

Addiction NEWS

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Rediscovering Church's Response to Drug Abuse!

The problem of drug abuse has been discussed at length from time to time within churches and what we have seen during the years has been quite encouraging. Churches in the affected areas have taken the initiative to address the problem in the best possible way. Today, a few churches in India can claim to have a specific ministry particularly where there is problem of substance abuse. Nevertheless, very few churches in India have a consistent and a qualitative approach towards addressing the problem.



Addressing drug abuse does not only mean opening a de-addiction centre or referring to a trained counsellor as and when the problem arises, it would also mean addressing all those factors within a community that leads an unhealthy lifestyle resulting in people abusing drugs. A range of problems come our way which cannot be addressed by a lone de-addiction centre but rather requires a community-based or a congregation-based response to the problem. Such a response can come only when we have the right atmosphere and the place to consistently talk about it. Today, we are still wrestling with a passive attitude to some common issues that stay unresolved within our community, which continue to enhance risky behaviour leading to drug abuse. Stigma and discrimination associated with it only add up to the problem, further isolating the affected.

This combined issue focuses on encouraging churches to actively engage in addressing the problem and also lays down the importance of meaningful interventions among Injecting Drug Users which can control the spread of HIV in the community.

We are indebted to the invaluable presentations made by Mr Toshi Sanglir and Mr Sundar Daniel, during the Biennial Conference at Shillong last year, and to Mr JVR Prasada Rao for his contribution at the 1st Asian Consultation on the prevention of HIV related to drug use in Goa.

In this issue, we have included excerpts from their presentations for the benefit of our readers. Do write to us your comments and suggestions.

Editor

Congregation-based response to drug abuse

The following excerpts are from the presentations made during Parallel workshop on the above topic at CMAI Biennial Conference 2007 in Shillong

1. Recognising the need...

By Mr Toshi Sanglir, Director, North East India Drugs & AIDS Care, Shillong

The problem of drug abuse has been with us even beyond the 60s. Now it is escalating, especially among regions that designate themselves as Christian, even more so, in the North East India. What is more alarming is that, it has not only divided families and communities, broken relationships, retarded the productivity of promising people but also brought in the spread of HIV/AIDS, STI, and Hepatitis C at an alarming rate. For almost two decades, programmes on intervention, prevention and care of drug abuse have been in place, yet more needs to be done.

The response of Churches towards drug abuse is more often judgmental rather than being compassionate and caring. However, this kind of a response is against the principles and teachings upon which the very foundation of Christianity was built. Therefore, for the church to engage in a prophetic role, it requires more than just compassion. It calls for embracing a theology of hope and love accompanied by practical care to help in the restoration and care of such individuals and their families. The church's action needs to rise above the rest. It has the moral obligation to offer its services of care to those in need. The church must keep in mind the teaching it professes and the example it manifests.

In this immediate task for the prevention and care of drug abuse, the church stands as an agent of change. However, changes are only subjective to the prevailing attitude and interpretation of the church's ministry of care and healing. The question at stake is, what kind of a care and healing ministry should the church be involved in?" Should it be a response or a plan of action?

Advantages of the church

1. Churches are closer to the community.
2. Churches hold a prominent place within the community.
3. Churches have the experience of working with the people.
4. The Gospel presented by the church talks about healing, restoration, forgiveness, grace, mercy, peace, love, salvation etc.—"A liberating message."
5. People generally listen to preachers and religious leaders.
6. Churches provide a nurturing environment.

How can a congregation respond?

1. Formulate a theological framework for a healing and a pragmatic ministry in the context of drug abuse.
2. The framework should facilitate discussion on the nature of God and His relationship with drug abuse and those in recovery.
3. Accommodate issues on various forms of injustice that underline the spread of drug addiction.
4. Stigma and discrimination, gender injustice and violence against drug abusers are important components to the framework.
5. Look at the church as a "community in restoration."
6. Advocate for justice and care in the light of drug abuse for prevention, care, support and treatment.
7. Develop a theology that is relevant to the infected and those affected with drug abuse.
8. Formulate a theology that is in line

with biblical examples of healing and restoration.

