or laws that incorporate the concept of the ‘whole person recovery’ in order to expand and offer opportunities to recovering drug users to receive basic education (numeracy and literacy skills where applicable and appropriate), vocational education and livelihood skills from all types of drug treatment and rehabilitation services.

   a. Advocate and encourage at a national and state level for drug prevention, treatment and rehabilitation facilities to undertake a mapping exercise in their locality to identify agencies, institutions, schemes or specific entitlement programmes that offer basic education, vocational education and livelihood skill training, either linked or with no prior association with drug treatment services, where appropriate.

   Responsible Agencies: MSJE, NISD and MoH in collaboration with Ministry of Human Resources Development, Ministry of Education, NACO, ILO, RRTCs, UNESCO

   b. Advocate and encourage at a national and state level for drug prevention, treatment and rehabilitation facilities to examine mechanisms already in place to enhance and develop partnerships, or memoranda of understandings with other agencies, services and schemes (government, non-government, private) that offer basic education programmes, vocational education and livelihood skill training.

   Responsible Agencies: MSJE, NISD, MoH and RRTCs in collaboration with Ministry of Human Resources Development, Ministry of Education, NACO, ILO, UNESCO

2. Improve and provide training opportunities and skill building for appropriate staff working at all drug treatment and rehabilitation facilities.

   d. Advocate at a national and state level for regional resource training centres and other suitably identified training centres, to be further empowered, acquire increased capacity and be appropriately resourced (both human and funding) to undertake the lead on providing a comprehensive package of education awareness on the therapeutic benefits of basic education, vocational education, and skill development through training of all appropriate staff (primarily counsellors or others considered appropriate) to serve the needs of recovering drug users, ex-drug users or people vulnerable to drug use.

   Responsible Agencies: MSJE, NISD and MoH in collaboration with RRTCs, ILO UNESCO

   e. Conduct training at a state level in skill assessment processes (assess job skill matching and appropriateness with individual needs, motivation, capacity and marketability of skills in the local labour market) and procedures to identify suitable vocational education and livelihood skills for recovering drug users, ex-drug users or people vulnerable to drug use.

   Responsible Agencies: MSJE, NISD and MoH in collaboration with RRTCs, ILO UNESCO
Advocate and encourage at a national and state level for policies, schemes, and/or laws that incorporate the concept of the ‘whole person recovery’ in order to expand and offer opportunities to recovering drug users to receive basic education vocational education and livelihood skills from all types of drug treatment and rehabilitation services.

Responsible Agencies: NISD and MoH in collaboration with RRTCs, ILO

f. Conduct training at a state level in skill development in how to network with other agencies for vocational education and livelihood skills for recovering drug users, ex-drug users or people vulnerable to drug use.

Responsible Agencies: NISD and MoH in collaboration with RRTCs, ILO

g. Conduct training at a state level as to how to prepare recovering drug users, ex-drug users or people vulnerable to drug use for attending job interviews and reorientation skills for a return to a more ‘structured’ lifestyle.

Responsible Agencies: NISD and MoH in collaboration with RRTCs

h. Conduct training at a state level in the preparation and assisting of recovering drug users, ex-drug users or people vulnerable to drug use to write a resume or complete job application forms where appropriate.

Responsible Agencies: NISD and MoH in collaboration with RRTCs and ILO

i. Conduct training at a state level in how to assist and facilitate the process of employment placement for recovering drug users, ex-drug users or people vulnerable to drug use. This can include mentoring of beneficiaries to access other services and be able to get official documents, health treatment, legal support, and so on as conditions enable them to be employed in a sustainable manner.

Responsible Agencies: NISD and MoH in collaboration with RRTCs and ILO

j. Conduct training at a state level as to how to empower family members to also be involved in accessing opportunities for vocational education and livelihood skill building (mainly for family members of relapsing drug users, ex-drug users or people vulnerable to drug use).

Responsible Agencies: NISD and MoH in collaboration with RRTCs

k. Conduct training at a state level in understanding the fundamentals of monitoring and evaluation skills (i.e., inputs, outputs, outcomes, impact, and awareness of appropriate indicators to best show if a programme meets aims and objectives) in a period of time going beyond the period when beneficiaries attend a programme. Training would be for suitable staff and to ensure the skills are shared with at least two staff within the facility so that understanding of processes and procedures does not ‘lapse’ following the exit of a trained staff member.

Responsible Agencies: MSJE, NISD and MoH in collaboration RRTCs and appropriate management agency.
3. Encourage drug treatment and rehabilitation facilities to explore more widely the benefits of alternative employment opportunities suited for social and economic reintegration of drug users and ensuring that human and funding resources are made available.

I. Explore the positive outcomes of micro-credit programmes linked to small business ventures that may not require extensive training and prove more appropriate to the capabilities of recovering drug users and their needs.

Responsible Agencies: NISD in collaboration RRTCs, All India Institute of Medical Sciences, ILO, United Nations Development Program

m. Advocate and encourage collaboration between drug prevention, treatment and rehabilitation facilities and NGOs or Government schemes focused on development and assistance to marginalised and socially disadvantaged groups to seek appropriate funding

Responsible Agencies: MSJE, NISD and MoH in collaboration with RRTCs, Ministry of Human Resources Development, ILO and local authorities

n. Ensure information about alternative employment are provided by treatment facilities that offer more than detoxification, such as offering drug substitution therapy programmes, to enhance more successful outcomes for recovering drug users, ex-drug users or people vulnerable to drug use

Responsible Agencies: Drug treatment and rehabilitation centres in collaboration with government and non government employment agencies

o. Conduct monitoring and evaluation, with clear indicators of alternative employment schemes to document successes, mistakes and failures and for lessons learnt to be widely shared with other appropriate services. Document best practices and lessons learned on vocational education programmes linked with drug related services needs to be ensured as well.

Responsible Agencies: MSJE, NISD and MoH in collaboration with RRTCs

4. Improve the coordination and harmonizing of all the different stakeholders directly or indirectly associated with education, vocational education and livelihood skill development, with those services providing drug treatment to improve the lives of recovering drug users.

p. Advocate at a national level for a multi-sectoral event to be organised at a national level with participation for all major and appropriate stakeholders to better understand the issues and challenges of the social and economic reintegration of drug users, ex-drug users or people vulnerable to drug use.

Responsible Agencies: MSJE and MoH

Undertake further research to address some limitations and gaps identified in the situation analysis

q. Research to be undertaken, specifically focused on drug use issues among children – adolescents, women, and youth to explore their basic education, vocational education and livelihood skill needs.

Responsible Agencies: Appropriate UN agencies, leading national and international donors, and research institutes

r. Review and update where appropriate, HIV and drug education information (particularly on drugs) as utilised by drug treatment and rehabilitation facilities, for quality and clarity of message.

Responsible Agencies: MSJE, NISD and MoH in collaboration NACO, UNODC, UNESCO

s. Research undertaken on quality assurance of the delivery modes of HIV and drug education information to drug users.
Research should be undertaken for a thorough examination of all Government schemes in place, exploring context, effectiveness and potential for access by drug prevention, treatment and rehabilitation facilities serving the needs of recovering drug users, ex-drug users or people vulnerable to drug use.

Responsible Agencies: NISD and MoH in collaboration RRTCs and appropriate research institutes

t. Research should be undertaken for a thorough examination of all Government schemes in place, exploring context, effectiveness and potential for access by drug prevention, treatment and rehabilitation facilities serving the needs of recovering drug users, ex-drug users or people vulnerable to drug use.

Responsible Agencies: MSJE, NISD and MoH in collaboration RRTCs and appropriate research institutes

u. Examine impact of alternative means of raising awareness of HIV and drug education for illiterate or low literacy functioning drug users, ex-drug users or people vulnerable to drug use through street outreach, theatre and other means of delivering educational messages.

Responsible Agencies: NISD in collaboration with RRTCs, UNODC, NACO, UNESCO and appropriate research institutes

5. Improve the lives of all recovering drug users (impoverished or not) that may be isolated from supportive networks to gain social and economic reintegration.

v. Fund a pilot project of a series of half way homes/shelters/supported housing (drug free ambience) in the community at major metro centres that would be associated with NGOs and agencies that provide basic education, vocational education, and the fostering of livelihood skills.

Responsible Agencies: MSJE and MoH in collaboration with national and international donors

w. Advocate at a national and state level on the right for education for all which includes the hard to reach community such as drug users, ex-drug users or people vulnerable to drug use.

Responsible Agencies: MSJE, MoH and Ministry of Education

x. Explore issues surrounding the enabling environment within each locality that can contribute towards recovering drug users, ex-drug users or people vulnerable to drug use having greater access to services offered to the rest of the community.

Responsible Agencies: Drug treatment and rehabilitation centres in collaboration with communities and local authorities, including law enforcement.
Situation Analysis of Basic Education, Vocational Education & Development of Sustainable Livelihoods in Drug Treatment & Rehabilitation Centres of India

Annexure 1

Survey Questionnaire

National consultations on education for drug demand and harm reduction programs in India.

Mapping Exercise

Introduction.
Education is a key to development goals, especially in the contexts of those affected by drug use. We know that education provides opportunities directly into people’s hands and is thus an effective, contributing factor to social inclusion and the potential for sustainable livelihood. Currently UNESCO is undertaking a mapping exercise of treatment and rehabilitation programmes to document mainly ‘who is doing what’ (with respect to education). This mapping exercise is conducted to identify all project activities and services relating to basic education (numeracy and literacy skills), HIV and drug education, combined with vocational education and livelihood skills. Consultations with senior staff within MSJE, NISD, MoH, NACO and various other agencies for this UNESCO initiative have occurred, and received their endorsement and support.

