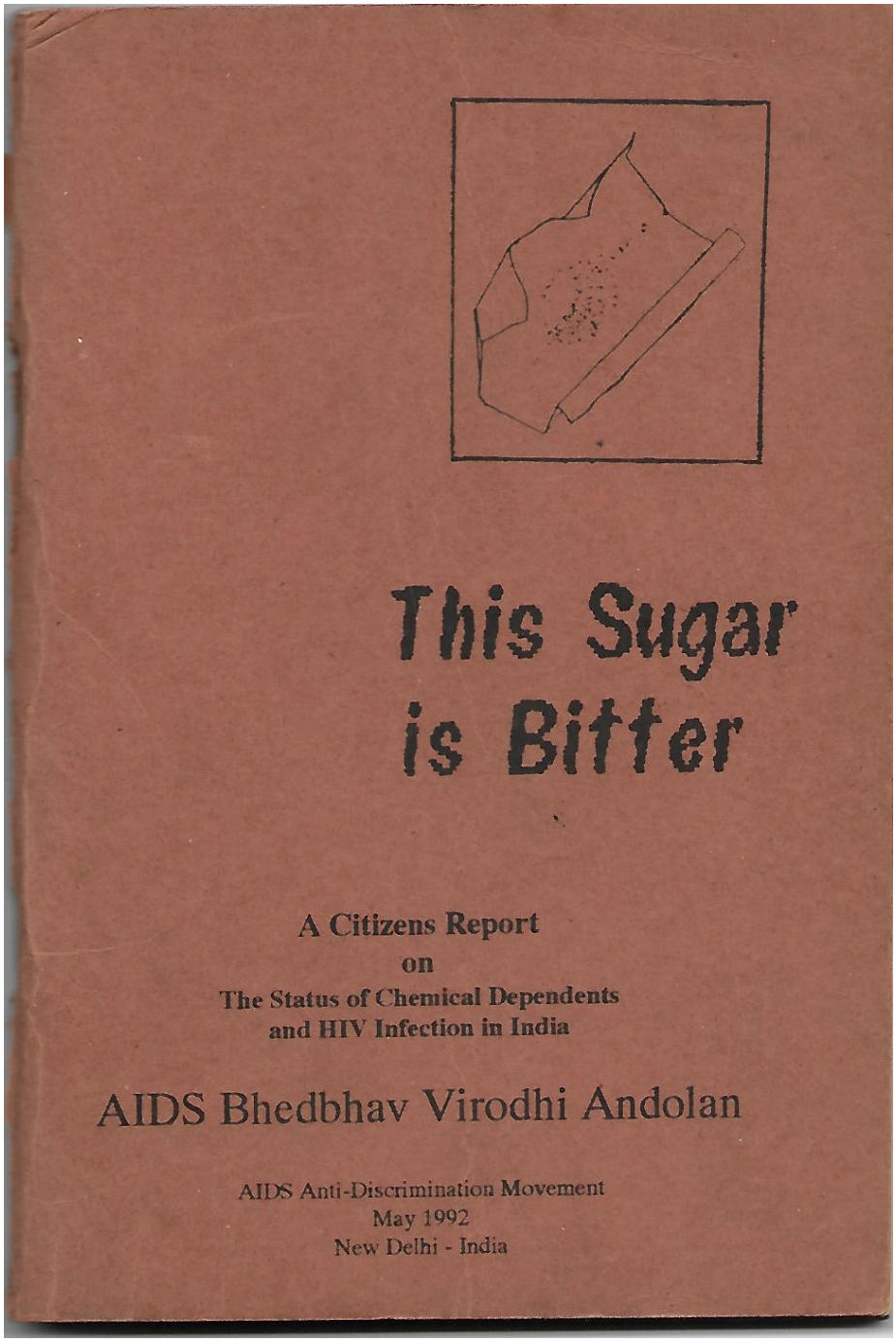

This Sugar is Bitter

A Citizens Report
on
The Status of Chemical Dependents and HIV Infection in India

AIDS Bhedbhav Virodhi Andolan

AIDS Anti-Discrimination Movement
May 1992
New Delhi - India

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A Citizens Report
on
The Status of Chemical Dependents
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AIDS BHEDBHAV VIRODHI ANDOLAN
(AIDS Anti-Discrimination Movement)
May 1992
New Delhi

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A TRIBUTE

Siddhartha Gautam
Fearless
Gentle, challenging
Preoccupied
With the rights
Of those discriminated

Questioned policies
That denied
Resources
To the people
Especially the poor
The marginalized

Life changed
For many an oppressed
Who encountered
Siddhartha
On the streets
In Courts, across tables
In Indian Coffee House
And even *dhabas*

Siddhartha has gone
But memories remain
Of convictions
Of battles won
Against discrimination
And of battles to be fought

Siddhartha Gautam, born on 25th January 1964 was involved with ABVA activities right from the beginning. He died on 13th January 1992.

DEDICATION

Dedicated to all the recovering individuals whose experience, strength and hope has made this report possible. To those still in active addiction may the message of recovery reach them.

"Decline and political disorder come to
those who neglect education, public health
and freedom. The rules apply regardless of race,
ethnicity, religion or climate."

- *Charles Lane*

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PART I

WHY THIS REPORT?

Four 'target' groups have been identified for specific action to control spread of HIV infection and AIDS. They are – Women in Prostitution, Professional Blood Donors, Gays and Intravenous Drug Users. For the past three years, ABVA has been trying to shatter the misconceptions associated with HIV and AIDS in the Indian society. The group has brought out three reports on the injustices suffered by the so-called target groups. This report deals with the fourth 'target' group – the intravenous drug user.

ABVA members interacted with a large number of recovering drug-dependents to have a first hand account of chemical dependency. It is surprising that very few people consider drug-dependency as a disease. No illness in any society is purely medical. The social and political dimension of the illness will determine the reaction of society to the illness, both socially and legally. ABVA therefore, has tried to document the politics of the problem of drugs and drug users.

ABVA being concerned about respect for the individual's rights, was shocked to read newspaper reports of intravenous drug users and HIV infected patients put behind bars in Manipur. What made this particular state of North-East different from other States of India? The group was keen on finding out the truth. But this meant a visit to Manipur. Being a non-funded, non-fund-raising group of volunteers, arranging funds was difficult. However, in a change from its earlier policy of not collecting funds, the members appealed for contributions from well-wishers, voluntary organization and friends. The response was overwhelming, enabling two members to visit Manipur. Part two of this report outlines the experiences of the members during their North-East mission.

As with earlier reports this also has been an education for all ABVA members. It helped remove some of the group's own biases and ignorances. Several group discussions were held and a large number or available literature was scanned and carefully studied.

When medical scientists announced the discovery of a new disease called AIDS, not many would have thought about the social and political implications of the illness. Though only a decade old, the disease has led to sexual, racial, religious, economic, occupational and at a global level, even a North-South discrimination.

Scientists, in an attempt to provide a solution to the threat of the spread of the disease, conveniently identified "high-risk targets". Targets of people who are already outside the mainstream of society. People who die a thousand deaths in their life-time; who barely manage to survive the physical and mental humiliation at the hands of "normal" society; people who are considered morally degenerate. It is as if the society, licensed as it were, with a moral judgement could now kill them socially. It is a sad commentary on human civilization that prejudices are allowed to cloud rational thinking. How long can this go on?

In writing this report ABVA has tried to present the perspective of the drug dependent and the HIV infected individual. ABVA has also tried to expose the exploitation of these individuals at the hands of the so-called "normal" society.

ABVA hopes that this report will make someone, somewhere to think again; to think humanely. To treat every human being, whether oppressed, stigmatized, marginalized or otherwise the only way every human being should be treated – with love, respect and dignity.

About ABVA

Four years ago a group of Delhi based citizens involved in community work in education, health, law, women's, gay, professional blood donors, drug abuse issues and in the peace movement came together over the plight of women working in GB Road, Delhi's Red light area. The entry into these communities was with a view to learning more about the problems of these defined groups and to see whether their viewpoints may be conveyed to the outside world. Also, if external support was needed, could it be extended on a long term basis?

When the group was started the focus was only on the issues related to women in prostitution. Around the same time forcible testing for HIV infection among the women in prostitution was started under an AIIMS-ICMR scheme with the help of the police. AIDS and HIV infection therefore became part of the group's concern. Public health policy for control of AIDS/HIV infection was based on targeting "high risk" groups. ABVA therefore started studying and documenting the issues related to these "target groups". In this process the group was joined by other concerned citizens. The group has since taken a stand on all kinds of discriminations against "target groups".

ABVA Members

Anuja Gupta (Professor of French), Arun Bhandari (Ankur), Ashwini Ailawadi (counsellor), Dimple (Social Activist), Jagdish Bhardwaje (Professional Blood Donors Welfare Association, India), Gauri (Social Activist), Lalitha SA (Joint Women's Programme), Manoj Pande (Service Civil International, Delhi Group), Mathew Varghese (Orthopaedic Surgeon), Dr. PS Sahni (Jagat Mata Kusht Ashram), Shalini SCN (Indian Social Institute), Shanta (Ankur), A Sriniwas(Social Activist).

The members of Aids Bhedbhav Virodhi Andolan (ABVA) have tried hard to broad base its work by mobilizing other voluntary groups and community people including people with leprosy, women in prostitution, women from slums around Delhi, the gay community, drug dependents and professional blood donors. ABVA has regularly met with concerned officials of Delhi Administration and the Union Government, and submitted memorandums to relevant authorities. With the help of Shobha Aggarwal, an activist lawyer, ABVA has been able to offer free legal assistance to women in prostitution.

ABVA was instrumental in stalling the Draconian AIDS (Prevention) Bill, 1989 through petitions in Parliament, public meetings, protest actions and networking both in India and abroad. As a result, the Bill was placed before a

Joint Parliamentary Committee. The Bill was withdrawn in October -November 1991 following a decision made by the Union Cabinet.

ABVA has organized several protests against the government's policies on testing, confidentiality and discrimination linked with AIDS.

On 28 February 1990, a demonstration was organized at the Indian Council of Medical Research (ICMR) headquarters, New Delhi, to protest against the refusal of doctors at AIIMS to operate upon an African envoy with AIDS.

On 30 November 1990, ABVA staged a protest demonstration at the head office of the Medical Council of India (MCI), urging it to remove from its Medical Register the names of doctors who refused to treat persons with HIV infection/AIDS. About five months later, the Indian Medical Association responded by publicly stating that a refusal to treat persons with HIV infection/ AIDS would be against medical ethics.

On 18 March 1991, ABVA protested outside the head office of the New Delhi Municipal Committee (NDMC) following the refusal by the NDMC Hospital at Moti Bagh, New Delhi, to treat children with Thalassaemia who had contracted HIV infection through blood transfusion.