9. Incorporate lessons from the healing of the man with leprosy (*Mt 8: 1-4*), the healing at the pool (*John 5:1-9*), the woman who bled for 12 years (*Luke 8:42b-48*), the good Samaritan (*Luke 10: 25-37*) etc.
10. Churches must face the reality of discrimination within the churches. *Galatians (3:28)* deals clearly with identity marks that were dividing the church. Some thought that to be a Gentile or a Jew was something that one has to be proud of. Paul argued that in Christ those identity marks were of no use.
11. Provide opportunities to hear practical experiences of those infected or affected by drug abuse. This can be a transforming experience when the congregation is well prepared to accommodate, listen to, and embrace the person sharing his or her experiences.
12. Create the atmosphere of a healing community in the midst of despair, pain and suffering. The ministry is to console (*2 Cor 1:3-5*); to reconcile (*2 Cor 5:19*); to love (*1Cor 13:1-13*); to minister (*Mt 25: 31-46*); to show compassion (*Mt 9:36-38*); and to heal (*Mt 10:8, Mk 16:18*).
13. Implement awareness and prevention programmes on drug abuse. (Sunday school curriculum, community mobilisation etc).
14. Implement counselling services, (spiritual, personal, career, marital, and relational).
15. Use the services of rehabilitation centers, or implement them.

II. Is it Biblical?

By **Mr Sundar Daniel**, Christian social worker and consultant, Shillong

Is the congregation-based response to drug abuse is biblical? Let us try to answer this question by understanding the two main parts in this question: *drug addiction* and *congregation*.

Drug Addiction

Each one of us respond in the best possible manner to situations that we face, whether of pleasure or pain. Very often we take the support of people around us - family and friends, even strangers. While such support is valuable it is not always consistent even in the best of relationships. On the other hand, inanimate things, say, television, car, money, chocolates and chemical substances, appear more consistent.

Because of their consistency individuals sometimes choose to use these psychoactive substances to help them cope with life. Repeated use of psychoactive/chemical substances creates a physiological and psychological dependence, and over a period of time progresses to addiction. Such extreme dependence is termed as drug addiction.

Drug addiction is characterised by compulsive behaviour of using one or more psychoactive substances. Another characteristic, essential though less recognised, is relapse. After periods of abstinence from drug use, the individual returns to periods of uncontrolled use.

'Compulsive' describes the condition where a person has little or no control over his/her behaviour. Although the use of chemical substances begins by choice, when an individual becomes addicted, there is very little of this choice being exercised. It is indeed ironic that while the individual began drug use to be in control of his/her situation, the very same behaviour becomes uncontrollable. Now, one of the facts of life that I cherish most is that God has given us, human beings, the ability to choose. I believe it is this endowment that makes us the crown of creation. Addressing the addiction of an

individual is the process by which we assist him/her to regain this ability. Is such a process of assistance biblical?

Earlier, I mentioned about the individual's efforts to cope with life. The painful truth about life is that it is full of ups and downs. In resource-rich times, social support was aplenty. A reduction in resources for survival has resulted in situations where even parental support for the psychological well-being of children is minimal. Addressing addiction is essentially the means by which we assist a person to cope with life, to face harsh realities. Is it not biblical to help people cope with life?

Drug addiction results in spiritual, physical, psycho-social and economic consequences for the individual, family and society. It even leads to premature death of the person. For the drug addict, a start to this abundant life requires that we address the negative consequences of his/her addiction. As in John 10:10 says, *I have come that you might have life, and have it abundantly...* It is, indeed, biblical that even the drug addict should have recourse to 'abundant life'.

Congregational Response

A congregation of Christians is a group of people who have been saved from death, saved by grace and saved to save. We are thankful that we are saved from death, and week after week acknowledge in our worship services that we have been saved by grace. Do we, with equal vigour, acknowledge our responsibility to save? Through words, or inaction or indifference, we seem to be saying 'you chose to use drugs; now, therefore, live and die with your choices.' But we justify our own addiction to material prosperity as essential and call ourselves 'blessed'. On the contrary, the drug user who is addicted is a 'sinner' who needs to be kept at best on the fringes of Christian fellowship, if not further away. We adopt a rather judgemental position

when it comes to drug addicts, when we ourselves are very similar to them in many ways. It is this attitude that spills over as our response to those infected with and affected by HIV, including children who are HIV positive at birth.

The question given to me as the focus of our discussion - A congregation-based response to drug addiction... is it biblical? - betrays a similar attitude. The question also betrays our bias against social concern. Over a hundred years ago, Christians in the ministry of healing in India came together as CMAI. It is unfortunate that we are still discussing whether it is biblical to care for the needs of those around us.