We wish for your views on a range of topics so that we can provide and advocate for increased support to your organisation, and improve our understanding of the holistic needs of drug users within a broad ranging education framework.

If you do not know the answer to the question, please answer ‘I don’t know, do not guess. Some questions will not be applicable for you. Please leave blank.

The results of this survey, including other aspects of this research, will be published in a report, which will be sent to you electronically or as hard copy in December 2008.

1. Name and address of the organisation/service including tele and email:
2. State type of organisation
   a. NGO – affiliated with MSJE/NISD.
   b. NGO not affiliated with MSJE/NISD
   c. MoH
   d. Private
   e. Other – (provide name)
3. Project Type:
   (Examples
   a. Detoxification Centre
   b. De-addiction Centre
   c. Rehabilitation Centre.
   d. Therapeutic Community
   e. Treatment Centre
   f. Counselling Centre
   g. Mixed Services - please provide detail.
4. Name of the State:
5. Respondents position in the organisation:

Information to be aware of when completing the questionnaire
To answer the various questions please place - ‘X’- next to what you consider the best answer. For example:

Do you provide basic education (numeracy and literacy skills) for drug users at your centre?
Yes - 
No - X
Do not know –

(Read the question carefully before answering)

Questions
1. Do you provide basic education (numeracy and literacy skills) for drug users at your centre?
   Yes - 
   No –
   Do not know -

2. Do you provide HIV and drug education for drug users at your centre?
   Yes -
3. If yes, HIV and drug education is provided through the following (please place ‘X’ with all that apply)
   - Outreach
   - Peer Education
   - Group Sessions
   - Mass media (radio/TV/internet/film)
   - School education programmes
   - Other (please describe)

4. If HIV and drug education is provided by your organisation highlight the delivery formats/mediums:
   (please place ‘X’ with all that apply)
   - Brochure – pamphlet
   - Poster
   - Flip Chart
   - Verbal explanation
   - Group discussions
   - Film (DVD, VCD etc)
   - Other (please describe)

5. If HIV and drug education is offered most beneficiaries are found in the following age group.
   (please place ‘X’ only with one age group)
   - Under 16 years
   - 16 – 30 years
   - 31 - 45 years
   - 46 years and older

6. Currently can you state the most common drugs that are being consumed among the beneficiaries in your organisation?
   (please place ‘X’ next to only one administration route)
   - Injecting
   - Inhaling
   - Smoking
   - Swallowing
   - Other (please describe)

8. Your organisation sources information about HIV and drug use from the following:
   (please place ‘X’ with all that apply)
   - From government agency (e.g., NACO, SACS, MSJE, NISD etc)
   - From United Nations agency (e.g. UNESCO, WHO, UNODC, UNAIDS etc)
   - From NGO (e.g., SHARAN, Indian Harm Reduction Network)
   - From technical assistance agency (e.g., FHI, PSI, Burnet Institute etc)

9. Do you have educational materials/approaches suitable for those who cannot read?
   - Yes
   - No
   - Do not know

10. If yes, how is the information delivered?
    (please place ‘X’ with all that apply)
    - Verbal explanation
    - Group discussion
    - Picture books
    - Film
    - Other (please describe)

11. Currently do you have educational materials available in any other languages, excluding the main language of your locality?
    - Yes

12. Do you conduct focus group discussion/testing of your educational materials? (NB This means showing the materials to your target group (drug users) and asking their opinion of the materials before you start using them)
Yes - 
No - 
Do not know - 

13. Do you provide HIV and drug education for alcoholics at your centre?
Yes - 
No - 
Do not know - 

14. Do you conduct monitoring & evaluation to check if your education programmes about HIV and drug education are successful? (NB This means, do you ask your clients/participants/patients if your education programme has changed their behaviour?)
Yes - 
No - 
Do not know - 

15. If you answered yes can you briefly describe monitoring & evaluation process?

16. The majority of drug users coming to your organisation in the past 12 months fall into the following category:
Unemployed - 
No fixed job with irregular income - 
Regular job -
If regular job please highlight some commonly described jobs:
Do not know - 

17. Do you provide vocational education and livelihood skills for drug users inside your centre?
Yes - 
No - 

18. If yes, could you please describe the different types of vocational and livelihood skill courses that you offer:

19. Do you provide regular (every 1-3 months) referrals or linkages with other organisations in your locality to ensure basic education (numeracy and literacy) vocational education and livelihood skills is offered for recovering drug users from your centre to elsewhere?
Yes - 
No - 
Do not know - 

20. If yes, could you name the main types of agencies/organisations/institutions where you have developed a partnership (please place ‘X’ with all that apply)?
Corporate - private companies - 
Community Groups (with business and employment orientation) -
Vocational Education Training Centres or Schemes (Government or NGO) -
Public or Private Schools -
Technical Institutes -
Partnerships with UN agencies -
Other - (please describe).

21. Has your organisation been involved in any of the following alternative employment approaches for recovering drug users (please place ‘X’ with all that apply)?
Micro-credit schemes -
Self Help Groups -
Self employment -
Supported work schemes -
Apprenticeships -
Other - (please describe)

22. The academic – educational achievement of most drug users served by your organisation would be (please place ‘X’ next to only one group):
Dropped out of school and are/is illiterate -
Primary School -
23. Do you think your organisation currently has the capacity to undertake basic education (numeracy and literacy skills) combined with vocational education and livelihood skills for drug users from your centre?
   Yes -  
   No –  
   Do not know -

24. How would you rank the overall contribution by civil society towards the drug use and demand reduction response in your locality?
   Make a vital contribution - 
   Make a important contribution - 
   Make a moderate contribution - 
   Make a small contribution - 
   Do not make a contribution -

25. How would you rank the overall contribution by civil society towards the drug use and harm reduction response in your locality?
   Make a vital contribution - 
   Make a important contribution - 
   Make a moderate contribution - 
   Make a small contribution - 
   Do not make a contribution –

26. How would you rank the overall contribution by government towards the drug use and demand reduction response in your locality?
   Make a vital contribution - 
   Make a important contribution - 
   Make a moderate contribution - 
   Make a small contribution - 
   Do not make a contribution -

27. How would you rank the overall contribution by government towards the drug use and harm reduction response in your locality?
   Make a vital contribution - 
   Make a important contribution - 
   Make a moderate contribution - 
   Make a small contribution - 
   Do not make a contribution –

28. Are you aware of any laws, regulations, policies or schemes in India that comment upon broad based education (numeracy and literacy skills), and/or vocational education and livelihood skills for drug users as part of their recovery and social – economic reintegration?
   Yes -  
   No -  
   Do not know -

29. If you answered YES could you please name the laws, regulations, policies or schemes?

30. If you believe there is a need for government improvement for policies and practice in the area of broad based education (numeracy and literacy skills), vocational education and livelihood skills for drug users which of the following interventions do you recommend? (please place X with all that apply)
   Mainstreaming drug use prevention in educational programs -
   Coordinating and harmonizing all different stakeholders in the field -
   Design a research strategy to plan, monitor & evaluate policies/programs/activities -
   Ensuring livelihood training for drug users as a means of social inclusion -
   Promoting of peer education model among drug users -
   Stimulating basic human rights by ensuring drug users have access to basic services -
   Creating/enhancing networks with different agencies to ensure comprehensive response to drug use -
   Other - (please name)

Thank you

Save this document and please return questionnaire by emmail to:
Mr Eldred Tellis: et.mumbai@gmail.com
Ministry of Health supplied UNESCO with a document that focused on drug treatment sites in India, under their responsibility. On the list were various categories titled as follows: National Centre and other Centres established in Central Hospitals/Institution; Drug De-addiction Centres established in General/Civil/other Hospitals/Institutions (State wise); De-addiction Centres established in District Hospitals (State wise); Drug De-addiction Centres established in Psychiatric Hospitals (State wise); Drug de-addiction Centres established in Prisons (State wise); and Drug De-addiction Centres established in Medical College (State wise). In total 122 facilities were identified as offering drug treatment services.

However, the list only provided the names of the facilities and the state they were found in, but no address or contact details of any description (including telephone numbers, email addresses). Communications with MoH revealed that no such directory or inventory of drug treatment facilities under the care of the MoH existed.

In order to communicate with those responsible or associated with the various drug treatment facilities nation wide required an extensive search utilizing the internet and search engines, primarily Google. Names of a hospital or the centre plus the state were typed into Google. Alternatively official government sites that fall under the State Ministry of Health were also examined. While this was moderately successful for some states, this did not prove successful such as states found in the North East (Manipur, Mizoram, Nagaland, Assam), Madhya Pradesh, Bihar and a few sites in Rajasthan. Existing networks were utilised mainly for North East India to access contact details of various drug treatment centres. As no such inventory of drug treatment centres, with addresses existed, UNESCO commenced the process to create one (see Appendix 5). While not all information could be accessed this list can act as guide for much further refinement.

Over a period of 3 weeks telephone calls were made where telephone numbers could be accessed, as well as email addresses. Often a combination of both tools of communication was utilised to build rapport. Generally a staff member was identified inside the facility by phone. This would be followed by a link to an appropriate person responsible for the unit either via a direct office number or their personal mobile number (for example Head of Department of Psychiatry). With contact established a brief introduction about the purpose of this mapping exercise, a request for their email address, followed by sending the questionnaire electronically. In most cases it was necessary to send a minimum of two email reminders or telephone twice to a contact person in order to receive a response to the UNESCO questionnaire.