On 7 August 1991, a 500-strong sit-in was organized at AIIMS following refusal by doctors at the premier medical institute of the country to conduct a delivery on an HIV positive pregnant woman.

On 6 December 1991, ABVA protested outside World Bank against the use of loan/grant of US $80 million to the Government of India. ABVA feels that rehabilitation of the HIV positive persons should be an important part of management. Any programme which does not take this into consideration should not be funded. No programme should violate the basic rights of the individual.

On 6 April 1992, the eve of World Health Day, ABVA and 37 other concerned citizens and organizations protested outside World Health Organisation (WHO), South East Asia Regional Office, New Delhi, against the plans for trials of AIDS Vaccine in developing countries.

CULTURE, HERITAGE, RELIGION AND THE DRUG USER

"We have drunk Soma and become immortal
We have attained the light the gods discovered
What can hostility now do against us
And what, immortal god, the spite of mortals?"

From The Rigveda Hymn AXX

Historical Perspectives

Indian society, like all societies of the world, has used mood-altering substances that suppress pain and sorrow. Early Aryan settlers used to regale themselves with intoxicating substances such as Somarasa. Opium was introduced into India around the 9th century AD, possibly by the Mohammedans. The period of the Moghuls saw the free use of hemp and other intoxicants. In the reign of Akbar, a beverage containing alcohol, opium, Indian hemp and poppy capsules (Chaharbaragh) was drunk by the well to do classes. Historical records clearly show that the introduction of poppy capsules dates long before the British rule was established. According to De Candolle (Indigenous Drugs of India-Chopra, 202, 1958) various species of poppy have been cultivated as ornamental garden plants and that there was little doubt that the merits of the seed as a food were recognized and employed in the preparation of soporific drugs .

In the time of the Moghuls, a beverage made from the poppy capsules known as kuknar was very commonly used throughout the country. In his AIN-i· AKBARI, Abul Fazl mentions that whenever the Emperor "was inclined to drink wine or take opium, or kuknar, trays of fruit are set before him." The use of the word kuknar apart from opium in the above passage shows that both the poppy capsules and the inspissated juice of Afyun were used. According to Watt (Chopra 1958) the beverage post at present taken in the Punjab closely resembles kuknar which was a luxury among the Mohammedans in the time of Akbar. Many other references in the Moghul literature indicate the extent to which the habit of drinking post or kuknar prevailed among the Indians during the 16th century AD and later Bontius, writing of Batavia in 1658 divided the Indians into Post, that is, those addicted to poppy capsules and Afyun or those taking opium.

In the history of Punjab during the time of the Sikhs there are many references to post drinking, but it is impossible to form an idea as to the extent to which the habit prevailed among the people. Since the introduction of restrictions in the cultivation of poppy the temptation has been undoubtedly removed from the doors of the peasant and there is no doubt that habit has considerably

decreased for that reason. Now it is difficult to get poppy heads in most parts of India. The beverage post or kuknar has become unknown and appears to have been replaced by opium. It is still indulged in some districts of the Punjab, chiefly Jullunder and Hoshiarpur and in some districts of Rajasthan and Madhya Bharat. (Chopra 1958)

The earliest mention of medicinal use of plants is to be found in the Rigveda which is one of the oldest (if not THE oldest) repositories of human knowledge (written between 4500 and 1600 BC). In this work, mention has been made of the Soma plant and its effects on man. In the Atharvaveda, which is a later production, the use of drugs is more varied although it takes the form, in many instances of charms, amulets. Mention of bhang and its synonyms jaya and vijaya is made in ancient Sanskrit literature and bhang specially mentioned in the Atharvaveda (said to have been compiled in 2000 BC). It is in the Ayurveda that the definite properties of drugs and their uses have been given in some detail. Ayurveda is the very foundation stone of the ancient medical science of India. Ayurveda was followed by two works – later written – that is Susruta and Charaka around 1000 BC. The strength and dimensions of the scientific knowledge of ancient India regarding therapeutic agents both organic and inorganic origin can well be gathered from these works. The progress of Hindu medicine may briefly be traced through four distinct phases. 1. Vedic, 2. The period of original research and classical authors, 3. the period of the Tantras and Siddhas and 4. The period of decay and recompilation. The second and third periods showed remarkable progress. A progress that made its way far beyond the limits of India.

The conquests of Alexander the Great brought Hellenic Civilization in contact with Indian/Hindu medicines. The Hellenic system of medicine (Unani) was brought into India by the invading Greeks. In the domain of drug therapy and toxicology (study of harmful effects of drugs) India was more advanced than other nations, because of the intensive study done on every product of the soil along with the systematic study of diseases and its treatment with drugs. The skill of these physicians in curing snake bites and other ailments among the soldiers of the Grecian camp bears testimony to this. There is every reason to believe that many Greek philosophers like Paracelsus, Hippocrates and Pythagoras actually visited the East and helped in the spread of Hindu culture to their own countries. The work of the great physician Dioscoroides definitely shows to what extent the ancients were indebted to India and the East for their medicine. Many Indian plants are mentioned in their first works, particularly the aromatic group of drugs for which India has always been famed. The smoking of dhatura in cases of asthma, the use of nux vomica in paralysis and dyspepsia and the use of croton as a purgative can be definitely traced to have originated from ancient India.

The Romans also took a great interest in Indian drugs. There is evidence to show that an extensive trade in Indian drugs existed between India and Rome many centuries ago. In the days of Pliny, this drug traffic assumed such enormous proportions that he actually complained of the heavy drain of Roman gold to India in buying costly Indian drugs and spices. Captain Johnson Saint's comment made in this connection is quite interesting. He said that an extraordinary advance was made in surgery in India "when Europe was groping for light in her cradle in Greece. ...if then this is what we found in surgery, what may we not find in medicine from India – that vast and fertile country which is a veritable encyclopedia of the vegetable world." (Chopra l958).

After the period of the Tantras and Siddhas, the glories of Hindu medicine began to degenerate. This process of decay became well advanced about the time of the Mohammedan invasions. With the establishment of the Mohammedan rule, the old Hindu or Ayurvedic system fell into the background. The Arabic system (Tibbia system of medicine) became prevalent with the reign of the Moghuls and then rapidly fell with the fall of the Moghul Empire. The result was that, though both systems had declined, a rich store of combined materia medica was left behind. With the advent of the Europeans the Portuguese, French and lastly the British – the decline was still further marked. When the British rule was established, the Western system (allopathic) was introduced and it was primarily intended to give relief to those who administered the country.

Religion and Drug use

History reveals that drugs have played a very important role in religions all over the world. Studies indicate that hallucinogenic drugs (drugs which induce hallucination) in certain conditions bring about a profound mystical experiences.

Most cultic drugs come from plants, though more recently formed Western cults have made use of the active principles of natural drugs in synthetic form. Probably the most widespread plant having psychedelic (expanding the mind's awareness) properties is the Indian hemp. It is used in religious practices in India, Africa and in the USA. Its most common form – marijuana, bhang, charas and hashish – has been known to induce what is described as a profound religious experience. The active principle that induces the effects described is Tetrahydrocannabinal.

The central aim of the cultic use of drugs is the pure delight in what is described as a direct experience of God. The consequence of such worship experience is a feeling of transcendence and rebirth. Thus the assimilation of drugs became a sort of sacrament in which the qualities of the gods were appropriated. Along with this sacramental function of the drug cults was the

concept of purification through drug use. Many psychedelic drugs produce nausea and the consequent vomiting was looked on as a purging of faults. In some of the more primitive cults magical beliefs were interwoven with minimal Roman Catholic beliefs. (The New Encyclopedia Britannica: 201, 1974)

There is less evidence for the historical use of drugs in Buddhism or Taoism, though it is mentioned occasionally. In Islam, which prohibits use of alcohol, Cannabis has been more widely used. The Prophet Mohammed (7th century AD) imposed on his followers some restrictions and obligations of an ascetic nature – abstinence from intoxicating drinks. He forbade adultery, games of chance and the drinking of wine and other intoxicants. Wine was connected with a number of features of life in the old *semitic east,* but the main reason should rather be sought in the connection with the MAISIR games. Drinking bouts with feasting on a specially slain camel and games of chance, which were in the eyes of the old Arabs, the bright spot in their hard struggle for existence, and in which they endeavored to display their mobility and hospitality, brought the Muslims into suspicious relations with pagans and with Christian and Jewish wine sellers. This might easily lead to their faltering in their new religion; and might explain why he forbade both at the same time. This of course does not exclude the possibility that forms of abstinence for other reasons may have been known to him. (Shorter Encyclopedia of Islam – by Gibb and Kramers, 1953). A sect (Assassins) found in the 11th century A.D. used Hashish. Their name is derived from an Arabic word denoting a consumer of hashish.

When the lndo-Aryans entered the North-West of India they brought with them a religion in which the gods were mostly personified powers of nature. They also brought with them the cult of fire and of Soma. The immortality of the gods was connected with the drinking of Soma. “We have drunk Soma and become immortal, we have attained the light the gods have discovered ...” Rigveda, Hymn XXX.

India, in the Ramayana Age witnessed an indulgence in “all manner of boisterous frolic.” The Panabhumi (literal meaning – a place of drinking) was divided into chambers and was literally supplied with everything one’s heart could wish for with various meat dishes, huge wine flasks and various kinds of wines and fruits. The habit of imbibing intoxicants was universal. All classes of people, both male and female kissed the cup. The Ramayana soldiers enjoyed spirited beverages just like the soldiery of all ages and climes. Sugriva celebrated his extraordinary fortune by drinking wine and he even enjoyed wine with his ministers and members of his assembly (Ramayana V.II.91). In the Uttarakanda, Rama took Sita by the hand and gave her the inebriating cup of pure, sweet, spiced liquor to quaff, while skilled women danced after imbibing heavily of intoxicants (Ramayana V.II.42). The frequent mention of taverns (a Panabhumi) in reference

to a place where low class people were served liquor in earthenware drinking pots. It is also an implication that the art of distillation of liquors must have been well known. (KRITA SURA V.II.22). In such an age of prolific drinking, the virtues of temperance were none the less highly appreciated. Abstinence from liquor was always associated with a pious and saintly life. Sita in captivity and the Brahmanas for fear of public slander abstained from imbibing intoxicants for different reasons. Rama's anger with Sugriva because he had neglected to fulfill his promise to find Sita due to his being steeped in wine point out to tolerance and temperance and its harmony in Rama's Age (India in the Ramayana Age – Dr. SN Vyas 1967).

The Old Testament – Book of Genesis says: "See I give you every seed bearing plant all over the earth and every tree that has seed baring fruit and let it be your food." (Gen.l.29-31) Further on the book of Genesis brings out the celebrative aspects of wine. Chapter 9:v.20-21 talks of Noah planting a vineyard "then he drank of the wine and was drunk, …".