Alternatively, we can say let us respond through our institutions. We create orphanages where children without parents get food, clothing and shelter and they are labelled as orphans. Similarly, addicts are 'put in' drug treatment centres where they get 'treatment', by their own parents, so that they are no more an embarrassment. Without a doubt, there is value to institution-based responses. And they are easier to plan and implement.

Congregation-based responses on the other hand are tougher. We will be more exposed to the manipulations of the addict. We will be frustrated that despite our best efforts, the addict relapses. Yet, it is when we are vulnerable to the ways of the addict, we can meaningfully share their pain and be a blessing to them. It is in becoming human that Christ was able to be our Saviour. 'It is in dying that we (and others) are born to eternal life'. And 'unless a grain of wheat falls to the ground and dies, it will not bear much fruit'. The more we come face to face with their struggles, the greater the meaning and value of our salvation. If we are to reflect that we are a group of people saved from death, saved by grace and saved to save, we must present ourselves as those willing to share the pain.

Prevention of HIV related to Drug use— Way Ahead!

Excerpts from the inaugural speech by Mr JVR Prasada Rao, Director, Regional Support Team, UNAIDS Regional Support Team, Asia Pacific at the Opening Ceremony of the 1st Asian Consultation on the Prevention of HIV Related to Drug Use in Panaji, Goa on January 28, 2008

The first golden rule in preventing a fast spreading HIV epidemic in any country is an early intervention to halt transmission. Countries that report injecting drug use need to start prevention before HIV is reported among injecting drug users. I cannot stress this fact enough. Countries that waited and hoped that information, education and communication programmes for the general population would show results, did not see them. In these countries, HIV prevalence among injecting drug users sky-rocketed up to 90%. On the other hand, countries, such as Bangladesh, that acted early and implemented focussed interventions aimed at preventing transmission among people who inject drugs, have been rewarded with prevalence of around five percent or below, a level comparable to Australia, Europe and the US.

Universal Access and barriers to access among drug users

Last year, UNAIDS and its co-sponsors endorsed a practical guideline on prevention interventions whereby giving priority to IDU interventions, it provides practical guidance on the core package of interventions which includes substitution treatment, needle and syringe programmes, peer education and outreach, voluntary HIV testing and counselling, prevention of sexually transmitted infections, primary health care and anti retroviral therapy.

At the UN General Assembly in June 2006, countries committed to developing targets for Universal Access, where international efforts will focus on supporting countries to meet their targets.

With these guidelines and the political commitment, we have a strong platform to take action. But let me now give you a brief snapshot of what's actually going on. It's not a comforting picture.

Take the latest data on coverage and access to the essential services by people who inject drugs. It shows that only a tiny proportion of injecting drug users in need of harm reduction programmes (3% in South-East Asia and 8% in East Asia, actually have access to these services.

Only a few countries provide access to substitution treatment, and where it is available, it is mostly at a pilot stage, for example Indonesia, Nepal, Malaysia, and Myanmar. Only one country, China, has demonstrated a significant scale-up effort.

Even though it has been quite some time ago that WHO included both Methadone and Buprenorphine to the WHO List of Essential Drugs, yet, as of today, Methadone is legally available in only five countries in Asia (China, Hong Kong, Indonesia, Lao PDR, Myanmar) and Buprenorphine is available in only three: (India, Pakistan and Nepal). Moreover in five countries, namely Bangladesh, Bhutan, Cambodia, Japan and Singapore, both Methadone and Buprenorphine are still illegal.

The priority now is to see that all countries which report injecting drug use make methadone legal, include it in the list of essential drugs and expand access to drug substitution treatment sites on the ground.

However, a comprehensive HIV response also means that drug users have access to needle and syringe exchange and distribution

programmes. Scientific evidence shows that easy and consistent access to sterile injecting equipment cuts transmission of HIV and hepatitis. Countries that took the initiative to implement needle and syringe programmes before a drug use-related HIV epidemic took off, have succeeded to-date in averting a generalised epidemic, saving lives and a huge burden of cost.

Yet, only 10 countries in Asia and the Pacific have at least one dedicated needle and syringe exchange programme and only two countries (Malaysia and China) have both NSP and substitution treatment programmes in place.

Countries that report injecting drug use need to significantly scale up the number of needle and syringe programme sites if they are to attain the goal of Universal Access.