It was discovered that several email addresses were no longer valid and consequently rejected. The same challenge also was found during the telephone calls. For example despite the telephone numbers (mobiles) for all drug treatment centres in Manipur (N -10) being provided by a leading NGO in Imphal, no direct telephone connection occurred due to either phones being switched off, but mostly not reachable. In Nagaland problems identified from drug treatment centres (N – 5) ranged from telephone number provided not existing, the centre does not offer such a service, electricity disruptions do not allow email access, and numbers not responding.

During the process UNESCO identified that some facilities for drug treatment had in fact ceased to exist. For example in the town of Tezu, Arunachal Pradesh, we were informed no such centre existed (it was not able to be confirmed if a treatment

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**Annexure 2**

**Detailed Methodology**

**Ministry of Health and Family Welfare**

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centre had been established at some stage). In Mizoram, a reliable academic source based in Aizawl had informed UNESCO that the district hospital in Aizawl has a 24 bedded psychiatric ward which provided detoxification, if and when they have patients, but it was not a specific detoxification or rehabilitation centre as such. However, excluding Aizawl none of the district hospitals in Mizoram (N – 6) as identified by MoH have drug treatment or rehabilitation centers. In Manipur, some District hospitals have services for drug users but only from Out-patient Department, and this depended upon the interest of the concerned doctor. The functional status of these district hospitals offering drug treatment was described as ‘uncertain’. For Imphal District Hospital based on reliable sources confidently suggested the drug treatment service was totally non functional. In-patient facility for drug users in Manipur was only found at the Regional Institute of Medical Services, Imphal and was not available at any district hospital in the State.

Of a total number of 215 phone calls, and 38 emails sent to various MoH contacts in India a total of 23 responses were received by UNESCO. Responses from various States (N – 15) include the following:

- Goa (N – 1, Mapusa);
- Kerala- (N – 3, Trivendrum, Trisur, Khozikode);
- Maharashtra (N – 1 Wardha);
- Uttar Pradesh (N – 1, Lucknow);
- West Bengal (N – 3, Burdhwann and Kolkata);
- Jammu and Kashmir (N - 2, Baramulla and Kathua);
- Punjab (N – 2, Amritsar and Bhatinda);
- Delhi (N – 3, RML, AllIMS, LHH);
- Chandigarh (N – 1, Chandigarth);
- Rajasthan (N – 2, Kota and Ajmer);
- Nagaland (N – 1, Kohima);
- Manipur (N – 1, – Imphal);
- Pondicherry (N – 1);
- and Tamil Nadu (N - 2, Chennai and Madurai).

Till date no information was able to be accessed from Orissa, Bihar, Madhya Pradesh, Himachal Pradesh, Haryana, Sikkim, Tripura, Uttranchal, Assam, Chattisgarth, Meghalaya, and Karnataka.

**Ministry of Social Justice and Empowerment, National Institute of Social Defence, Private and Others**

**Mapping Exercise for UNESCO Study.**

**Survey Methodology.**

Prior to the consultant formally agreeing to undertake the UNESCO assignment some preliminary work had commenced to create a list of drug treatment centres around the country. Soon after the work commenced on 1st September, the consultant hired various people. One person was employed for 4 days to undertake a basic search and create a list of treatment centres around India. Since mid September another person has been employed to continue on the search and also to address out and in-coming emails in relation to the formulated questionnaire for this study. Other resources for information have included Dr. Shanthi Ranganathan of TTK Hospital, Chennai and Dr. Rajesh Kumar of SPYM New Delhi. Both are part of the Regional Resource Training Centres (RRTCs) under the Ministry of Social Justice and Empowerment (MSJE). RRTCs are empowered as instructed by the MSJE to support and guide the nation’s drug treatment centres. The first two lists of South Indian NGOs and North Indian NGOs under MSJE were obtained. Dr. Shanthi also provided additional names and contacts of other
The consultant then prepared an introductory letter and began sending out the emails to the lists that were obtained. These lists included:

- 8 lists of NGOs working in the area of drug treatment under the RRTCs sponsored by MSJE;
- A list of those drug treatment centres associated with the Indian Harm Reduction network;
- A list of Private drug treatment centres in Hyderabad;
- A list of Private drug treatment centres in Bangalore;
- A list of private centres in Delhi.

It had been agreed between Gary Reid (UNESCO Delhi Office) and the consultant that Gary would examine drug treatment centres under the Ministry of Health.

The entire exercise of sending out a designed and agreed upon questionnaire to the various drug treatment centres of India was expected to take about 2 weeks and a tentative date of 15th September had been set to conclude the mapping exercise. This turned out to be wishful thinking as there were many challenges during the contact period with the drug treatment centres. Firstly not even 50% of those on the various lists had email addresses listed. Among those which had email addresses, almost half of them bounced back as these addresses were not in use over extended periods of time. The consultant had to hire a special person to begin making direct phone calls to the various drug treatment centres (here again, not everyone had a listed telephone number), and begin talking to the key functionaries as per the lists.

Some organisation directors said that they had not received grants for over 2 years and had stopped functioning. They would resume only when the grants were released. Some mentioned that the email address on the list was done by a particular staff who had left the organisation and therefore the account was not operational. Some of the organisations mentioned that they did not even have a computer. For these the consultant inquired if they could access the form from a cyber café and began creating email addresses for them.

Since there were less than 10 responses in the first 2 weeks, the consultant began calling those whose emails had not rebounded and found that many had not received the emails. This then began the creation of another list of those willing to reply with hard copies. A total of 87 questionnaires were then sent by post. Of these 87 who had agreed over the phone to send in their responses, only one had been returned by the end of September and a total of 6 by the time the analysis began on 20th October. It is difficult to conclude but this may reflect a sceptical enthusiasm among various treatment centres of this important study.

The consultant also visited Pune personally for a day and managed to complete three interviews. This included an in-depth interview with the RRTC – West Region. A trip to Bangalore for two days also helped the consultant understand the mindset of some commercially inclined treatment centres, even though it was not in the original plan. A week long visit to Kolkata, Imphal and Aizwal also helped bring in responses from that part of the country but more importantly also allowed the consultant bring in the voices of drug users through Focus Group Discussions (FGDs). A database which was prepared by Dr. Suresh Kumar was used for entering the coded survey forms which commenced in early October. An FGD with drug users who have been through treatment was also conducted in Mumbai to add to the previous three.

During the period of the survey the following was undertaken:

- 300 telephone calls have been made to staff working at drug treatment centres in India requesting information
- An estimated 380 emails have been sent to various drug treatment centres in India, either as follow up to telephone calls or as first contacts with staff working at such facilities.
- A total of 87 hard copies sent to organizations not having access to work on soft copies.
- Despite this mass calls for responses and 22 personal interviews, at the end of the period on 20th October 2008, a total of 119 responses were received from around 25 States of the country.

The excel sheet with the coded answers were then analysed by Dr. Suresh Kumar and returned to the authors for presentation of findings, Discussion and Recommendations.
Annexure 3

Literature Review References


Goswami, A. (2004). Inventory of Programmes and Schemes to Facilitate Rehabilitation of Drug and Alcohol Dependents. UNODC and MSJE. India.


Situation Analysis of Basic Education, Vocational Education & Development of Sustainable Livelihoods in Drug Treatment & Rehabilitation Centres of India


Annexure 4

Themes and Questions for Key Informants

1. Can you explain to me your understanding of the specific laws, policies or guidelines linked with broad based education ranging - basic education (numeracy & literacy skills) vocational education/livelihood skills regards to the drug sector.

2. Can you explain to me your understanding of the specific laws, policies or guidelines linked with broad based education ranging - basic education (numeracy & literacy skills) vocational education/livelihood skills regards to the education sector.

3. What are your views regarding the relationship between laws, policies or guidelines on broad based education (basic education, vocational/livelihood skills), with regards to drug use and drug user issues and how this relates to practice at a grass-roots level?

4. Can you describe to me your understanding about HIV and drug education inside the treatment centres and the method in which this may be delivered?

5. Basic education (numeracy and literacy skills) combined with vocational education/livelihood skills is important for social inclusion. What do you think are the challenges or barriers to the development and fostering of social and economic reintegration of drug users into the community?

6. From your perspective and that of your department or organisation, what do you think are the solutions to initiate, promote and sustain a change in policy and practice that will strengthen the capacity of organisations towards development and fostering of the social and economic reintegration of drug users into the community through broad based education?

7. Could you explain to me, to what extent beneficiaries from treatment centres are involved in broad based education interventions and what value is given to participatory approaches?

8. Can you describe to me any surveys or monitoring undertaken to assess the marketability of specific entrepreneur skills or products made within a local context?