The New Testament further elaborates on the celebrative aspect of wine. At a Wedding feast in Cana when wine had run out Jesus changed water into wine (John 2:1-12). Again when the feast of the unleavened bread arrived, Jesus took the cup and gave thanks saying: "Take this and divide it among ourselves". Later, he equated the drinking from "the cup" with the coming of the Kingdom. "I will not drink of the fruit of the vine until the kingdom of God comes." (Luke 22: 16-18). Jesus talked in the common language of the people –wine being easily understood by all. His disciples later, however, condemned the excessive use of wine. Peter ascribes drinking to the "Gentiles" – the non-Jews/pagans when he says: "...we have spent enough of our life time in doing the will of the Gentiles when we walked in lusts, drunkenness, revelries, drinking parties and abominable idolatries."(l.Peter :4:3)

Drinking was a fashionable vice among the people during the time of Kalidasa. The drinking of wine appears to have been an extensive habit of the people and Kalidasa makes innumerable allusions to the occasional intemperance of people – not only men but also of women. It was believed that intoxication gave a special charm to women. In the Kumarasambhava we read of Siva himself drinking wine and making his wife drink it. In the Raghuvamsha mention is made of the whole army of Raghu drinking wine extracted from coconuts. Further references are made to the drinking peg (Casaka), a grogshop on the road side and to an open place of drinking (Panabhumi) (Raghuvamsha XIX.11). Kalidasa's writings refer particularly to three kinds of preparation of wine, apart from the preparations of the juices, his writings also refer to the perfume of the various wines and the removal of the trace of ill odour of wine breath through the chewing of betel leaves and nuts. The use of the betel roll had been quite old in

India even in the time of Kalidasa as is evidenced by the Kamasutra (the oldest treatise on sexuality), where a detailed description of a nagarika's room and habits is given. The writings of Kalidasa may be placed about 445 AD. A period known as the Golden Age of Indian History

A later development of Hindu religion (later than the Puranas) the Tantras give prominence to the female energy of the deity. There are five requisites for Tantra worship, the five Makaras or five M's – l. Madya, wine; 2. Mansa, flesh; 3. Matsya, fish; 4. Mudra, parched grain and mystic gesticulations; 5. Maithuna, sexual intercourse. There are a few Tantras which make Vishnu's wife or Radha the special energy concerned with magical powers.

One may be able to quote many other poets and prophets to show that India's traditions did not exclude the imbibing of intoxicants. However, prior to looking at our folklore it may well be worth our time to reflect on Mirza Ghalib's responses to wine. A noble poet and wit of Mughal Delhi, in the twilight years before the crushing of the revolt of 1857 which finally extinguished Mughal power, Ghalib had always liked wine which was not permitted to a true Muslim. He openly sang the praises of wine, realizing that he was breaking the laws of Islam. He found wine a stimulus to write poetry. Once a man in Ghalib's presence, strongly condemned wine-drinking, and said that the prayers of wine drinkers are never granted. "My friend," said Ghalib, "if a man has wine, what else does he need to pray for?" (Shorter Encyclopedia of Islam by Gibb and Kramers -1953).

Tradition, Folklore and Drug Use

Drug use, especially certain forms of it, constitutes long established and culturally integrated social habits. Traditional drug habits take root, become widespread and survive the passage of time because they serve useful cultural purposes and respond to significant social needs. The more festive a Drug habit, the more likely it is to establish itself as a social custom. Drugs were and are still often used as facilitators of recreation. Some traditional ceremonies require the use of psycho-active drugs. Examples of this are seen in the use of cannabis as used at Hindu festivities, ayahuasca and mescaline in Latin American folk healing, peyote in American church ceremonies and medicinal use of opium in rural Thailand.

In the middle of the rainy season, the 11th day of Bhadon (August/September) boys and girls go to the jungle, cut a branch and set it up in the village. The people drink and dance around it all night. Wine is poured on it, rice and sweetmeats offered to it and a chicken is killed. The beautiful Mahua (Bassia Latifolia) is held sacred by the forest tribes who eat the succulent corrola

tubes, distill spirits from them and use the tree in their marriage rites. The Gonds bury their infants under it as it is a supposed fact that their spirits will suck the liquor from it and be nourished as if by their mother's milk. Adults are cremated under it in the hope that it will give a supply of liquor in the next world. (Crooke, William - Religion and Folklore of Northern India, Delhi 1925).

During the festival of Holi, bhang is used as "Shiv ka Prasad". Large and small groups get together and drink and celebrate. Women are also part of this celebration. They are sent this drink as prasad and the women drink this with great devotion. The use of bhang in some parts is connected with religious and social observances. The acceptance of bhang is well exemplified in this small verse: "Buti Nitya Ligiye, Bina Buti Sab Sun, Buti Se Chinta Mite, Tel, Lakri, Lun. (Take Buti (Bhang) regularly for without the consumption of Bhang (Buti) life will be without color and spice. Buti's help in mitigating the worries of life – that of oil, wood and salt.) Anonymous. In the Bhairo Baba Temple in the Capital, daru (liquor) is considered as the favorite offering to Baba unlike other temples in the Capital. Baba's Bhaktas – which comprise both the opulent as well as the poor – come with their fondest brand of liquor. Then the lone priest takes the bottle to the sanctorum, pours a few drops on Baba's (dog-riding) idol and gives the bottle back to the devotee. There are also devotees who cannot afford liquor and offer bundiya and other mithais. (Indian Express: 24.2.1992)

As a result of such importance accorded to cultural functions and traditions, and because these functions are not perceived as being harmful, most of these traditional habits are supported by masses. Some of them are so deeply rooted in history that they predate the political and legal structures under which these populations live in the present time. In addition, they have acquired importance with local economies and so any change is resisted as it threatens the main source of the communities' livelihood. Understandably then, the legal status of many traditional practices is ambiguous. Government and health authorities tend to ignore their existence, to minimize their desirability, or to challenge their influence and lawfulness.

Some drugs occupy a recognized place among a community's acceptable social practices. Tea, coffee, and cinchona (whose bark produces quinine) had received the East India Company's attention from quite early times. Their successful establishments gave India tea and coffee to big semi agricultural industries and two new staples for the export trade (A Cultural History of India during the British period A.Yusuf Ali 1940). British firms had discovered that the foot-hills of the Himalayas were excellent for cultivation of tea. Similarly, there were hilly areas in the southern peninsula where coffee could be grown. But all this needed a large labour force. The increasing population of tribal folk which suffered from the shortage of land offered a tempting field for recruitment. British

companies established depots for the recruitment of indentured (bonded) labour. These were in Bihar, Orissa and MP where a large number of Santhal Oraon, Munda and Kharia labourers were drafted for service in the tea plantations of Assam and North Bengal. (Tribal Life in India by NK Bose) These officially approved drug intake habits – such as coffee and tea – are part of human existence and routine. Alcohol and tobacco arc also examples of the above category. Though Alcohol is banned in some Islamic countries major economic activities are geared in this direction by industries. Indeed drinking has thus to be regarded as customary action which relates to social rules and morals, as also to material conditions of life.

A further dimensions of this issue is that the upper classes have always had an ambiguous attitude towards the intake of alcohol. A popular class given to drinking could hardly in such a view become a disciplined work force. In most regions peasant manufacturers of country drink have become a fugitive occupation banned by the law. This is because drink which was previously obtained free by custom has now in the upper class epoch become an important commodity providing a profitable item of manufacture for capitalists and as a source of taxation for Governments. This development has come about through political means that is through formulation of liquor controls by modern states and enforcement of these controls by the police.

In India temperance was advocated strongly from mid nineteenth century onwards by middle class social reformers. This middle class reform affected certain elements among the poor. From the late nineteenth century onwards there was a growing number of reform movements, which promoted a middle class morality. This continues till today. One of them being the programme to give up intoxicants. Obviously the popular classes have not accepted this.

The history of intoxication during the colonial period in India has been a subject of almost complete neglect. The reasons for this could be that the taxation was borne by the lower classes and that few historians have felt moved to examine the plight of the popular classes.

Before the advent of British Rule in India, there was no system of excise taxation. There, however, was a system of land revenue under the Mughal rule. No attempt was made on the part of the Indian rulers prior to the advent of British, to derive any material revenue from the traffic in drinks and drugs. Possible explanation could be that those who consumed liquor and drugs were in a small minority and the use of intoxicants was not considered a legitimate source of State revenue. The East India Company and its successor – the then Government of India – suffered from no inhibitions of traditions; moreover excise duties on alcoholic beverages were a substantial source of public revenue in the UK. This

in 1790, led to the enactment of the excise laws and framing of excise rules in British India in consonance with the policy of maximum revenue with the minimum consumption, a policy that was followed in the UK. It was at this time that excise departments were established in all the major provinces and excise police were required to assist in the enforcement of excise laws.

Thus it was the government through the system of taxation that is, still-head duty and vend fees acquired an interest in production and sale of country spirits which contributed nearly half of the total excise revenue. Therefore the advent of the British increased the trade in intoxicants thus expanding what already existed. A system of controlled monopolies came into existence for the manufacture and sale of drinks and drugs. Gradually it developed into an organized commercialization of the traffic in intoxicants permitted and protected by a system of licenses. The demand created by the drink habit supported by trade interests as never before in Indian history resulted in further increasing consumption. The various Provincial Government Excise Manuals portray the possibility that the policy of deriving maximum revenue from minimum consumption was applicable generally to all excisable articles including liquor, opium and hemp drugs. Examples of this subtle inference can well be gleaned from the following facts:

The types of drink consumed in India have changed considerably over the past century.

Intoxicants which were previously obtained to a large extent freely by custom has now became an important commodity.

The formulation of liquor controls by modern states and the enforcement of these laws by the police.

Drinks and intoxicants provide a deeper understanding of the chasm between the dominant classes/religious classes and the popular classes.

The increase in the degree of commercialization.

The taxes on Toddy and levy on toddy trees.

The do-away of the liquor farming system to be replaced by proper control in limited number of factories under close supervision of excise officers.

LAW, POLICE AND JUDICIARY

Drug Addiction and Law

The Narcotic Drugs and Psychotropic Substances Act of 1985 was introduced in India in order to deal with the growing menace of drug trafficking. This enactment was intended to arm the enforcement authorities with more powers than in the earlier laws (such as the Opium Acts of 1857 and 1878 and the Dangerous Drugs Act, 1930). It was hoped that this will facilitate the apprehension of narcotic offenders. However, illicit drug trafficking continued to increase. This led to the amendment of the 1985 Act and the introduction of the Prevention of Illicit Trafficking in Narcotic Drugs and Psychotropic Substances Act in 1988. Despite these legislations the rate of offenses still remained high which was an indication that the legislations were incapable of realizing the objectives for which they were framed.