Another issue of concern is equity, or should I say, the lack of equity, in access to HIV treatment by people who inject drugs. Of all injecting drug users receiving treatment globally, an astonishing 90% live in just one country, Brazil (WHO, 2007).

Too often people who use drugs are denied the services that they need and have a right to. We hear that drug users are being told by physicians that "as long as you use drugs, you cannot have ART". Similarly, we have heard that drug users on methadone treatment have been denied access to ART.

Denial of treatment is a denial of basic human rights. But let us be clear, it is also bad practice. Current or past drug use cannot be used as a criteria for deciding who can and cannot access treatment.

To curb and reverse the spread of AIDS, treatment needs to be provided based on clinical criteria, not on moral grounds. Secondly, healthcare services need to be comprehensive, with good referral mechanisms between general medical care, drug dependence treatment, harm reduction services, HIV testing and counselling and psychosocial support.

Delivery of anti retroviral therapy for IDUs through public healthcare services alone will not work. We need to expand the access to anti retroviral treatment through community-based organisations and experience shows us that the more we involve people who use drugs in the design and delivery of treatment and care programmes, the more successful those programmes will be. Treatment services also need to reach HIV positive persons in closed settings,

discrimination associated both with HIV and injecting drug use. The prejudice encountered by people living with HIV is well documented. But people who use drugs also report stigma and discrimination, and being an HIV-positive drug user brings with it a "double-stigma" that makes it all the more difficult to access relevant services.

We also know that in several countries drug users and positive people's networks are still not allowed to organise themselves and that drug users and their networks are excluded from decisions that affect them. This needs to change. The stigma and discrimination associated with drug use and HIV need to go, communities and governments need to embrace the reality of what works in curbing the epidemic.

By treating drug users and their



such as prisons and drug rehabilitation centres.

In 2010, we will take stock of the progress made towards achieving Universal Access. So our main challenge in the next two years are to increase access from 3% to 80% for all injecting drug users in need of these prevention and treatment services.

Stigma and discrimination, involvement of drug users

One of the main barriers for access to prevention, treatment and care services by people who inject drugs continues to be the stigma and

representatives as equals, by including them in consultative processes and the decision-making and policy-making bodies that shape the HIV, drug, and other relevant policies, we are more likely to succeed. We also need to support direct involvement of drug users in provision of services, such as outreach, substitution treatment, needle and syringe programmes, delivery of anti retroviral treatment, and prevention of overdose of drugs. After all, who understands the health and social needs of drug users better than the drug user?

Legislation and policies; management of national programmes

There is an urgent need to harmonise drug policies with HIV policies. Criminalisation of drug users hampers access to treatment and prevention services.

In most countries, the HIV programme is managed by the Ministry of Health while the National Narcotics Control bodies have been left out of the response and as a result, they often lack understanding and ownership of the national HIV programmes. Ministries responsible for controlling narcotic drugs should come forward to participate in these programmes and work closely with the national AIDS programmes. China is a good example of such collaboration.

Call for Action

The consultation was used as a platform to invite all those who are involved in the response to HIV to move for concerted action on the following agenda:

- To review and revise laws that criminalise drug use
- To tackle the stigma associated with drug use and HIV
- To ensure comprehensive coverage of IDUs with prevention, treatment and care interventions
- To involve networks of drug users and community-based organisations in delivery of prevention, treatment, care and support services
- To maximise financial and technical resources for prevention, treatment and care programmes for injecting drug users
- And finally to promote and facilitate organisations of people who use drugs.

We have over 20 years of experience at hand, we have the evidence, we have the resources, we have the commitment. So let us just get on and make Universal Access a reality.

Addressing HIV related to IDUs: Sharan Model

As long as HIV in injecting populations exists, its potential to spread into general populations continues. The management of HIV is distinct from the management of drug use per se, but, paradoxically, cannot be isolated as it affects the same person. Indeed, drug use has to be managed at the same time as HIV interventions begin.

HIV interventions start with needle exchange but must address the severe abscesses that unsterile and unsafe injecting can lead to. Injecting drug users are the poorest category of drug users outside of northeast India, as they cannot afford sterilised needles. All injecting populations in India are affected by Hepatitis C and are highly vulnerable to TB. They are also frequently affected by STIs and report a national HIV prevalence of around 10%. This indicates a high level of medical care that requires stabilisation to keep essential adherence to medications such as ARV and anti TB.