9. Can you inform me of any research to assess the impact of interventions that have measured the extent of basic education and livelihood skills as a therapeutic activity to assist drug users to reduce relapse?
Annexure 5

List of Ministry of Health and Family Welfare Drug Treatment Centres

Contact Details - As Available
N.A. - Not Available

Goa
Asilo Hospital, Mapusa, Goa
Rajwaddo, Mapusa,
Goa-403507
Phone No: 0832-2262372
Contact Person: Dr. Rajesh Dumey
Dr. Sanjeev Dalvi
Email: sanjeevdalvi@yahoo.com
Email: asilohs2211@vsnl.in

Kerala
Government Medical College, Trivandrum
Address: Not available (NA)
Phone No.: 91 – 471- 2444270
Email: yvkrishnan@gmail.com,
Email: dr.rajud@gmail.com, raju@email.com
Contact person: Dr. B. Raju; Dr. Vijay Krishnan
HOD Department of psychiatry

Government Medical College, Kittayam
Address: NA
Phone No.: 0481597311
Email: medal@md2.vsnl.net.in
Contact person: NA

Government Medical College, Kozhicode
Medical College, Kozhikode,
Kerala- 673008
Phone No.: 91-495-23552331, 2740298, 2356991
Email:drgeetha_sukumaran@yahoo.com
Contact person: Dr. Geeta Parucherry

Government Medical College, Trissur
Address: Medical College, M.G. Kavu. Thrissur,
Kerala- 680596
Contact person: Dr. Shaji KS
Phone No.: 0487-2200310 to 319
Email: drshajiks@gmail.com

Maharashtra
Mahatma Gandhi Institute of Medical Sciences,
Sewagram, Wardha
Mahatma Gandhi Institute of Medical Sciences,
Sewagram, District Wardha,
Maharashtra - 442102
Contact Person: Dr. Prakash (H.O.D),
Phone no.:07152-284412
Email: pbbehere@gmail.com

KEM Hospital, Mumbai
Address: Dr E Borges Mg, Mumbai City,
Maharashtra
Contact Person: Dr. Parker
Phone No.: 022 24136051 Ext-2015
Email: NA

District Hospital, Nasik
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

Uttar Pradesh
Institute of Medical Sciences, BHU, Varanasi
Address: Institute of Medical Sciences,
Banaras Hindu University
Varanasi-221005
Contact Person: Prof. Sanjay Gupta
Phone no.: 0542-2367568
E-Mail: guptavaranasi@hotmail.com

Medical College, Merrut
Address: NA
Contact Person: Dr. A.K Aneja
Phone No.:0121
E-Mail: NA
King George Medical College, Lucknow
Address: Chowk, Chhatrapati Shahuji Maharaj Medical University, Lucknow
Contact Person: Dr. S.C Tiwari
Phone no.: 0522-2257540
E-Mail: sarvada1953@hotmail.com, gmail.com

Gorakhpur Medical College, Gorakhpur
Address: NA
Contact Person: NA
Phone No: NA
E-Mail: NA

**West Bengal**

IPGMER Kolkata,
Institute of Post Graduate Medical Education and Research
244 A.J.C Bose Road,
Kolkata - 700 020
Contact Person: Prof. Malati Gosh
Phone No.: NA
E-Mail: malatighosh@hotmail.com

Medical College, Burdhwan
Address: NA
Contact Person: Dr. Om Prakash
Phone No: NA
E-Mail: opsingh.nm@gmail.com

Medical College, Bankura,
PO Kenduadihi, Bankura,
West Bengal-722102
Contact Person: Phone No.:03242-63915
E-Mail: bku_bsmc@Sancharnet.in
Fax: 0342-251324

North Bengal Medical College, Siliguri
Sushrntagar Po, Siliguri, Darjeeling,
West Bengal-734432
Contact Person: NA
Phone Number: - 0353-551285
E-Mail: NA Fax: 0353-450285

Bihar
Jawaharlal Nehru Medical College
Bhagalpur- 846007
Contact Person: Dr Ashok Kumar Bhagat
Phone No.: 0641-2401078
E-Mail: NA

Sri Krishna Medical College, Muzaffarnagar
Address: Sri Krishna Medical College, Muzaffarpur Umannagar, Muzaffarpur, Bihar – 840004
Contact Person: NA Phone Number: 0621-2230271 E-mail: NA

Medical College, Gaya
Address: NA
Contact Person: NA
Phone Number: -0631-420339
E-mail: NA

Munger Sadar Hospital,
Sadar Hospital Campus,
Leprosy Building,
Nawada – 805. 110
Contact Person: NA
Phone Number: NA
E-mail: NA

Haryana

District Hospital, Rohtak
Address: NA
Contact Person: - 01262-211308
Phone Number: NA
E-mail: NA

District Hospital, Ambala
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

Himachal Pradesh

District Hospital Mandi
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA
District Hospital Dharamshala
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

Indira Gandhi Medical College, Shimla
Contact Person: Dr. Surender Kashyap, Principal
Indira Gandhi Medical College,
Shimla – 171001 India
Phone: (0177) 2804251, 2808011(O), 2805502 (R)
PBX: 2652654-59, 2655436, (Ext.) 201, 401
Fax: (0177) 2658339
Email: info@igmcshimla.org

Jammu and Kashmir
Medical College, Jammu
Contact Person: Phone No.: 0191-2584234
Fax: 2584247
E-Mail: principal_gmcj1@dataone.in

Medical College, Srinagar
Contact person: Dr. Shah
Phone Number: (M) 09419003252
E-mail: drshahhamid@gmail.com

District Hospital Baramulla
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

District Hospital Kathua
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

District Hospital Ratlam
Address: NA

District Hospital Ujjain
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

District Hospital Indore
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

District Hospital Gwalior
Address: -NA
Contact Person: -NA
Phone Number: -NA
E-mail:-N.A-

District Hospital Jabalpur
Address: -NA
Contact Person: -NA
Phone Number: -NA
E-mail:-NA

Chattisgarh
District Hospital, Raipur
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

Madhya Pradesh
District Hospital Mandsaur
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

District Hospital, Bathinda
Address:NA
Contact Person: Dr Nidhi Phone No: NA
E-mail: nidhi@dineshgupta.com

Punjab
Medical College, Amritsar
Contact Person: Dr. Paramjit Singh
Circular Road Amritsar 143001
Phone No.: 0183-2421977
E-Mail: prof_bbaser@dataone.in

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Government Medical College, Patiala
Government Medical College, Patiala, Punjab - 147001
Contact Person: NA
Phone No.: 0172-212018
E-mail: NA

Medical college, Faridkot
Government Medical College, Faridkot
Contact Person: HOD
Phone No.:01639-251111
E-mail: NA

District Hospital, Taran Taran
Address: NA
Contact Person: NA
Phone number: NA
E-mail: NA

Andhra Pradesh
Institute of Mental Health, Hyderabad
Institute of Mental Health.
Erragadda, Hyderabad - 500018
Contact Person: Dr. Ashok Reddy
Phone No.: (M) 09391041531
E-mail: imhhyd@yahoo.com

SVRRGG Hospital, Tirupati
Address: NA
Contact Person: NA
Phone No.: 08574-87368
E-mail: NA

GGH Warangal: Andhra Pradesh
Dr T. Surendar,
Nodal officer of ART centre,
MGM Hospital, Warangal,
A.P-506007,
Contact Person
Phone No: NA
E-mail: NA

Delhi
AIIMS
Safdarjung Enclave,
Aurobindo Marg, Ansari Nagar, Delhi, 110029
Contact Person: Dr. Atul Ambekar
Phone No.: 26593236
E-Mail: Atul.ambekar@gmail.com

Lady Harding Medical College and Hospital
Bhagat Singh Road, Pin - 110001
New Delhi
Contact Person: Dr. Dinesh Kataria
Phone No.: 23363728, 23408321, 23363266 (D)
E-Mail:NA

Ram Manohar Lohia
Baba Kharak Singh Marg near Gole Dakkhana
New Delhi-110001
Contact Person: Dr. Smita Deshpandey
Phone No.: 23365525.
E-Mail: smitadeshp@gmail.com

Institute of Human Behaviour and Allied Sciences
Address: NA
Contact Person: Dr. N.G Desai
Phone No.: 22113395
E-Mail: NA

Central Jail Tihar
New Delhi
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

Chandigarh
Post Graduate Institute of Medical Education and Research, Chandigarh
Sector-12, Chandigarh
PIN- 160 012
Phone: EPBAX: 0091-2746018, 2756565, 2747585
Email: pgimer@chd.nic.in
Contact Person: Phone no: NA
E-Mail: NA

Government Medical College, Chandigarh
Sector 32, Chandigarh
Contact Person:-N.A
Phone no: NA
E-Mail: NA
Gujarat
Medical College, Baroda
Medical College Baroda
Vadodara-390 001, Gujarat
Contact Person: Dr. Chirag
Phone No.: 0265-2421594
E-Mail: gladiator_dhara@yahoo.com

Medical College, Ahmedabad
B. J. Medical College,
Asarwa, Ahmedabad-380016
(Gujarat)
Contact Person: Dr. G.K. Ventkar
Phone no.: 079-22681024/22680074
E-Mail: drgvantkar@yahoo.com

Karnataka
NIMHANS
NIMHANS Hosur Road
Bangalore - 560029
Contact Person: Dr. D. Nagaraja
Director / Vice Chancellor
Telephone: 91-080-26995001/5002, 26564140,
26561811, 26565822
Fax: 91-080-26564830
Email: dnn@nimhans.kar.nic.in

Government Medical College
Bangalore
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

Orissa
S.C.B Medical College, Cuttack
S.C.B Medical College, Cuttack,
Orissa-753007
Contact Person: NA
Phone number: NA
E-mail: NA

Rajasthan
Government Medical College, Kota
Rangbari Road
Kota-240009
Contact Person: Dr. Divendra Vijay

Phone No.: 0744-2470674
E-Mail: drdevendra_2006@rediffmail.com

Jawahar Lal Medical College, Ajmer
Ajmer-305001
Contact Person: Dr. A.P. Mathur
Phone No.: 0145-2627686
E-Mail: drdevendra_2006@rediffmail.com
Fax: 0145-2627686