> Section 27 of the NDPS Act 1985 states that: "Punishment for illegal possession in small quantity for personal consumption of any narcotic drug or psychotropic substance or consumption of such drug or substance – whoever, in contravention of any provision of this Act or any rule or order made or permit issued thereunder, possesses in a small quantity any narcotic drug or psychotropic substance which is proved to have been intended for personal consumption and not for sale or distribution or consumes any narcotic drug or psychotropic substance shall notwithstanding anything contained in this Chapter be punishable.-
>
> (a) where the narcotic drug or psychotropic substance possessed or consumed is cocaine, morphine, diacetyl-morphine or any other narcotic drug or any psychotropic substance as may be specified in this behalf by the Central Government by notification in the Official Gazette, with imprisonment for a term which may extend to one year or with fine or with both, and (b) where the narcotic drug or psychotropic substance possessed or consumed is other than those specified in or under Clause (a) with imprisonment for a term which may extend to six months or with fine or with both.
>
> Explanation: - (1) For the purposes of this section "small quantity" means such quantity as may be specified by the Central Government by notification in the official Gazette. (2) Where a person is shown to have been in possession of a small quantity of a narcotic drug or psychotropic substance, the burden of proving that it was intended for the personal

consumption of such person and not for sale or distribution, shall lie on such person.

Comment: This section provides for punishment for illegal possession in small quantity for personal consumption of any narcotic drug or psychotropic substance or for consumption of such drug or substance."

The Indian Constitution lays down provision for promoting prohibition. "The State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and drugs which are injurious to health." (Article 47 of Constitution of India). Yet the government itself is promoting alcohol through several agencies for its own revenue and other benefits. According to a report: "With the nominal exception of Gujarat and Tamilnadu, liquor is available freely in the market, all licensed, all blessed by the state. The liquor vends are often auctioned at astronomical figures. In the Capital city of India, the Government is directly involved in the sale of liquor. There are four agencies namely: DTDC, DSTDC, DSCSC, DCCWS all under Delhi Administration, which operate the liquor vends. No other agency has any right to sell liquor in the Union Territory. Is it the business of these agencies to sell liquor? Delhi Tourism Development Corporation is supposed to look after tourism in the Capital." (Patriot: 24.12.1991)

"According to officials, the total earning from the 10 vends of country liquor in 1990 was over Rs. 86 crores and that from the 84 vends of Indian Made Foreign Liquor (IMFL) vends was over Rs. 58crores. The figures speak for themselves. DTDC is selling more country liquor popularly known as Desi than IMFL." (Patriot: 24.12.1991). But does the government care when the excise levies collected from liquor manufacturers keeps the Government coffers flowing? Isn't the Government itself violating the provisions of the Indian Constitution?

The Extent of the Problem of Drug Use

As per press reports (Indian Express: 20.11.1991) "The US$ 800 billion narcotics industry will, if unchecked and allowed to grow at its present rate, in three years time enjoy the status of the largest organized industry in the world, says Dr. Yusuf Merchant, President of the Drug Abuse Information Rehabilitation and Research Centre (DAIRRC), Bombay. At present the narcotics industry occupies second slot behind the global defense industry in terms of turnover. With an estimated one million heroin, two million opium and several million cannabis dependent the Indian narcotics industry itself is phenomenally large – worth at least Rs. 5,000 crore."

At a global level international policies have also decided the marketing of substances like tobacco to developing countries. In 1954 tobacco became eligible for inclusion in the Food for Peace program under which the US Department of Agriculture shipped millions of dollars in tobacco products per year along with food to the hungry countries of the world. A recent strategy of the US tobacco industry to open foreign markets has involved an amendment to Section 301 (Super 301) of the 1974 Trade Act. This amendment enlists the cooperation of the executive branch of the federal government in threatening trade sanctions against countries not permitting the sale of US tobacco products. It seems hypocritical that a developed country like the US is encouraging the sale of a dependency producing substance (tobacco – albeit more socially acceptable than cocaine) to developing countries, at a time when they are pleading for the prevention of entry of cocaine into the US. (Michele Batry, The New England Journal of Medicine: Volume 324 No. 13, page 917 -919, 1991).

Defined as an epidemic by the WHO, fighting the supply side of the problem is a subject which falls under the purview of the government. With the help of the NDPS Act 1985 government apprehends the drug offenders. But can the epidemic be contained through a legal approach alone? The government may be releasing as many as 3,000 drug traffickers, some of them without trial, in the near future. According to Mr. C. Chakroborty, Director General of the Narcotics Control Bureau, "Absence of sufficient members of special courts for expeditious trial of criminal cases is affecting the preventive action against the abuse of narcotics in the country. Only 30 % of the cases could be disposed off between 1987 and 1991 because of the shortage of special courts. The NDPS Act of 1985 envisaged setting up of special courts of the level of sessions courts to try all offences under the Act. Again, of the 6,492 cases so far disposed of, about 35 % have ended up in convictions, and 65 % in acquittals" (Times of India: 20.2.1992). He said that the governments of Maharashtra, West Bengal, and Manipur had created some special courts, but they were not adequate. Other states, including the Union Territory of Delhi, were yet to make any beginning. The delay was also because of inadequate laboratory facilities. Also, the two major agencies for combating the evil practice – the customs and the police – are busy elsewhere. Will increasing the number of courts and judges alone do? Often the judges themselves are not aware of the process and problems of drug dependence. ABVA feels that judges be provided special education and information for diagnosing and evaluating the process of drug use.

What happens within the jail premises?

Behind the "solid" prison walls, in Tihar Jail, allege undertrials, flourishes a drug trade involving top jail staff, convicts and undertrials. Enquiries from undertrials (UTs) produced at the Patiala House and Tis Hazari courts over the

last week revealed that the drug trade involves daily transactions of over Rs.40,000. The jail staff including top ones are behind the trade. The staff smuggles the dope in and it is circulated inside by the inmates. It is the jail staff that brings in the drug. Although there are four checkpoints, the UTs say it is not very difficult to smuggle in the stuff. A five gram packet of smack is smaller than a matchbox and thus not very difficult to conceal. Rs. 20 is believed to fetch a quarter gram of smack. With so much money at stake, there are frequent clashes. The jail staff is on the look out to eliminate those inmates who become too big for their boots, they say (Indian Express: 16.3.1992).

Commenting on the problem in West Bengal, police sources say: "Getting a conviction is even harder. Sometimes months of police work goes up in smoke as an arrested drug lord is quickly released on bail ... Nor is the state government interested in preventive detention for drug-dons." (The Telegraph: 24.11.1991) Is it the right thing for the State to be given Draconian powers like preventive detention even on this issue? The government, more inclined to satisfy voter-pressure is in no position to put a check to demand, simply because it has no effective method of containing supply.

Are Drug Dealers above the Law?

How the drug dealers are given time to vanish while the government dithers can be gauged from the following: Two of Bombay's most notorious drug dealers were allowed to escape when the office of the Secretary (Preventive Detention) passed an order saying: "There seems to be no likelihood of repeating the alleged activities in future by the proposed detenus" (Times of India: 26.12.1991). That a bureaucrat should go so far as to assure the good behaviour of criminals he should hardly know, only shows how far the sticky tentacles of the city's drug lords reach. The orders referred to ARMS and BVT who jointly ran a drug storage operation on behalf of large scale drug traffickers at Vashi until recently. "The proposals for the detention of the two arrested in June 1991 were drawn up by the narcotics cell and recommended by a screening committee comprising senior officials of the anti-corruption bureau (ACB), the Directorate of Revenue Intelligence (DRI), Customs, the Narcotics Control Bureau (NCB), and the city police." (Times of India: 26.12.1991)

Is it not strange that a bureaucrat rules out the likelihood of known gangsters indulging in drug-running? Was a deal struck by someone who pocketed the money? ARMS and BVT had been found in possession of 2 kg of heroin each. As per the Prevention of Illegal trafficking in Narcotics Drugs and Psychotropic Substances Act (PITNDPS) the two could have been in detention for up to two years.

DSK and NK (drug distributors) are equally well known to the police. Both were arrested by the Narcotics Cell in 1991 but managed to escape from judicial custody. One of them at least is stated to have bought his freedom while the other made his escape with the help of a friendly police man!

Smuggling of Drugs from India

"The drug traffickers in India within a span of few months have become one of the major supplier of illegal chemicals which are needed to convert raw materials into narcotics. They supply to drug cultivators in both "golden triangle" and "golden crescent" areas. Intelligence sources disclose that the item which is smuggled out and is in high demand is Acetic Anhydride (AA). This is because from 10 kg of opium and 1 kg of AA the drug processor can churn out 1 kg of heroin. Since the sale of this chemical is restricted in countries like Pakistan, Burma, Afghanistan, Thailand and other opium producing countries, Indian smugglers have become the main suppliers of AA" (Indian Express: 23.12.1991).

India is one of the foremost manufacturers and importers of AA and there is an open sale of this chemical in the market, except on the 100 kms border of Burma and Pakistan. The traffickers buy AA at the rate of Rs.190.00 per kg and the price of the commodity jumps to Rs. 22,000 per kg once it reaches the borders. According to underworld sources the traffickers use a sick factory or an industrial unit in an isolated area to manufacture chemicals. Most of these units are located in Indore (Madhya Pradesh), Gujarat, Uttar Pradesh, Rajasthan and Maharashtra. In fact, many of the pharmaceutical units in the surrounding areas of Indore have been found to manufacture the chemicals. Recently the city police narcotics cell nabbed Indubhai Dhirajlal Seth, a laboratory processor from Ratlam. During interrogation Seth confessed that, on an average, he was supplying over 100 litres of AA from his Ratlam laboratory, to traffickers operating in the vicinity of Taluka Jawra.

Intelligence sources disclose that along with flourishing opium cultivation laboratories to process and churn out AA for other countries are also mushrooming. The main areas where both cultivation and laboratory processing operation takes place are in Uttar Pradesh (Faizabad, Azamgarh, Ghazipur, Barabanki, Lucknow, Rae Bareilly, Bareilly and Badaiyun), Madhya Pradesh (Madsaur, Shahjapur, Ratlam and Ujjain), Rajasthan (Udaipur, Bhilwada, Chittor and Kota). However, according to Indian Intelligence sources, because of political problems in the North Eastern states the traffickers in Burma's Kachin State spotted an accessible route and increased the AA imports from India. With profit margin reaching 700 per cent, the incentives to smuggle AA from India and heroin has become overwhelming.

What is the Indian Government doing to prevent the smuggling of AA which leads to the manufacture of Heroin?

Till recently India was known only as an opium producing country. However, production of refined heroin and brown sugar has started here now. Most of it gets smuggled to Europe and also to USA.