A hybrid Continuum of Treatment model has been developed by Sharan that follows a three-step approach:

- Primary, including safe injecting, wound and vein management, TB detection and access to HIV counselling and care
- Secondary, including access to oral substitution or drug replacement leading to no injecting, and includes access to TB medication and other health referrals

- Tertiary, that includes residential care, ARVs, detoxification and counselling related to no drug use and access to work.

All of the three stages require access to food, clothing and shelter, and attention needs to be given to family needs of spouses and children, so far neglected in our continuum. This appears to be a tremendous task, are we up to doing this for the nearly 200,000 injectors in our country? My belief is we can, and we are already on a headstart compared to other SAARC countries. The challenge remains in terms of applying the significant resources we have access to, and we have shown that we can fit most of the services into a dollar a day if we do programmes to scale.

Drug injectors among the Christian communities especially in the Northeast and South of India. Perhaps, the charitable side of the church can be shown to "these the least of our brethren", who have lost all hope and are the poorest and sickest populations. If rehabilitated, they have the tremendous potential to get engaged in care and support services. Our care could lead to the restoration of these lives and that of their families, and they can be transformed into economically productive citizens.

Mr Luke Samson
Director, Sharan
New Delhi

NEWS



National Policy on HIV & AIDS of the NCCI

A series of consultations and meetings were organised by the NCCI for developing a National Policy on HIV & AIDS, which will be a guideline for Churches in India. The whole process with financial support from ICCO, Kirk en Actie and the World Council of Churches was aimed at involving 29 member Churches, 17 regional Christian Councils, 7 related agencies and 19 all India Christian organisations. A team from CMAI consisting of Dr Vijay Aruldas, Dr Sunita Abraham and Fr Thomas Ninan worked closely with NCCI in making the whole process happen. A core group consisting of Bishop DK Sahu, Ms Sagarika Chetty and Rev PBM Basaiawmoit from NCCI, Dr Ashok Dyalchand (ICCO consultant), Rev Dr Abraham Kuruvilla (Principal,

Marthoma Seminary, Kottayam), Dr Evangeline Rajkumar (UTC), Bishop Cyril Cornelius (Methodist Church in India, Lucknow diocese), Dr Daisy Dharmaraj (Hon. Advisor - NLHMB of UELCI), Mr Paulus Samuel (Red een Kind) and the CMAI team was formed to work towards the policy. The series of meetings at Delhi, Nagpur and Bangalore culminated in a National level consultation at ECC, Whitefield which was held from March 27 - 29, 2008. The consultation brought forth active participation from both the NCCI partners and representatives from 20 independent Churches in India. There were unique contributions from international organisations like ICCO (Ms Karin de Graf & Ms Christina de Vries), WHO (Dr Karthikeyan), UNAIDS (Mr Alankar Malviya), INERELA+ (Fr Johannes Heath), CCA (Fr Philip Kuruvilla) and PRISMA (Mr Reiner Van Hoffen) and presentations from Rev Dr KC Abraham (Former Director, ECC & SAATHRI), Dr Evangeline Rajkumar, Ms Edwina Pereira (INSA), Dr George Zachariah (Gurukul), Rev Peter Singh (TTS), Rev Basaiawmoit, Rev SS Majaw, Mr Fernando Sohtun and Mr KK Abraham (INP+). The core group will further work towards proposing a draft policy which will be presented at the Quadrennial Assembly of the NCCI in May, 2008 at Shillong for suggestions and ratification.

Two-day workshop at Lunglei

A healing ministry workshop on HIV and Substance Abuse was conducted at Lunglei, Mizoram in association with the



Baptist Church of Mizoram from February 28-29, 2008. A total of 107 participants, pastors, elders, women's group leaders, youth leaders and representatives from local NGOs attended the workshop. The main objective was to challenge the Church to respond to HIV & AIDS and Substance Abuse and to initiate them to have a church policy. The various topics covered in this workshop included facts on HIV; Stigma and Discrimination; Addiction; Problems faced by PLHAs; Challenge the church to respond to HIV and Substance Abuse; Church's response in India and Africa; Develop Action Plan.