Medical College, Bikaner
SPM Medical College,
Bikaner-33400
Contact Person: Dr. L.N. Gupta & Dr. Prerna Gupta
Phone No.: 0151-226325,
E-Mail: Damse_mumbai@hotmail.com

Medical College, Udaipur
R.N.T Medical College
Udaipur-313001
Contact Person: NA
Phone Number: 0294-2523613
E-mail: NA

Medical College, Jodhpur
SN Medical College,
Jodhpur
Contact Person: NA
Phone Number: 0291-431987
E-mail: NA

Tamil Nadu
Medical College Madurai
Park Town,
Chennai-600003
Contact Person: Dr. Sabeshan
Phone no.: (M) 09443350070
E-Mail: sabhesansivam@gmail.com
Government Stanley Medical College, Chennai
Address: N.A
Contact Person: Dr. M. Thiru
Phone no.: 09444034647
E-Mail: drmthiru@yahoo.com

Government Medical College, Tirunelveli
Tirunelveli, Tamil Nadu, 627011
Contact Person: Dr. Elango
Phone no.: (M) 9443439175
E-Mail: shamnugiah_dr@hotmail.com

Institute of Mental Health Chennai or GMC Kilpauk
Address: -N.A
Contact Person: Dr. Sachin Nandan
Phone no.: (M) 09841019910
E-Mail: sathianathen@yahoo.com

Government Medical College, Coimbatore
Avinashi Road,
Coimbatore,
TN, 641014
Contact Person: Dr. Prabaharan & Dr. Hari
Phone no.: 0422-2301393,
E-Mail: hariind@hotmail.com

Government Medical College and Hospital, Thanjavur
Address: N.A
Contact Person: Dr. Elango & Dr. Shan Mugiah
Phone no.: 9443939175
E-Mail: shanmugiah_dr@hotmail.com

Government Mohan Karunamanglam Medical College and Hospital, Salem
Address: NA
Contact Person: NA
Phone Number: NA
E-Mail: NA

Government Medical College, Tuticorin
Address: NA
Contact Person: NA
Phone Number: NA
E-Mail: NA

Government Chengalpattu Medical College and Hospital, Chengalpattu
Address: NA
Contact Person: NA
Phone Number: NA
E-Mail: NA

Government KAP Vishwanathan Medical College and Hospital, Tiruchirapalli
Address: NA
Contact Person: NA
Phone Number: NA
E-Mail: NA

Government Headquarter Hospital, Nagercoil
Address: NA
Contact Person: NA
Phone Number: NA
E-Mail: NA

Pondicherry
Jawaharlal Institute of Post Graduate Medical Education and Research, Pondicherry
Jawaharlal Institute of Post Graduate Medical Education and Research,
Dhanvantri Nagar,
Pondicherry.
Contact Person: Dr. M. K Srivastava
Phone no.: 09443482405
E-Mail: manoharkant@yahoo.co.in

General Hospital Karaikanal
Address: NA
Contact Person: NA
Phone Number: NA
E-Mail: NA

Assam
Civil Hospital, Diphu
Address: NA
Contact Person: NA
Phone Number: 03671 - 272228
E-Mail: NA

Civil Hospital, Dhubri
Address: NA
Contact Person: NA
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Phone Number: 03662 - 230959
E-mail: NA

Civil Hospital, Jorhat
Address: NA
Contact Person: NA
Phone Number: 0376-232283
E-mail: NA

Civil Hospital, Nalbari
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

Civil Hospital, Nagaon
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

Civil Hospital Tezpur
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

District Hospital, Jorhat
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

Guwahati Medical College,
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

Medical College, Dibrugarh
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

Manipur
District Hospital, Imphal West

Address: NA
Contact Person: Dr. Laksana, DAO
Phone Number: NA
E-mail: NA

District Hospital, Imphal East
Address: NA
Contact Person: Dr. Birachandra, DAO
Phone Number: NA
E-mail: NA

District Hospital, Chandel
Address: NA
Contact Person: Dr. Ishek, DAO
Phone Number: NA
E-mail: NA

District Hospital, Churachandpur
Address: NA
Contact Person: Dr. V.C. Pao
Phone Number: NA
E-mail: NA

District Hospital, Ukhrul
Address: NA
Contact Person: Dr. Ask Felix
Phone Number: NA
E-mail: NA

District Hospital, Thoubal
Address: NA
Contact Person: Dr. Ng. Tomba Singh, DAO
Phone Number: NA
E-mail: NA

District Hospital, Moreh
Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA

District Hospital, Bishnupur
Address: NA
Contact Person: Dr. Iboton, DAO
Phone Number: NA
E-mail: NA

Phone Number: 0376-232283
E-mail: NA

Address: NA
Contact Person: NA
Phone Number: NA
E-mail: NA
District Hospital, Senapati
Address: NA
Contact Person: Dr. Loli Mao, DAO
Phone Number: NA
E-Mail: NA

District Hospital, Tamenglong
Address: NA
Contact Person: Dr. David, DAO
Phone Number: NA
E-Mail: NA

Regional Institute of Medical Science, Imphal
Address: N.A
Contact Person: N.A
Phone Number: 03852414591, 03852414629, 03852414633
E-mail: art.rims@yahoo.co.in

Tripura
Kumarghat Rural Hospital, Darchai-Tripura
Address: NA
contact Person: NA
Phone Number: 0370- 2222916/2222893
E-mail: NA

Arunachal Pradesh
District Hospital, Changlang,
Address: Changlang District,
Contact Person: NA
Phone number: 03808-22264
Email: NA

Tezu, General Hospital
Address: NA
Contact Person: NA
Phone Number: 03804-223034
Email: NA

Nagaland
Naga Hospital, Kohima
Address: NA
contact Person: NA
Phone Number: 0370- 2222916/2222893
E-mail: NA

Civil Hospital, Dimapur
Address: NA
Contact Person: NA
Phone Number: 0370- 232224/229474
E-mail: NA

District Hospital, Tuensang
Address: NA
contact Person: NA
Phone Number: 03861- 220216
E-mail: NA

District Hospital, Mokokchun
Address: NA
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Situation Analysis of Basic Education, Vocational Education & Development of Sustainable Livelihoods in Drug Treatment & Rehabilitation Centres of India

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Annexure 6

Education and Harm Mitigation Pathways to Social Inclusion

National Consultation on Education and Harm Reduction related to drug use, HIV and AIDS in India

Monday 10 November, 2008
UNDP Conference Hall, 55 Lodi Estate, New Delhi, India

Introduction
A global series of country-based consultations, including India, funded jointly by UNESCO with the European Commission, were planned to review the status of drug demand and harm reduction strategies, and strengthen the educational dimension and responsiveness of such approaches. Within UNESCO there is an emphasis on universal access to education (bearing in mind that 60%+ of the global population remain illiterate), sustainable livelihoods, prevention, treatment, care and support for people vulnerable to drugs and affected by HIV and AIDS. Education is a key to development goals, especially in the contexts of those affected by drug use, through offering effectiveness and dignity in development along with empowerment for the poor and most vulnerable. We know that education provides opportunities directly into people’s hands and is thus an effective, contributing factor to social inclusion and the potential for sustainable livelihood. Additional benefits are evident when education is associated to other services, especially in relationship to prevention, treatment and care.

Prior to the event a letter accompanied by a poster designed by UNESCO Headquarters was mailed and sent electronically to various stakeholders primarily in New Delhi, but also to some others outside of the capital city. A mailing list was developed and this comprised of 55 agencies or individuals primarily, but not solely, New Delhi based. All United Nation agencies were invited, Ministry of Social Justice and Empowerment, Ministry of Health, international donors and agencies, including European Commission, International NGOs, Local NGOs, and those involved in drug treatment services. The event was attended by 36 individuals in total (see annex 6).

Each participant was provided with an outline of the proceedings and an Executive Summary of the research findings from a situation assessment on education issues inside drug treatment and rehabilitation centres of India.

Proceedings
Prior to the commencement of various presentations a series of speeches by invited guests took place, outlining a brief overview of specific agencies and some linkages with the topics to be presented and discussed on the day.

First speech was made by Ms Cecilia Barbieri representing UNESCO. The key points that were presented focused on the following:

- Expressed understanding about the relevance of the event at a time when both governments and agencies involved in addressing the needs of drug users needed to seek a solution to some of the issues that will be examined today.

- There was a need to address the issue of harm reduction within the following groups who were vulnerable to adverse risks, and often socially and economically excluded from the broader community: adolescent substance users; injecting drug users; and poor and illiterate drug users.

- An outline of the days agenda was presented accompanied with a brief explanation of each presentation

- The program aimed to also provide an overview
on the situation analysis of who was doing what in the area of education inside treatment centres and explore the issues of vocational training, development of livelihood skills and the provision of basic education among the drug using population.

- It was highlighted that to achieve solutions required a multi-sectoral response that would need to involve the appropriate Government ministries, combined with the relevant NGO sector involved in the drug treatment, and other agencies outside this sector. A combined effort, with focus, would be a suitable approach for the way forward.

Second speech made by Mr Laurent Le Danois representing European Commission. The key points that were presented focused on the following:

- Acknowledged that some projects were important for the European Commission (EU) to be involved with. There is an acknowledgment some areas are not always easy such as Human Rights. This remains a very sensitive issue for many nations.

- EU has a keen interest in strengthening governance in various countries of the world.

- EU has a focus on saving lives and protecting people. It can also be stated that UNESCO in the area of education is widely appreciated. That their current work of getting involved in a broader area of education is welcomed.