The Enemy within

Until the early eighties, only a trickle of Pakistani heroin routed through Jammu and Kashmir, Delhi or Gujarat and Bombay, seeped into Calcutta (The Telegraph: 24.ll.l991). Today the poppy farmers of Barabanki and Ghazipur and not the Kalashnikov clutching Afghan Mujahideen or the shadowy Karems of Central Burma are the principal suppliers, while media attention is still focussed on the Golden Triangle (Burma, Thailand, Laos) and the Golden Crescent (Afghanistan, Pakistan and Iran).

Rajat Mazumdar, DIG Operations, refutes theories of the foreign hand and instead points towards the Golden Quadrangle "The threat is from within ... of the smack seizures in the last three or four years, 95% came from the Benares, Ghazipur, Lucknow, Barabanki areas." he says. Heroin is stockpiled in Lalgola. Murshidabad, Hoogly and also Santoshpur, Howrah, Kharagpur and Burdwan, from where it flows into Calcutta. Dr. D Mohan, Head psychiatry department, AIIMS says "what awaits us is absolute disaster. We have enough opium in India, enough expertise to manufacture our own heroin. We are in it already. The illicit heroin manufacture which is happening in Bihar is almost indigenous. Five years down the line when it gets into the rural population we will be in a mess". It has been suggested that a strongly advocated crackdown for "total destruction of all cultivation of opium, poppy, coca leaves and hemp plants" be undertaken. But how successful have the UNFDPC aided crop substitution programmes been? How many farmers have been lured away from growing the highly profitable drug crops? "There is an anarchy of intellectual corruption, financial corruption and administrative inadequacy. If the United Nation's Fund for Drug Prevention Control gives you US $80 million they are not giving you this money because they want you to get any better, they are giving it to you, because they don't want you to export the problem to them. Why can't we kick the UNFDPC in the ass? Show us one country in which your programme has succeeded. If it has then please stay. The point is, it hasn't, so please go home" says Dr. D Mohan angrily. The likely ecological effects of any technological eradication of coca or cannabis plantations (hemp) could also have been discussed. Cannabis is a very sturdy plant capable of widespread and fast propagation, particularly in dry areas. In the Kazhakistan republic of the erstwhile Soviet Union, a State farm cultivated cannabis for a couple of years for production of hemp fibre more than two decades

ago. By July 1991, wild cannabis had covered 130,000 sq km of arid land and was threatening a total area of 600,000 sq km. Much of the cannabis on and along the Himalayas is the result of the plant's capability for propagation." (C.Chakrabarty – Director General Narcotics Control Bureau. The Statesman: 30.1.1992).

Punishment for Vexation, Entry, Search, Seizure or Arrest

Any person empowered under sections 42, 43, or 44 of the NDPS act is liable to be punished with imprisonment for a term which may extend to six months or with fine which may extend to one thousand rupees or with both if he:

1. a) without reasonable ground or suspicion enters or searches or causes to be entered or searched, any building, conveyance or place.

   b) vexatiously and unnecessarily seizes the property of any person on the pretence of seizing for any narcotic drug or psychotropic substance or other article liable to be confiscated under this Act, or of seizing any document or other article liable to be seized under Sec. 42 , Sec 43 or sec. 44 or

   c) vexatiously and unnecessarily detains, searches or arrests any person.

2. Any person wilfully and maliciously giving false information and so causing an arrest or a search being made under this Act shall be punishable with imprisonment for a term which may extend to two years or with fine or with both.

Comments: This section makes provision for punishment for vexatious entry, search, seizure or arrest made under the proposed law.

PERSON – The word "person" has been used to make it clear that in order to exercise the powers of a controller under the Act, the statutory functionary has to be duly appointed by the Government and that he is persona designata or designated person. (NDPS Act 1985- p. 34w)

NDPS Act As An Excuse For Police Extortion

Notwithstanding the above sections, the police continues to harass innocent people in the name of search and seizure. The drug trade continues to flourish evidently with help from the police (Sunday: 29.12.1991).

"There are at least five major drug traders operating out of Calangute, about 15 km from Panaji, Goa. They have been doing so for several years without any

interference from the law. Yadram Dhuria, Inspector General of the Goa Police confesses that no big time dealer has fallen into the police's net."

"In their bid to enforce the laws associated with the NDPS Act policemen in Goa seem to have gone overboard. In many cases, innocent people, mainly tourists are being rounded up and released only after they have coughed up a healthy amount of cash.

Such actions on the part of the police has led to speculations that they may deliberately be out to catch small time drug dealers while turning a blind eye to the big fish. An interesting statistics which adds credence to this speculation is that 90 % of the arrests made under the act deals with possession of amounts of less than 50 gm of narcotics. In several cases, arrests have been made for possession of less than 10 gm. Trifling amounts that hardly come to anything in the big bad world of the drug trade". This highlights that there should be a distinction between small time pushers-cum-users (who use it for survival), and the drug dons. The drug users should be rehabilitated while the drug dons should be behind bars.

"The police have been accused of planting drugs, especially on foreign visitors and whimsically registering or dropping cases, depending on the financial means of the accused to provide them with a 'consideration'." One of the better known cases is that of AB who was arrested for possession of 2.16 kg of hashish in October. AB claimed that he was framed by the police due to a personal beef with one of the arresting officers. The police claim that AB was arrested fair and square and a sackful of drugs found on him. Still claiming that he was framed AB has gone on a hunger strike to seek justice" (Sunday: 29.12.1992).

Police, Lawyer, Judge Nexus

Peter D'Souza, a leading narcotics lawyer alleges that there is corruption in all branches dealing with the law – the police, lawyers and even a few judges. This is more so as under the NDPS Act some offences are bailable and policemen have been taking advantage of the situation. "The police have a fairly slick modus operandi. An arrest would be made and the suspect remanded to custody. The police would recommend a lawyer telling the suspect that this was his only hope of acquittal. Meanwhile, the police would carry out a thorough background check ascertaining the suspect's financial status. At this stage the lawyer would tell the client that bail could be arranged for a consideration – an amount usually pegged between Rs. 40,000 and 70,000. The entire amount of course would be divided between the lawyer and the policemen, leaving aside Rs. 10,000 as the real bail money" (Sunday: 29.12.1992).

On condition of anonymity, a senior state minister admitted that several cases where innocent foreigners had been implicated have come to light, yet the government refuses to rein in the police. (Ibid).

News items regarding arrests of persons carrying small amounts of narcotic drugs appears frequently in the press. One hardly reads about any big drug dealer being arrested. Corrupt officials harass the small drug user and shield the big time drug dealers.

* The Chandni Mahal police arrested one MJ and recovered l kg of charas from him. He was booked under the NDPS Act (Indian Express: 12.11.1991).

*DR was caught with a kg of opium on him, the man, "the police said was a vagabond. The man was waiting for a city bus" (Indian Express: 3.12.1991).

* MK was arrested for allegedly being in possession of five and half kg of charas. He was nabbed from near a railway crossing and arrested under NDPS Act (Indian Express: 28.ll.l991).

The public has a right to know how many kingpins have been punished under the law; as also the number of policemen/personnel of enforcement agencies, involved in extortion.

The NDPS Act states that:

> (1) When any addict is found guilty of an offence punishable under Section 27 and if the Court by which he is found guilty is of the opinion, regard being had to the age, character, antecedents or physical or mental condition of the offender, that it is expedient so to do, then notwithstanding anything contained in this Act or any other law for the time being in force, the Court may instead of sentencing him at once to any imprisonment, with his consent, direct that he be released for undergoing medical treatment for detoxification or de-addiction from a hospital or an institution maintained or recognized by Government with or without sureties to appear and furnish before the Court within a period not exceeding one year, a report regarding the result of his medical treatment and, in the meantime, to abstain from the commission of any offence under Chapter IV.

This section empowers the convicting Court to release an addict offender after admonition and on probation for undergoing medical treatment for detoxification or de-addiction. (NDPS Act 1985 - p.26-27) But how effective is its implementation? According to a report published in 'The Telegraph' - 24.11.1991:

Dragging a drug addict to a detoxification centre is all very well. After a month's treatment an addict is 'thrown out'; the monkey is off the addict's back, but his mind is craving for the drug. More often a patient drifts back to his old haunts, his old friends. Sometimes, he has no where else to go ... Simple de-toxification does not help permanently. 85% of our patients return within a year; 50% return after 4 or 5 months. According to a WHO Report, drug addiction is a no-cure disease and the success rate enjoyed by most detoxification centres is 4%. Even if facilities exist for all, the results are no different.

It is argued that unless the basic problems are solved, the environment altered, no amount of detoxification will help the drug dependent to regain his inner equilibrium. But can the environment be altered, or should the drug users attitude to the environment be altered? Should not s/he learn to cope with earlier environment? Perhaps this should be the focus of treatment.

While detoxification centres are sprouting, there are very few counselling or rehabilitation centres. As per the Annual Report, 1990-1991, of the Department of Welfare, Ministry of Welfare, Government of India, the following are the programmes for providing services for treatment of drug dependents:

No. of Counselling Centres	–	112
No. of De-addiction Centres	–	44
No. of After-Care Centres	–	10

Estimated Drug-Users:

Heroin	–	1 million
Opium	–	2 million
Cannabis	–	Several million

Cases disposed off under NDPS Act (1987 -1991):

Total cases	6,492
Convictions	2,272
Acquittals	4,220

Special Courts Created only in Maharashtra, West Bengal and Manipur.

Former drug-users have problems in getting job-placements, because of the stigma attached to drug-users. Some of the employees tend to overlook the dependency problem on humanitarian grounds. The draw-back of this policy is that no attempt is being made simultaneously towards de-addiction of this person. There is no rationale, however, in refusing job/employment to recovering drug-

user. Innumerable examples can be cited where former drug users are usefully working and not just as counsellors in the detoxification/ rehabilitation centres all over the country. The Chemical Addiction Information and Monitoring Treatment and Recovery Centre (CAIN) in Bangalore was founded and run by former drug-users.

Who Benefits by Treatment – The Rich or the Poor?

A report by Professor J Mandal of the Department of Applied Psychology, University of Calcutta, is a grim reminder that the city's under-privileged is likely to go without treatment, the middle and upper income groups, educated with access to treatment facilities and the obvious targets of the anti-drugs campaign, could well win the war. For the illiterate poor, scrambling on the edge of existence in the city's sprawling slums, there may be no hope. Few families from the low income groups can afford the expensive detoxification and the psychiatric treatment required. Far fewer are aware that treatment may be necessary at all. Though Dr. Mandal found 4% of the 68,000 drug dependents in the city to be females, but very few women came forward for detoxification/counselling. But then, women in our society are expendable.

But in the opinion of Dr. Yusuf Merchant, it is the poor who are quickest to recover because they are the ones who have hit rock bottom both financially and emotionally. A former drug-user agrees:
"the poor are the ones who realize that drugs never solved any of their problems. And unlike rich people, they don't have the security of a job or money to fall back on" (Sunday: 9.2.1992).