The workshop was able to make them understand why as a Church and as a congregation they need to respond to the care and support of PLHAs and addicts. It made them realise issues on stigma and discrimination within them towards those infected and affected. They were also convinced that the church has a major role to play both in prevention, care and support. We convey our heartfelt thanks to the leadership of the Baptist Church of Mizoram who assisted CMAI in every possible way and its members who participated with openness. We recognise the commitment in the leadership of BCM to respond to HIV and Substance abuse and identify it as a major challenge. We acknowledge the initiative taken by Rev Lalrintlaunga, and hereby thank Dr RL Sanghluna and his team for facilitating the sessions in the workshop. On behalf of CMAI, Dr Ronald Lalthanmawia and Dr Rosy L Khuma coordinated the workshop.

Healing Ministry Workshops in CHDP- NE projects of CMAI

• Silchar, September 10-12, 2007

Organised at Burrows Memorial Christian Hospital, Assam, the workshop was locally coordinated by Dr J Gyanaraj, Pastor Nabin Singba and Mr Babil Biswas, BMCH, Assam. The workshop provided clear biblical understanding among the participants that each one of them are agents of change in their communities. They were also provided skills on how to draw the social map of the village, why to draw the social map, seasonal diseases chart, how to generate information (population profile etc) how to prioritise the health and social problem/issues and find solutions. Sessions on Substance abuse were taken in Hindi by Mr Vinay John.

• Moreh, September 24-26, 2007

Organised at Kuki Baptist Central Chawangphai Church, Moreh, Manipur, the workshop was locally organised by Rev James Alien Haokip and Rev Tunlal Haokip. It was a similar workshop that was done at the mother church level where representatives from village church level participated. Healing ministry topics were taken by Rev Sharath David, Sr Programme Coordinator, CMAI while sessions on Substance Abuse and HIV/AIDS was taken by Mr Dineshwar Singh in Manipuri. Translations were done in local dialect for better understanding of the topics.

• CHDP Khangshim (Manipur), October 21, 2007

A workshop to create health awareness on HIV/AIDS and substance abuse & youth life at Ngairong village in which 21 youths (8 male and 13 females) participated.

CHDP-NE programmes of CMAI were coordinated by Mr Yuhanna Pradhan, Programme Officer, CMAI.

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Workshop on Congregation-Based Response to Drug Abuse at CMAI Biennial Conference, Shillong

The workshop was one of the parallel workshops at the CMAI Biennial Conference that was held at Central Library, Shillong from October 17 - 20, 2008. The workshop invited active participation from 25 participants from different

hospitals and churches. Moderated by Rev Fr Johns Abraham, TRADA, the workshop had unique contributions from Dr Sanghluna (Presbyterian Hospital, Durtlang), Mr Toshi Sanglir, (NEIDAC) and Mr Sundar Daniel, Consultant. Mr Manoranjan Nayak, CMAI and Fr Thomas Ninan coordinated the workshop.



CACSAN activities in Kerala

As part of the CACSAN initiative to bring together churches at an ecumenical level in the Trivandrum region in Kerala to address HIV/AIDS and addiction, a second meeting was planned at Peyadu Mission Centre of the Marthoma Church on March 1, 2008. The one-day programme had 65 participants from the Malankara Orthodox Church, the Salvation Army, CSI and the Marthoma Church from the Trivandrum region taking active participation.

The participants witnessed the de-addiction programmes that happen at Peyadu Mission Centre, namely AA meetings, outreach visits to affected families and interaction with recovering addicts. The programme was also part of an 8-day programme arranged by the Marthoma Church at Peyadu Mission

Centre which specifically focussed on reaching out to families affected with addiction. As a result of visiting 16 affected families, four families were able to take positive decisions through this programme.

This was the second such meeting at an ecumenical level, which helped

participants from 4 different denominations to learn from each other. CMAI acknowledges the key initiatives taken by Mr PC Koshy Panicker, Coordinator of De-addiction Ministry, Marthoma Church (Trivandrum-Kollam diocese) and Mr Alexander Jacob, ICSD, Valakom, who as active members of CACSAN could motivate participants from four churches in sustaining a learning process that would contribute to their own initiatives in the respective churches.



Announcement

Dear Reader,

We appreciate your interest in our newsletter and would like to record our gratitude for the same. However, with the steep increase in production costs, bringing out each edition is an uphill task. We would therefore, appreciate your support by donating Rs 50/- for a year's supply of *Addiction News* (4 issues).

Please send the amount by Demand Draft in favour of *Christian Medical Association of India, New Delhi*.

Errata

Kindly note that the previous edition April-September 2007 was a combined one of the Issue numbered 36 & 37

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A CMAI publication on substance abuse and alcoholism



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