- In India the EU is focused on health and education. In health we are not focusing on disease but on the health system.

- It is our aim is to put USAID and NACP-III together.

- There is a hope that the funds provided can reach the beneficiaries through the efforts of those that receive our funding.

- Current global economic landscape and financial systems are under stress and as a result we need to be less optimistic for our next budgeting.

Third speech made by Mr Sunil Kumar representing Ministry of Social Justice and Empowerment. The key points that were presented focused on the following:

- MSJE has started a few treatment centres in Delhi where education services are provided.

- Currently there are 420 treatment centres in India basically run by civil societies and NGOs. These centres focus on creating awareness and providing services such as detoxification, psycho-therapy, counselling, rehab and early treatment.

- It is how we can best promote vocational training that will be of much importance.

- Currently we have eight regional resource training centres in different parts of the country. Part of their function is to assess training needs, assess the capacity of NGOs to respond, develop training modules, and to undertake capacity building programs.

- There is an interest to identify other issues that are taking place in the area of drug treatment. That is why today’s agenda is really appreciated.

- Ministry has started prevention of HIV among IDUs, including harm reduction programs and with this technical support from AIIMS is being provided.

- From October MSJE will start a new program which will be an integrated, comprehensive program for IDUs and focused on addressing their needs.
Fourth speech made by Prof Rajat Ray representing Ministry of Health, and All India Institute of Medical Sciences. The key points that were presented focused on the following:

- Health is a state subject in India.
- Ministry is investing in infra-structure and next investment is capacity building.
- MOH has supported training programs for doctor nurses, In National Rural Health Mission capacity building of ASHA workers.
- Ministry is also aware of many drug treatment centres which are not active or self-functioning.
- WHO India office and UNODC are providing program support.
- Most recent development in the Ministry is the integration of Drug Control Program with other health programs.

Outline of the Program

On Monday 10th November 2008, UNESCO, New Delhi, presented a diverse range of projects in India that the organization funds jointly with the European Commission. The four projects that were to be presented included the following:

A) ‘Situation analysis of basic education, vocational education and development of sustainable livelihoods in drug treatment and rehabilitation centres of India’. Research of this type has not previously been undertaken in India. The aim is to improve our understanding of the holistic needs of drug users within a broad ranging education framework, and is expected to contribute towards an informed, evidence based, practical response. Preliminary findings will be highlighted on the day.

B) ‘Prevention of Substance Use amongst vulnerable adolescents and young people’ The focus of project is imparting of education and empowering vulnerable adolescents and youth in New Delhi and National Capital Region for prevention of substance misuse and rehabilitation of active drug users through puppetry, social work through peer education and alternative media.

C) ‘Awareness Project for Marginalized Groups in Tamil Nadu’ This project is reaching out and providing education to thousands of rural women on topics such as alcohol, HIV and AIDS, STDs whilst also encouraging and effecting personal development of women through enhancing their parenting skills, self-esteem and mental health.

D) ‘Mainstreaming of recovering substance users with vocational education and livelihood skills through capacity development programs’ A recently funded project with the goal of working towards the social and economic inclusion of recovering substance users back into the wider community of Kolkata.

Discussions following Presentation of India Report

Question - NACO. Were NGOs registered or part of the India Harm Reduction Network contacted?

Answer: Yes, they were recruited as part of the mapping exercise.

Question - WHO Regional Office. What is the role of the Education Ministry in all of this, as it is my understanding it is not the mandate for MoH and MSJE to provide education. What sort of education would you provide in a period of 15 days if this was considered a normal period for detoxification?

Answer: It is agreed that the Education Ministry should be involved but it is only very recently that Ministries in this area are starting to work together. It is a relatively new concept and much effort has been undertaken to formalise such collaborations.
An important step to take is to move towards a multi-sector response and the Ministry of Education have a role to play and this will need to be explored (response by MSJE).

It is highly likely that any basic education could not be offered by treatment centres if a person is only admitted for detoxification. But it is important for specific staff within a treatment centres to have the capacity to identify the literacy status of a client. Just as important is the staff need to have the capacity to know about referral procedures to other agencies or schemes that could offer educational services. It would be important to have the knowledge to define what is meant by literacy and that it should be more than the ability to write ones name.

Question – Sharan. Did you examine how people entered treatment centres?

Answer. This was not the focus of the research and was not examined.

Lawyers Collective: This is not a question but an observation. The findings in many ways are similar to what we would find among sex workers and in many ways there is no real surprise in what has been found. The challenge now is to move forward. We need to ask ourselves is it time for one Ministry to deal with all the issues that deal with drug use?

MSJE - This is also not a question but an observation that effort also needs to provide education about prevention messages and to help drug users get away from their problems.

Question - European Union: Could you please clarify what is meant by Self Help Group?

Answer: Self Help Group (SHG) and support groups are often interlinked and mixed up and thus the reason for the confusion. But the reality is SHG are suppose to be small income generating groups and support groups are more like psycho-social support groups that can come together discuss similar issues and problems then seek a possible solution.

SPYM – Comment. We need to understand that drug use issues are overall viewed as an uninteresting subject which is difficult to address. There are very limited resources for this subject except perhaps in Nagaland. The salary of the staff of those working in treatment centres is poor and we have found that many counsellors that are trained decide to move to the HIV sector where they will finds jobs and often far better wages. The disparity of money available between the HIV and the drug sector is dramatically different. I think the RRTC has the potential to address the drug use issues but they are not doing this at the moment often as a result of poor funds. NACO is doing a good job but only up to the referral stage. What happens after this seems to be not addressed. What we need to understand is to explore what strengths can be identified among organisations that address drug users needs successfully, and then design a strategic program based on those findings.

The session closed for a tea break.

Group work to discuss suggested recommendations

Upon return from the tea break participants were divided into three groups and provided with a more extended list of suggested draft recommendations put forward by the researchers (see annex 4). Each group had 30 minutes to discuss the point raised and present the collective views through a group representative.

Group One: Key points

- Do these recommendations really reflect the concerns of IDUs?

- Recommendation structure requires improvement. It would be best to clump them together under themes and to be clear.

- Issues of national level and state level treatment should be explored.

- Under training needs you need to highlight would this be done at National or State levels and specifically for which type of treatment
centres (MSJE/NISD or MOH).

- Drug users need more than education but also access to health services.

- There can be a lack of motivation for IDUs to access opportunities that are offered to them and this needs to be acknowledged.

- Ultimate aim of vocational training is very important but it is important to review the content of existing schemes within the MSJE. There is a need to look at the other schemes that are in place and see where they can assist in the rehab process (this could be further research). Review the context of the various schemes and see how they could be linked to rehab centres. It will be important to measure the effectiveness of the schemes.

- We understand you did not examine categories of drug users/risk groups such as children, youth, and women but this needs to be acknowledge in the report. New research should also focus on special needs of women and children.

- Be very specific with the recommendations and ensure that they are practical and clear.

**Group Two: Key points**

- **Recommendation 1 and 6 should be rejected as treatment centres do not have capacity to address these issues**

- **Drug treatment centres should be independently evaluated and reviewed for quality assurance to determine if and how they have the capacity to provide basic education, vocational education and livelihood skills for drug users**

- **Recommendation-2 we believe a platform exist for this but there will be a need for updates and for scaling up.**

- **HIV and drug education information utilised by treatment centres should be reviewed and evaluated for appropriateness, impact, quality, factual, cultural context, and clarity of message not only for literate but also illiterate drug users. Evaluation and quality assurance of the delivery modes of education to drug users should be undertaken.**

- **Recommendation -3. We believe this is good provided there are funds and resources. There should be State level directed resources made available.**

- **Exploring the need and special requirements for HIV and drug information other than that produced in Hindi and English should be considered, with the development and production of an inventory of all education linking HIV and drug use publications, in all languages, and available for easy access. Acknowledging that illiteracy among drug users was identified alternative means of raising awareness should consideration such as through street outreach, theatre and other means of delivering education messages**

- **Recommendation- 5. The NGO Sharan has done commendable work in this area and benefits are good. Funding and human resource need to be provided. Important that evaluation be undertaken.**

- **Alternative employment opportunities should be more widely explored. Micro-credit**
programs linked to small business ventures that may not require extensive training and appropriate to the capabilities of drug users should be given greater prominence, with collaboration between drug treatment centres and appropriate NGOs.

- **Recommendation – 7.** We support this recommendation and is something that UNESCO should advocate for with MSJE
  - MSJE need to take into consideration funding as a pilot project, half way homes/shelters in major metro cities that would be associated with agencies that provide basic education, vocational education and the fostering of livelihood skills. This would ensure greater likelihood of impoverished drug users and those isolated from supportive networks to gain social and economic reintegration.

- **Recommendation –8.** Finance resources are limited, and salaries are not reaching in time to centre. A separate budget will need to be developed to address this issue. Human and funding resources need to be made available.
  - Centres assisting with drug treatment should examine their ability, capacity and know how to include at least one component of education, be it basic, vocational or livelihood skill training. An evaluation process and procedure would need to be developed within each component to ensure value and that lessons can be learnt from the task.

- **Recommendation –9.** Last week collaboration between MOH, MSJE and NACO came to an agreement that a person receiving treatment under MOH can be absorbed by MSJE. This approach is something that could be up scaled by NACO. Drug users should not need not to go to three different bodies for one package of service.
  - Provision of comprehensive training for all facilities including those linked with MoH and MSJE/NISD in the following areas:
    - assessment processes and procedures to identify appropriate vocational education training for drug users;
    - networking with other agencies for vocational training;
    - preparing the clients for attending job interviews;
    - preparing and assisting the clients as to how write bio data when needed;
    - assist and facilitate the process for employment placement;
    - empowering family members to take up vocational training (mainly for the family members of relapsing clients).