ABVA feels it is the quality of the programme of recovery in a centre that is important, rather than the economic status of the drug user. Also, increasing the number of centres will not achieve the desired results. What is needed is to use the available funds on preventive activities; educating the masses on what the process and consequences of drug use is all about, as also the disease concept of drugs. Since the urge, once indulged, stays for life. Prevention, rather than cure, should be looked into.

Armed with the NDPS Act, the police continues to harass drug users while establishing links with the big tycoons of drug dealers. The newer Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act passed by Parliament in 1988, has also become an instrument of exploitation of the otherwise marginalized and socially condemned groups. The socio-economic and political system that breeds drug-use needs to be changed.

CHEMICAL DEPENDENCY
NATURE AND TREATMENT

Disease Concept

In 1964 the WHO expert committee on addiction producing drugs recommended that the term "drug dependence" should be substituted for both "addicts" and "habit". The various drug dependencies are a group of diseases with some common features. However, contrary to popular belief, it is not a unique or special disease, in the sense that it possess characteristics that are not unusual from other diseases.

Chemical dependency l. has a cause. 2. It has specific signs and symptoms 3. has a natural history and course 4. has an outcome 5. may or may not have treatment 6. recovery may or may not be possible 7. relapse is likely to occur if not treated properly or appropriate treatment is not followed.

Drugs used for non-medical purposes are often classified as hard and soft. Though there is no clear cut line dividing the two groups. Heroin, cocaine, morphine and its analogues are considered as hard, and substances like alcohol, tobacco, cannabis are considered soft. Hard drugs are more liable to seriously disable the individuals functioning in society. Even a "soft" drug like alcohol can significantly impair a person's interactions in society. However, society accepts the consumption of alcohol as part of normal living. Once a person becomes an alcoholic he is in no way different from other chemically dependent individuals. ABVA has therefore, tried to give details of the disease process of alcoholism, to have an understanding of the whole process of drug dependency.

Alcoholism

Alcohol intake at a random non-describable pattern is known as social drinking. This may be for social events, rituals, religious ceremonies and other such functions. If there is a set frequency and that frequency is measurable, then it is not social drinking. When there is a deliberate appointment with alcohol, and a pattern emerges, then the individual has reached the stage of purposeful drinking.

Social drinkers who can function without any problem are labeled to be drinking without dysfunction. It is assumed that this is not a problem stage. However, in the progression of the stages of alcoholism, dysfunction at a social, economical, occupational, physical or family level may not occur till the last stages. Therefore, it is essential to be aware that though the alcoholic is one whose

drinking causes trouble, he is also the person who is on the road to developing trouble on account of his drinking pattern.

Dr. EN Jellnick researched with two thousand alcoholics and came up with the following phases of alcoholism:

Controlled, Social, Cultural drinking: This is how it starts, because without alcohol, you cannot become an alcoholic. It is drinking which is random without purpose and without trouble.

Occasional escape drinking: means purposeful drinking to relax. Has a pattern and definite reason.

Frequent escape drinking: This phase also begins without much notice. It's pattern is more frequent.

Early alcoholic phase: Starts when the first "black-out" occurs. When an alcoholic does some activity fully and consciously but later on does not remember it at all it is called a "black –out".

True alcoholic Phase: Occurs over a period of time, during which the capacity to drink increases and pre-occupation about alcohol develops. In this phase appearance, home, job, relations and possessions are neglected.

Complete Alcohol Dependence: Morning drinking and continued drinking takes place to avoid withdrawal.

Last Phase: Thus enters the last phase, where social, medical and psychological help must be given to alcoholic or he will die.

Social Drinking
Problem Drinking
Alcoholism
Death

Who is an alcoholic?

While there are numerous definitions of an alcoholic, a few simple ones are listed below.

1. Anyone whose drinking causes problems, it is a problem (Fr. Martin)

2. Anyone who uses an alcoholic beverage that causes any damage to the individual or society or both is an alcoholic.

3. The alcoholic is one who continues the use of alcohol in the face of adverse consequences, physical harm, legal or financial problems, difficulty in school or work, or in relationships.

Features of the Disease

It is beyond the control of the alcoholic to stop. He may manage to abstain temporarily, but recurrence is always sure if the disease is not treated properly. The disease progresses, to deteriorate from early to middle to late stage and finally terminates in death if untreated. The disease affects family relationships therefore, it is a family illness and one which destroys families.

The diagnosis of alcoholism is made primarily by obtaining a history or a drinking pattern, that is predominantly, not social drinking. Eliciting a history of any consequence that results from this, non-social drinking pattern reflects the seriousness or the degree of alcoholism.

The following represents the non-social or pathologic use of alcohol:

1. Preoccupation – With alcohol or the next opportunity to drink.

2. Gulping drinks – Usually drinks a double or downs first a couple of drinks rapidly.

3. Increased tolerance – Drinking much more than others and still functioning relatively well.

4. Drinking alone – This includes drinking in bars, but alone.

5. Use of alcohol as medicine – For relief of tension or anxiety or as aids to sleep.

6. Black-outs – Drinking sufficiently such that the next morning brings amnesia for some of the events of the previous evening.

7. Secluded bottle – Having a bottle hidden in the home or somewhere in case a drink is needed.

8. Non Pre-meditated drinking – Drinking much more than planned or drinking differently from what one had planned.

9. Morning tremors – Fine tremors of fingers from over indulgence.

10. Morning drink – To help one get hangover.

If four or more of the ten criteria listed are fulfilled, this constitutes pathologic or non-social drinking and a positive diagnosis of alcoholism.

DRUGS

The consumption of drugs falls into three categories. l. Drug use 2. Drug misuse 3. Drug abuse.

Drug Use – There are medicinal drugs for different purposes, that is, substances which will alter the function of the body or its structure so as to help in healing. This is a socially permitted and acceptable feature of society.

Drug Misuse – The use or experimentation of a drug may start when a person believes that a drug can solve problems which in reality it is not capable of solving. Drug misuse is the taking of a drug for the purpose of fulfilling a need other than what the drug is capable of doing in the form of medicine for example, taking Amphetamines to improve athletic qualities, taking dexedrine to help study longer, taking alcohol or hashish to improve one's social personality and several other such misuses. These hoped-for reactions are beyond the powers of the drug being misused.

Drug Abuse – Drug abuse, therefore, is a repeated misuse of drugs. Usually it is from a never ending need for euphoria. A constant search as to how to deal with the pain of reality and the frustration of everyday stress.

There is a curious tendency among some researchers to give frequency limits in order to define drug abuse, use and misuse. The frequency limits vary from drug to drug and person to person. In other words, if an experimenter is someone who uses only four times a month and a user is someone who uses 4-9 times a month, then does using four times a month give you a better or worse category. The major focus is to look at drug misuse and abuse as a continuous process, as one leading to the other.

Often the term habit is employed by the professionals in the field and the family members to describe the alcoholic or drug dependents use of his choice of chemicals. In social terms, people have a habit of exercising in the morning,

drinking milk before sleeping and other such habits. These activities all possess a regular pattern and do not necessarily cause a person bodily harm. In the problem with drugs, a habit means something similar. It is a regular pattern and the individual shows a psychological need to use the drug. If the desire is not fulfilled, the person does not necessarily go through a withdrawal symptom or does not keep using higher and higher amounts of drug. Habituation is thus known as psychological dependence. It is not without a cause for fear in the area of drugs because it may be the first step towards the physical dependence.

Physical dependence is recognized by 1. Psychological desire to use the drug 2. Physical withdrawal sign, if the drug is not taken. 3. Tolerance which means needing larger and larger doses of the drug. 4. A repeated tendency to restart using despite periods of staying off drugs.

From a long time it has been widely discussed that individuals with some type of personality or type of character are more prone to develop addiction. It has been associated with a number of features and various studies have been conducted in this area. There have been researchers, who declared anxiety prone individuals, introverts and neurotic persons who fall prey to drugs. However, other studies show that the extrovert, out-going persons may be more likely to develop addiction! Thus it is quite clear that there are conflicting reports about the pre-drug features of a drug dependent. Hence, anyone is capable of developing dependency to drugs. The addictive personality is considered to be a post drug feature. The personality development of the drug dependent also gets retarded owing to problematic, social and living conditions.

The symptoms of drug dependency

1. Character Change - The person shows personality Shifts. He withdraws socially, becomes rigid and unpredictable, may change friends.
2. Black outs- Functions under influence of drug, but has no recall or memory of the total event.
3. Changes in use patterns -Changes own rules and schedule to accommodate drugs.
4. Preoccupation - Keeps own supply plans the whole day around the chemical.
5. Physical problems - Problems with health not identified with use. Hangover or withdrawals, long range effects like liver damage, malnutrition, and psychosis.
6. Sneaky behavior - Hidden supplies and plans ahead to maintain supplies.
7. Loss of control - Loss of choice. Use of the chemical becomes primary, despite consequences.
8. Defensive postures - Rigid personality. Overdoes things, denies anger.

9. Tolerance - An increase in tolerance. Gradually uses beyond his financial capacity.
10. May use alone - Even drug peer group is shunned.

An individual who is dependent on heroin and forcibly kept off the drug will develop severe withdrawal symptoms. During the first 8-16 hours of abstinence the person develops nervousness, restlessness and becomes anxious. Soon he will start yawning frequently, sweating profusely, develop running of the eyes and nose as if he is having a severe cold. He will get severe twitching of muscles (the origin of the term 'Kick the habit') within 36 hours and painful cramps develop in the backs of the legs and in the abdomen, all body fluids are released copiously with severe vomiting and diarrhoea. The person cannot fall off to sleep and his breathing becomes rapid. The symptoms reach their peak in 48 to 72 hours. There are a large number of other subjective symptoms. It is agonizing to go through these. Abrupt withdrawal is therefore inhuman if these symptoms are not treated. A treatment of the dependent should therefore be planned out carefully by experienced and trained personnel.

Treatment

There appears to be a growing confusion about what treatment in the field of chemical dependency is all about. Treatment has come to mean seeking employment for the dependent, occupational therapy, arranging matrimonial alliances for them, providing food and shelter, chaining and physically abusing them and even funding them! As a consequence of this belief, treatment centres have turned into employment agencies, matrimonial programmes, torture chambers or funding agencies. Predictably enough, none of these methods have even remotely succeeded. Treatment in this field is a highly specialized affair requiring special training. It should include a screening process, a residential and internship period. A treatment programme is rich, diverse, creative and a spiritual experience.

Treatment Programme: Components and Protocol

1. Complete medical evaluation: Each patient is examined and evaluated by a physician or medical consultant upon admission to the inpatient programme. Assessment includes a history of acute medical, emotional or social problems. The family is also interviewed to provide additional collaborative data.