- **Recommendation – 10.** We support this recommendation.
  - Training in monitoring and evaluation (M&E) should be encouraged and offered to appropriate staff in treatment centres. Skill training in M&E should be shared with at least two more staff within the organisation in order that understanding of the process and procedures do not ‘lapse’ following the exit of the trained person.

- **Other recommendations: not opposed or no comments**

**Group Three: Key points**
- There is urgent need to look at vocational training and link it with job placement.
- There is an urgent need to look at the literacy levels of the drug users and respond.
- There is a need to advocate on the right to education for all which includes the hard to reach communities.
- Need to look at the enabling environment and to ensure that drug users have greater access to the services that exist out in the community.
- There cannot be a standard procedure for all the various steps that are required but suggested templates can be put forward and used according to what exist in the community.
• Focus should be given on linkages with existing services, schemes and entitlements. For example integration with Sarbha Shiksha Abhiyan

• There is a need focus on the linkages with existing services and schemes and the mechanisms that could enhance closer ties between NGOs looking after recovering drug users and others. This needs to be scaled up.

• Treatment programs have a number of obstacles for drug users. There is a need to build a strategy where drug users can navigate the system and during the process there are choices based on their needs.

• Develop strategies and build upon them based on drug user’s desires and needs. There is a need to consider the individual and thus provide choices based on capacity and motivation. A multi-level strategic approach needs consideration.

• There is an overall weak monitoring system thus there will be a need to include clear indicators. How many achieved literacy, how many found job placement, how many achieved vocational education, how many formed self-help groups for business. There is a need to track the progress and there needs to be in place a robust system in place to monitor the success, mistakes, and failures.

List of Participants Attending Event

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<td>37</td>
<td>Gary Reid</td>
<td>UNESCO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Program Outline

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.00AM</td>
<td>Registration</td>
<td></td>
</tr>
<tr>
<td>9.30AM</td>
<td>Welcome, Introduction, Outline of Program, Participants Attending</td>
<td>Cecilia Barbieri (UNESCO) Mr Laurent Le Danois (European Union) Mr Sunil Kumar, Deputy Director Ministry of Social Justice and Empowerment Prof Ray (representative for Ministry of Health)</td>
</tr>
<tr>
<td>10.00AM</td>
<td>Situation analysis of basic education, vocational education and development of sustainable livelihoods in drug treatment and rehabilitation centres of India</td>
<td>Mr Gary Reid and Mr Eldred Tellis</td>
</tr>
<tr>
<td>11.15AM</td>
<td>Tea</td>
<td></td>
</tr>
<tr>
<td>11.30AM</td>
<td>Discussion of the Findings, Group Work, and the Way Forward</td>
<td>Facilitated by Mr Gary Reid &amp; Mr Eldred Tellis</td>
</tr>
<tr>
<td>1.00PM</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>2.00PM</td>
<td>Prevention of Substance Use amongst Vulnerable Adolescents and Young People (includes performance by puppet troupe)</td>
<td>Mr Dadi Pudumjee (Ishara Puppet Project,)</td>
</tr>
<tr>
<td>3.00PM</td>
<td>Mainstreaming of recovering substance users with vocational education and livelihood skills through capacity development programs</td>
<td>Ms Anindita Roy (Society for Community Intervention and Research. Society, Kolkata)</td>
</tr>
<tr>
<td>3.30PM</td>
<td>Tea</td>
<td></td>
</tr>
<tr>
<td>3.45PM</td>
<td>Awareness Project For Marginalized Groups in Tamil Nadu</td>
<td>Ms Sudha Mani (T T Ranganathan Clinical Research Foundation)</td>
</tr>
<tr>
<td>4.45-5PM</td>
<td>Round up and concluding remarks</td>
<td>Mr Gary Reid</td>
</tr>
</tbody>
</table>
1. Society for Community Intervention and Research Kolkata

Slide 1. Mainstreaming of Recovering Substance Users by Vocational Education & Livelihood Skills through Capacity Building Programs

Slide 2. Salient Features
- Pilot project which includes focus on action research
- Aims at empowerment & mainstreaming of recovering substance users (SUs)
- Aims to provide social recognition, economic independence & basic literacy
- Model to reintegrate with families & society
- Creates enabling environment for sustainable behavior change
- Aims for best practices: potential for replication & scaling up in other parts of India

Slide 3. About the Organisation
- Society for Community Intervention & Research established in 1996
- A leading NGO in Eastern India working for different target groups: SUs specially IDUs, Prisoners & PLHAs
- Implements IDU intervention program in 3 sites of West Bengal through 11 DICs
- Reach out to more than 8000 SUs & their families
- Specialize in Harm Reduction, OST management, Targeted Intervention & Care & Support
- One of a small number of NGOs that has a focus on income generation & self employment for client group

Slide 4. About the Organisation
Client Profile
Total no of clients 8000 (3000 - 2000 - 3000)
- Male - 95%  Female - 5%
- Literate – 35%  Illiterate - 65%
- Skilled - 20%  Unskilled - 80%
- OST – (198-124-96 )

Slide 6. Objectives
- To Conduct a Community Needs Assessment (CNA) using KABP related survey. Focus is towards attaining livelihood-vocational skills in informal or formal employment to ensure social- economic reintegration, of recovering substance users
- To develop income generation for self employment and improvement of employability among the recovering substance users by involving different NGOs, corporate sector and Government agencies
- To mainstream, strengthen and sustain the capacity of the recovering substance users in society through education and skill development and capacity building
- To create an enabling environment for recovering substance users in order that they
can lead a meaningful life and minimise potential relapse
- To help recovering substance users to regain social recognition and self esteem

**Slide 7. Country Needs Assessment**
- Backbone of the project
- Identifies needs of the target groups
- Helps in formulation of strategies for employability and self employment
- Ensures participants of the target groups from the planning stage
- Develops ownership for sustainability

**Slide 8. Overview of Project**
**Objective 1:**
- Designing the CNA methodology and creation of tools & questionnaires
- Training the recovering substance users for conducting the survey
- Conducting series of interviews with key stakeholders
- Mapping exercise of services that offer vocational education and livelihood skill-building
- Compilation, analysis and interpretation of the findings

**Slide 9. Overview of Project**
**Objective 2:**
- Assessing key areas of vocational education and livelihood skills identified through the CNA
- Matching vocational and livelihood options with skills of substance users
- Identification of Trainers or training institutions to be identified
- Preparation or adaptation of existing basic training curriculum by the training
- Institutions will be adapted where appropriate, and training to be conducted
- Formation Self Help Groups (SHGs) (10 in number) to be formed and marketing of services and products to be started through them.
- Exploring a micro finance based approach as part of the recovery process of substance users will be undertaken

**Slide 10. Overview of Project**
**Objective 3:**
- Counseling of recovering substance users to provide some social – lifestyle structure and take up social responsibilities within communities and families
- Encouraging substance users to participate and play an active role in social functions and community rituals where appropriate.
- Helping recovering substance users become role models for others in society and among their peer

**Slide 11. Overview of Project**
**Objective 4:**
- Identifying the local schools, through micro level resource mapping.
- Identifying potential school students for providing basic education to the substance users.
- Providing basic education to 60 percent of the illiterate substance users (based on the findings of CNA) through non formal education

**Slide 12. Overview of Project**
**Objective 5:**
- Provision of day care unit and night shelters for having a stigma free and safe environment and for relapse prevention.
- Reintegration with the families or with SHGs
- The SHGs will have regular interaction with the police, chemists, health care providers, NGOs, appropriate education and livelihood skills agencies and corporate sector
- SCIR will conduct regular advocacy events and document and highlight the success stories of interventions for the recovery of substance users through this project
- Referral process with other appropriate agencies and networks to be developed & established

**Slide 13. Linkages and Networking**
Linkages and Partnerships will be developed for:
- Skill building & entrepreneurship development
- Civil society mainstreaming
- Placement of trained individuals
Marketing of finished products
Micro-financing and obtaining soft loans
Program sustainability

Linkages to be developed with government, non-government and corporate training institutes, micro-financing agencies, entrepreneurship developing agencies etc

Slide 14. Linkages and Networking
Alliances and networking with following Training Institutes and other agencies
- George Telegraph
- Don Bosco Technical Institute
- Ankur Kala
- SEOMP
- Don Bosco Evening School
- Tijola Primary School
- Lady Queen Of the Mission Evening School
- Partner NGOs
- Calcutta University
- AVJ training Institute
- ICMR
- Subornashram

Slide 15. Enabling Environment
Creation of an Enabling environment helps to bring about sustainable change in behavior and prevents relapses. This is achieved by:
- Providing a safe environment and social protection through the creation or referring of night shelters & day care units
- Reintegration with families
- Regular interaction with the police, chemists, health care providers, NGOs, appropriate education and livelihood skills agencies and corporate sector
- Through referrals and networking

Slide 16. Expected Outputs
- Comprehensive CNA document will provide insights to guide the process of empowerment, employability, training & issues of socio-economic regards to recovering SUs
- Creation of a complete database for agencies involved in generation of self-employment, employability, capacity building, micro-financing & development of linkages & network
- Capacity building & training of 175 recovering substance users for creation of self-employment opportunities & employability. Indirectly reach out to 800 - 900 people
- Creation of enabling environment for sustainable behavior change
- Mainstreaming & reintegration of the SUs with their families & society

Slide 17. Regain Social Recognition & Self Esteem
- Through counseling and life-skills training
- Encouraging participation in social functions and playing active role
- Substance users becoming role models for others in society & peers

Slide 18. Partners
- West Bengal State AIDS Control Society - Provide comprehensive package of services for preventing the spread of HIV infection among the SUs & counseling and referral services for the prison inmates
- National Institute for Cholera and Enteric Diseases (NICED) – assist in research
- University of Calcutta - to provide technical support & evaluation of the program.
- World Vision India – will provide referral support & support towards PLHAs

Slide 19. Sustainability Issue
- Trained peer educators, will continue to build up capacity/skill of other peers by providing basic training and education
- SHGs will be applying for Micro Credit for expanding their work, and also will further add more members from their peers
- The best practices and success of this pilot project will be disseminated with all the stakeholders (Government, Non Government, Private Sectors and other National & International Agencies) and thus helping to potentially access more resources for the future
- On the individual basis the employability and economic independence of SHG members and other trainees, will contribute towards sustainability
2. T T Ranganathan Clinical Research Foundation, Chennai

Slide 1. Awareness Project for Marginalized Women in Tamilnadu Through SHGs.

Slide 2. Why women empowerment?
Women form 50% of the world’s population but don’t get even 25% of the rights a man gets

Slide 3. Gender Bias leads to
- Female feticide even before birth
- Female infanticide after birth
- Female babies abandoned after birth
- Nutrition of the girl child is neglected
- Education of the girl child gets the last priority

World over it is accepted that women form the backbone of the society
- Girls are married off early even when they are physically and mentally too immature to take the burden of a family

Slide 4. Problems of women
- Women have to face dowry harassment, domestic violence and are also deprived of their rights to ancestral property or wealth
- She has no say in either education/ profession nor does she have right to decide when and how many children she should produce.
- In this bleak scenario, women’s empowerment is burning need of the day

Slide 5. What is the vision of the project?
- Preventing alcohol and drug use and creating awareness about HIV/ AIDS, STDs and encouraging and effecting personal development of women through enhancing their parenting skills, self esteem and mental health.
- Promoting health-seeking behavior among women.

Slide 6. What is the Vision of the project?
- Resource mapping and networking among GOs and NGOs
  - Treatment centres for alcohol and drug abuse
  - HIV testing
  - STD treatment
  - Vocational training centers
- Teaching some of them one particular skill towards generating additional income
- Building capacity of TTK & partner NGOs in documentation and evaluation

Slide 7. Periods of contract- 30 months
Staff Structure
- Implementing through an NGO in each location
- Appointed 3 Outreach Workers and One Coordinator
- TTK plays the role of training and monitoring

Slide 8. Target Population
- Women form remote rural areas in 3 locations in Tamilnadu
  - Thiruvarur
  - Trichy
  - Karamdai
- Members of /micro credit groups (SHGs)
- 6500 women from each location and in total 20000 women

Slide 9. Profile of Participants
- All are women
- Majority in the age group of 31- 40 years
- A large number of them have education up to 6th to 8th Std/ In Karamdai have no education. (In rural areas less than state average of 63%)
- Majority of women either unemployed or unskilled workers
- Many have no income or very meager income
- Majority are married
- All of them have been in self-help groups from 1-3 years
Slide 10. Needs Assessment
Dr. Panda conducted a three day workshop
- To involve the target audience, needs assessments conducted
- 5 focus Group Discussion in each location
- Interviewing 12 key informants in each location
- One to one interview of 650 women in each location

Slide 11. Topics identified
- Facts about alcohol and drugs
- HIV and STDs
- Strengthening self esteem
- Parenting skills
- Laws related to women
- Gynecological problems
- Mental health which includes suicide prevention
- Group Dynamics

Slide 12. For Each Groups
- One warming up games
- Minimum of 2 or 3 activities
- Information through flip charts
- Group home work
- Jatra
- Preparing Posters
- Women with gynecology problems access help
- Making specific changes to improve relationship with children
- Street play condemning violence

Slide 13. What is the target each month for each outreach Worker
- 40 lessons to be taken, lessons for 2-1/2 to 3 hrs. Each group to have 15-20 participants
- Each month, each worker would cover 600 women

Slide 14. Documentation
- Monthly report of no. of programs and participants conducted by outreach workers and coordinators
- No. of referrals made and reasons for referrals
- No. of women went through vocational training and the type of training
- Feedback forms of women who have completed 8 sessions
- Feedback forms from NGOs and coordinators regarding the effectiveness of the programs
- Monthly visit report by a representative from TTK

Slide 15. What have we done so far
- Needs assessment completed and reports written
- Four training to provide knowledge on 8 topics
- Conducted GO/ NGO network meetings in three locations
- Conducted in 3 locations exposure visits to GO and NGOs to strengthen the relationship
- Developed resource mapping and network directory
- Initiated vocational training in 3 locations

Slide 16. No of Programs conducted from Sept 2007 to October 2008

<table>
<thead>
<tr>
<th>Locations</th>
<th>No. of beneficiaries</th>
<th>Villages covered till now</th>
<th>Total villages to be covered by project end</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karamdai</td>
<td>2546</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Valparai</td>
<td>1186</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td>Trichy</td>
<td>3858</td>
<td>31</td>
<td>62</td>
</tr>
<tr>
<td>Thiruvarur</td>
<td>4169</td>
<td>30</td>
<td>59</td>
</tr>
<tr>
<td>Total</td>
<td>11759</td>
<td>96</td>
<td>196</td>
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</table>

Slide 17. No. of Referrals

<table>
<thead>
<tr>
<th>Condition</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Discharge</td>
<td>65</td>
</tr>
<tr>
<td>HIV testing</td>
<td>5</td>
</tr>
<tr>
<td>Treatment of HIV</td>
<td>11</td>
</tr>
<tr>
<td>STD testing</td>
<td>25</td>
</tr>
<tr>
<td>Cancer Detection</td>
<td>3</td>
</tr>
<tr>
<td>Treatment of Addiction</td>
<td>2</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>1</td>
</tr>
<tr>
<td>Other Medical Problems</td>
<td>8</td>
</tr>
</tbody>
</table>
Slide 18. No. of Beneficiaries through Vocational Training

<table>
<thead>
<tr>
<th>Activity</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tailoring</td>
<td>110</td>
</tr>
<tr>
<td>Preparing Pickles and Other Items</td>
<td>25</td>
</tr>
<tr>
<td>Making Squash, Medicinal Tablets, Herbal Oil Soap Making</td>
<td>120</td>
</tr>
</tbody>
</table>

Slide 19. Baseline Indicators
- Knowledge and Awareness among women about substance abuse and HIV-AIDS
- Awareness about the availability of services and utilization of services by the community

Slide 20. Process Indicators
- Increased knowledge on HIV and substance abuse among 20000 women who have undergone training
- Increased awareness among women about the services available in the community for HIV, substance abuse and other health related issues.
- A small no. of women making use of the vocational skills to earn an income
- The effectiveness of networking strategies

Slide 21. Outcome Indicators
- Enhanced capacity building of TTK and partner NGOs on documentation and evaluation
- Quality of training module – through discussion with SHG women
- Quality of communication kit – through FGD with extension workers

Slide 22. Long Term Indicators
- Changes in attitude of women in accessing health services
- Increased health seeking behavior among women
- Openness towards HIV counseling and testing

Slide 23. Mid Term Evaluation
About ORWs
- Extraordinary efforts and commitments
- Diligence in imparting education

Feedback From Participants
- Very rewarding
- Project has made significant positive impact
- Enhanced confidence and higher level of self esteem
- For some vocational education resulted in financial independence
- A mix of education and livelihood skills leading to empowerment

Slide 24. Mid Term Evaluation
Referral
- Process of referral clearly understood
- Dramatic change in the attitude of women and health professional
- TTK planned and brought various services in a common platform
- Greater accessibility to health services among rural women

Slide 25. Documentation
- Diligently documented
- Information is analyzed by TTK
- Senior project manager has excellent rapport with staff

To conclude
- Inspirational
- Significant positive impact on women
- Many had adopted new knowledge & experience
3. Ishara Puppet Project Theatre Trust, New Delhi

**Slide 1. Substance Abuse / HIV Awareness Program With Street and Working Youth in Partnership with Salam Baalak Trust Delhi**

- Project Primary beneficiaries 8 seniors from SBT till date.
- Today program run by 5 seniors of SBT

**Slide 2. We Believe**

- Puppets being an objective theatre form, one can say far more through puppetry then the theatre of actors.
- Culturally sensitive topics and subjects can be effectively handled through puppetry.
- We have a strong tradition of puppet theatre in India / Asia- also a strong story telling and narrative tradition.
- Puppets, masks, objects tend to break barriers of subjectivity, and inherent cultural inhibitions.

**Slide 3. Training in Puppetry**

- For Awareness programs.
- HIV and Substance abuse amongst youth - street and working children - others.

**Slide 4.**

- Through the 2 projects on HIV and Substance Abuse more than 100 Persons have received training in simple puppetry for street theatre and awareness programs.
- Ongoing at the moment 5 training workshops with 45 participants
- 2 plays on HIV and discrimination by the group
- 2 plays on substance abuse by the group
- 1 puppet animation film on substance abuse made by the group.
- Work in progress on final substance abuse play with actors and puppets.

**Slide 5 – 8. Pictures**