2. Detoxification is not merely admitting a patient into a nursing clinic and loading him with sedatives. Detoxification is most safely accomplished in a hospital setting under the care of a treatment team. Appropriate medications are used, which reduce the withdrawal symptoms. Detoxification also includes a

method for patients to examine the meaning of dependency and reach some level of identification of the disease which they can later transfer into action.

3. In-patient Programme: The main emphasis of an inpatient programme should be directed towards rebuilding of a life, free from alcohol and drugs. Length of inpatient programmes vary from centre to centre and according to the recovery process of each patient. The Programme should be able to provide an environment for the patient to be involved in a therapeutic community experience on a daily basis. The structure of the programme should include lectures, films, tapes, treatment plan, psycho-socio sexual history and nurturing processes which cover the physical, emotional and spiritual aspects of the disease.

Patients will enter a group therapy programme which is held on a consistent basis. Personal experiences are shared in order to enhance each patient's understanding of chemical dependency as a disease. A group approach of feedback, confrontation and validation is emphasised, so that each patient can overcome feelings of isolation, abandonment, anger, guilt and shame, which are so common in this disease.

Alcoholics Anonymous and Narcotics Anonymous (AA/NA): Each patient attends AA/NA meetings regularly. The purpose here is to help and get a better understanding of these two fellowships and build the foundation for their involvement in a long term recovery programme.

Outpatient: An outpatient treatment programme should be considered for those who are in the early course of the illness and are free of medical and psychiatric disorders. Other factors which support an outpatient treatment include motivation, employment, support of family and other social networks, the ability to discontinue alcohol or other drugs outside a protected environment.

After care: A six month – one year follow-up at the centre is meant to provide the basic for the patient once he is away from the in-patient programme and help the transitory process. Usually it comprises weekly sessions for individuals and groups.

Co-dependency treatment: meant for the family as well as others who are involved in the life of the dependent (it could be friends, relatives, colleagues or employers). This is one of the most neglected areas of treatment and one which requires a special looking into. Since chemical dependency is a family illness, the family needs equal amount of healing and nurturing process. The purpose of this treatment is to help those involved with dependents to deal with their pain, lower their defenses, experience some positive feelings and accept responsibility for

their roles and behavior. The involved people should be made aware and educated on the disease concept of chemical dependency.

Women's programme: Most treatment centres in India do not seem to have recognized the need for a specialised programme to deal with women dependents. Chemically dependent women face issues such as those of self-image, divorce, separation, male dependency, anger, guilt, marital problems and single parenting.

Treatment Team: Chemical dependency counselling cannot be accomplished by one individual alone. It demands team work. An ideal team should include therapists, counsellors, doctors, recovering individuals and social workers. A well-knit team ensures a treatment approach tailored to individual needs rather than being tied to any particular professional stand point.

Relapse: Relapse is "a return to a former condition of illness after partial recovery." Relapse for the alcoholic or drug dependent does not begin with the first drink or drug he or she takes. Relapse begins on recognizable changes in behavioural characteristics which reactivate old patterns of resentment, denial, stress, isolation and impaired judgment. A relapse is neither a mark of defeat nor evidence of moral weakness. It is a mistake anyone could make without sufficient understanding of themselves. Preventing relapse means treating the components that help initiate it. For example, recovering individuals can learn to recognize harmful personality traits. One effective way is to go through the fearless and moral inventory suggested by AA. A programme of self-exploration and learning from others who are also recovering from addiction.

Understanding how personality, thoughts, feelings and actions may lead people back to a dependence can save them from that traumatic experience from time to time. (The Caron Foundation USA, Research Material).

Alcoholics anonymous and narcotics anonymous

Alcoholics Anonymous officially dates its beginning to June 10th 1935 and was founded by two alcoholics, Bill Wilson, a New York stock broker and Dr. Bob Smith (A Medical practitioner). Narcotics Anonymous was founded by a group of recovering drug dependents. Both these fellowships serve as a vehicle of recovery for thousands of people drawn from different communities, castes, races, religion, socio-economic and cultural backgrounds from all over the world. They are the oldest currently accepted methods of helping alcoholics and drug dependents.

What is AA/NA? They are informal fellowships of men and women who have discovered that they cannot control the use of alcohol or any other mind

altering chemicals. Thus they have joined together in an environment of mutual bonding to share their experience, strength and hope with each other. They provide help to anyone else who may turn to these fellowships to achieve sobriety.

AA/NA has no connection with any religious sect or denomination or any other cause or group. They charge no fees, the only requirement for membership is a desire to stop drinking or using. While they do not go by any rigid norms, they do have a minimum of organization and guidelines.

Meetings: The fellowship meeting consists mostly of talks to share the experience of fellows in achieving sobriety. The meeting place offers a non-judgemental setting with no obligations imposed on its visitors. All sharing is informal and voluntary. These meetings foster emotional arousing and hope, not by threat or blackmail but subtly through unconditional acceptance. Underlying everything that is said are the 12 steps, the prescription for recovery.

Meeting format: While the meeting format is same regardless of country, race, caste or creed, there are varieties of different structures to meetings. For example, discussion meeting, open meeting, step meeting, speakers meeting, and closed meetings. The consequence of this universally appealing format is that even in a strange city or country, members can go to a meeting and feel at home.

Al-Anon and Al-Ateen: For relatives and friends of alcoholics, there are two related, yet independent fellowships. Their purpose is to offer those whose lives are intimately entwined with chemically dependent individual with a source of support through others who have successfully handled the same problem. People are welcome to Al-Anon and Al-Ateen regardless of whether the dependent in their lives is participating in the AA/NA programme. Frequently family membership in the Al-Anon and Al-Ateen group can be a prelude to the dependent taking the first important step towards sobriety.

Co-Dependency

Co-dependency is one of the most significant psychological concepts of the twentieth century. This concept seems to have emerged simultaneously in several different treatment centres in Minnesota (USA) during the late 70's. It has had several definitions to its credit, with each definition describing only a part of its actual meaning, thus giving rise to considerable confusion. In an attempt to allay the confusion 22 professionals in the addiction treatment field gathered together in Arizona and came up with a consensus description of codependency. "Co-dependency is a pattern of painful dependency on compulsive behaviour and on approval from others in an attempt to find safety, self-worth and identity. Recovery is possible". (Co-Dependent No More: Melody Beattie, l987.

Understanding Co-Dependency: Sharon Wegscheider-Cruse and Joseph Cruse, 1990)

Co-Alcoholism

As people progress into the disease of chemical dependency it is most normal for the spouse to become increasingly pre-occupied with the behaviour of the chemically dependent. In alcoholism this pre-occupation is called co-alcoholism. For the children in the family, the combination of alcoholism and co-alcoholism results in neither parent being responsive and available on a consistent basis. Consequently, children are affected by this abnormal family dynamics.

Professional Enablers

When a chemically dependent individual is prevented from experiencing the consequences of his behaviour then, the persons who help the individual in this are known as enablers. Many professionals unwittingly fall into the trap of enabling, they may be the psychiatrist who prescribes tranquilizers to the dependent who complains of anxiety or the supervisor at the workplace who delays taking action for fear of disturbing the status quo.

Roles of Spouse and Children

The people involved with the chemically dependent, usually adapt certain roles which they think will help the chemically dependent to get into recovery but which actually worsens the situation.

The Protector: Plagued by guilt about the inability to help the alcoholic, the spouse takes on the role of the protector. For example, by paying debts, making excuses on behalf of the alcoholic to the employer. In this manner the spouse protects the alcoholic from the consequences of drinking.

The Controller: Makes unconscious attempts to control the alcoholic. Methods include buying liquor, hiding bottles, cancelling social events where liquor is served and assuming all responsibility of family finance.

The Blamer: Projects feelings of fear and failure on to the drinking partner. Gets into a cycle of blaming, attacking and sarcasm.

The Loner: The spouse is locked into a self-defeating pattern of relating to others. The roles of the loner include: The super-parent, the self-righteous and the martyr.

The Children: Assume certain roles which they take up voluntarily or are forced on them.

The Responsible Child: The oldest or only child becomes the responsible one in the family. For example, this child looks after the younger siblings, takes care of the alcoholic parent, and other responsibilities.

The Adjuster: This child is usually the middle or the younger child. The youngster finds it easier to simply follow directions, adjust to any given situation of the day.

The Placator: This child is sensitive to other people's feelings and is very easily hurt. Most of the placator's years are spent in trying to fix the sadness, fears angers and problems of brothers, sisters and parents.

The Acting Out Child: These children often display delinquent behaviour which symbolizes the state of the family. In doing so, they provide distraction from the issue of alcoholism.

Unwritten Rules in an Alcoholic Home

Don't talk – children of alcoholics never talk openly about the situation at home and when they do, they experience a sense of betrayal. Their loyalty makes them rationalize their parents' behaviour.

Don't Trust: Children find it difficult to trust their parents when the parents are not consistently available to them, because they are drunk or emotionally and mentally preoccupied with alcohol or the alcoholic.

Don't Feel: The environment at home teaches children that it isn't safe to share feelings. As a consequence of the belief that their feelings will not be validated, they learn to deny or suppress them.

Conclusions

Obviously chemical dependency is not a disease of an individual in isolation. It is a family disease. Those individuals who do not fall into the traditional family systems will affect persons and groups around them. Support for any chemically dependent individual can come from all persons/groups who share a concern for the individual whether they belong to a family or not.

The treatment patterns outlined in this report draw heavily from those followed by the Alcoholics Anonymous and Narcotics Anonymous. This does

not mean that there are no other working programmes. It is only that ABVA's interactions were predominantly with these groups.

In writing this report ABVA has borrowed freely material from the following books and notes:

1. *A Layman's Guide to Alcohol and Alcoholism* by Dr. Jayant Malhotra.

2. *A Layman's Guide to The Smack And Drug Problem* by Dr. Jayant Malhotra.

3. *The Treatment of Alcoholism* by Edward P. Nace.

4. *Another Chance* by Sharon Wegscheider.

5. *The Caron Foundation Treatment Manual* – The Caron Foundation.

6. *It Will Never Happen To Me* by Claudia Black.

7. *TTK Ranganathan Institute Notes*.

8. *Clinical Pharmacology* by DR Laurence.

CASE HISTORIES

ABVA spoke to several recovering as well as chemically dependent persons undergoing treatment. ABVA has also excerpted some stories from popular magazines. There are more stories of recovering individuals than those currently in dependency, this has been done deliberately to give a clearer and more accurate picture of life under dependency. Initials of individuals have been used instead of their names to protect their identity.

Starting Young

"I had my first drink when I was six years. From the time I was eight, I had started sneaking liquor from my father's cabinet. It didn't occur to me for a moment that it was odd. It just made me feel good, comfortable. I didn't like the taste, it was just to get that 'buzz'. This carried on, twice, or thrice a week.

I started on pills when I was thirteen. I took it out from my father's briefcase, something called Vesparax, he used to take to sleep. It really made me feel good, like I could handle the world. I didn't need to feel scared. I was really frightened of my Dad, he was always yelling and screaming, beating us up. I used to hate walking into my house. I used (pills) to shut the noise out. It was a big relief. I was going to school, I had behaviour problems, but I didn't know what normal was -I had never known a life without using. I developed a dual personality. There was this 'devil may care' attitude on top. Inside of me, I was petrified, lonely and I didn't know who to turn to. By nature I was shy, but when 1 used, the shyness went away. At 16, I went to the first of my psychiatrist trips. They did some stupid tests on me – knocked my knees, saw my arms, saw my eyes and said that l was not using drugs. I laughed, I'd got away with it.

Then, I went heavily into Mandrax. I was in college and was drugged all the time. I had to drop out. I never thought I shouldn't be using drugs – all my life I'd used them. I thought I'd die if I didn't. I joined another college and graduated. I stopped using Mandrax and got on to Valiums and I thought I was fine. From that day till the age of 32 when I went into treatment, it never crossed my mind that I had a problem. On my wedding day I was drunk out of my mind. Nobody knew because I could handle it so well. So, I was Valiuming it and I was living my life. I'll tell you what it cost me. From the age of 16, I would wake up every day and pray to God to take me. It didn't happen. I used to write, play basketball, I lost all that. I became wild. I went in and out of relationships. Even today, I can't talk about love or commitment. Whatever, I've wanted in life I've actively destroyed it, my marriage for instance. To this day my addictive patterns

begin running to self-destruction. I lost my memory – used to have a terrific memory. I don't remember large parts of my life. Life wasn't much fun. I just remember feeling pits. I was always down, depressed and to get out of that I was doing wild things. A feeling I never knew was – peace. I had zero self-confidence. My rock-bottom was when my marriage broke up. I was really traumatised. I thought I was going insane, and that was so frightening. You see, I didn't even know I had a problem with drugs, so I didn't even know what was happening. Those days I was looking for a job. I happened to go to a drug rehabilitation centre looking for one. They did a routine D and A test (Drug and Alcohol history) on me and told me I was an active user. I was shocked out of my wits. I just didn't believe it. Then I went into treatment."

"SM's" Story

"My first contact with drugs, was with alcohol at the age of 13, a glass of beer with few friends on a Diwali. It made me feel good and I enjoyed every happening under the influence of alcohol. I started dry drugs like hash, with a few friend. I stuck on to hash because it did not smell, and people could not make out. It gave me a better feeling than alcohol, it made me think properly and it was cheap and easily available. Then came hard drugs like Tablets, Heroin and Brown Sugar, which was my ultimate chemical of choice. I used drugs because it made me feel good and also made me sort of believe that it can help me in building my future, my relationships, solving my problems like tensions, frustrations, self-pity, resentment and sex.

I was caught thrice by the police, just for a day and was bailed out in the evening. I always got away from the brutality and torture by saying that I am a student, those days, during 1984-1985, it was not a big scene. My only experience was the treatment of withdrawals and rehabilitation. Withdrawals of 72 hours were painful, like the aches, headaches, cold sweats, cramps and most of all, the obsession to have one smoke, when I didn't want to smoke. Anyway, by God's grace I got over it and went to Rehab, where I stayed for two months, learnt how to discipline myself, learnt about certain facts of life and myself. 1 was introduced into the NA programme of 12 steps of recovery which I apply till today. It has helped me a lot, what nobody could do, NA has done it. It is a very simple program which I practice on a day to day basis. And I am away from drugs for the past three years, not only clean, but happily clean, thanks to NA, I also used drugs to escape the facts which I knew about life, like working hard, responsibility of family, dark future I saw because of no qualification, fear of the future, inferiority complex towards people who were better off than me in studies, clothes, money and sports. Resentment towards my family for being poor, for the partiality shown to my other brothers and sisters."

Man, it was Great!

"Hi,

I am an addict, my name is SL, by God's grace and the help of NA, I have been kept away from that first high AS YET. Curiosity was my first leap into a world full of smoke and booze. Coming from a background of Army Officers, alcohol was an accepted factor. My dad after booze in the evenings would be a different person than what he was before he left for office in the mornings and I wanted to know why? My first drink was by stealing – I drank down a glass of raw rum which I had stolen from my dad's cupboard and bang! I blacked out. I had not forgotten the trip. I started looking out for occasions to drink and man, I had to steal more to do so. All this began at a very early age of 11. And within a couple of years I was drinking to be normal – but I could not afford it – the fears of being caught and beaten by Mom (which was always there whenever I did something wrong, had created so much of resentment and complexes since my childhood. So, when alcohol came into my life I thought I was free from problems). To support myself financially was out of the question so was the question of my friends circle. They were a bunch of guys who spoke nonsense but smoked and unconsciously I was attracted to them more than my own family. First smoke I had was in a room of blasting music and some seven guys. The pot was going around, I said NO- full of fears and excitement as to what I was going into. I was obsessed with the idea, but scared. At the third round, my hand went out around the pot – not knowing how to hold it – so my friend (so-called) helped me, a couple of drags - BLUE MOON, I was there! In a world I would never have foreseen and wasn't it beautiful. Each instrument on the stereo playing separately, my mind racing that this was what I've always been looking for. The drug took its toll over the years. I was an average student in class and an outstanding sportsman. I started losing interest in things. I started using people right, left and centre and did not hesitate who it was – family, friends, relatives. Dropped out of college and did not mind it at all. Relationships at home were nil – used it as a guest house and could not communicate with anyone – wasn't concerned about what was going on around me, but drugs from grass in the beginning to hash to coke to acid and stopped at brown sugar. Boozing at times when available. I went into isolation. The guilt of what I was doing, my fears of what was happening to me, for, my resentment towards people, places and things stank. My inferiority complexes, my self-pity were all hidden behind what I would call a facade (drugs). How comfortable I felt at that time till my first detoxification after being nabbed from home, injected, gagged and put into detoxification. When there was no high everything came back and choc-o-block, I could not think but drool on self-pity (What am I? Why me?). Resentment towards my mother, of the past and that without being told showed in and I was damn uncomfortable about the whole deal with life? Who wanted to live in these conditions? Not me! I wanted to commit suicide, but man, no guts. After my first detox, I actually started my see-

saw in life. Took geographical changes, thinking that Calcutta wasn't for me. But I stepped back into town only to use again. I always carried this feeling that nobody can help me in any way and no one can teach me anything. I know it all I can quit on my own, whenever I felt like, but I would not do it under pressure. Always wanted a carefree way of living. I never wanted to be questioned about what I was up to. I rebelled at the thought of authority and retaliation was my first reaction to anything that did not go my way in the house. Of the years that followed, I went to detox. 8 times, to hospitals in Calcutta and Delhi and went to rehabilitation Centre 9 times in Calcutta, twice in Bombay and once in Bangalore. Priests prayed over me, I got prescribed power pills by some Sadhu babas, but no doc or psycho could help me – firstly, I wasn't willing to get help after my second or third rehab. I was kicked out of the house and that was a real humiliation. But none of my emotional black-mails helped at that time. I felt lost – no one or nowhere to turn to. My parents had made it a point of telling all our family and friends not to help. I had to survive. So, I started stealing, cheating and begging at Howrah station in Calcutta. I had lost the battle and had to surrender again. Even though I was given the message of Alcoholics Anonymous and Narcotics Anonymous, I did not pay much heed to it because I thought that I was much better than those addicts. No one trusted me, I had lost trust in myself, not knowing what I would do or say next, I was afraid to be by myself. I was caught on a couple of occasions by the cops, once in Delhi near the "walled city", when I was caught red handed and humiliated and hit by them in front of a crowd of people. Once in Calcutta when I was caught I paid my way through with Rs. 100.00 but these experiences did nothing for me. I was obsessed by drugs and my feelings had turned and left me. Nothing affected me but using. Nothing made sense to me in life, but using. I dreamt; slept, ate roamed around thinking of using only and how to procure money to use. I had come to know a little about NA through the rehabs. I had been to and then could never think that it could help me. But over the years, I hit my rock-bottom and the last time by God's grace I was in the detox, I left my pride aside and got down on my knees and cried out for help and did it with an honest motive. My obsession lifted overnight and I haven't looked back as yet. NA is a fellowship of men and women who share their experience, strength and hope with each other in order to recover. The therapeutic value of one addict helping another. I try and make a meeting a day. I had come to hit a crisis in my life where I was financially bankrupt – this led me to stop and ask for help. But coming into this programme was like my first high. I came into the programme with an honesty, (a desire which came after cleaning out physically). The initial 6 months was at a treatment centre in Bombay. I had an argument with the Director and was asked to leave and those six months I was in a blank cloud. The sequence that followed in my life after leaving and for me to be able to face reality was all God's grace and the help of the fellowship of NA. I try to follow the 12 steps and 12 traditions of NA today. I can see positive changes in my life. I make meetings regularly. I've become a little more patient

with myself and people. Get a little less angry, and am able to keep a good relationship with my family members. I care for them quite a bit. My relationship with myself has improved to quite an extent and with God it is improving on a day to day basis. My resentment towards a lot of people has been taken care of by God. On the whole, communication has improved with everyone and circumstances around me. I am not a saint. I am trying to live this positive way of life today. By God's grace, I have got a job which I've hung onto for the third year running. I am engaged to a member in AA and am planning to get married if God wills, by the year end. I try to do my work honestly and am trying to build my relationships around me. Problems are there daily, but God's grace and the help of the NA fellowship has helped me to cope with the problems (my negativity, self-pity, procrastination, possessiveness of people close to me or my things), but the beauty of the programme is that if I don't give what I have, I will lose it. Praise God."

Police Brutality

"I began with smoking hash when I was just out of school and it continued for 10 years. It had a very good effect and my parents didn't know as I wasn't smelling of liquor. It was very convenient. Though when I tried it for the first time I never thought I would get addicted. I was then smoking it all the time – it was easily available in the Cantonment areas in Delhi where I was staying. In college, I started using pills and there was always '*daru'* at home. Soon I started on brown sugar and in no time, I started getting caught by cops. I had to pay them whatever money I had. I started going to police stations and getting brown sugar in return for some booze. But when they wanted to round up people taking or selling drugs, they would catch me too and beat the hell out of me. If they didn't get money they could do anything. In one incident, I remember there was no mercy. My pleading made them even more annoyed. I had just bought some brown sugar when the police caught and searched me. There were four-five of them. They shaved off my head, took my shirt and put a placard on me saying that I used smack and they kept beating me in that lane. I somehow managed to run, they chased me but I escaped. Cops would pick us up whenever they wanted money, beat us, lock us up. And they're very clever. They wouldn't use themselves. They would just drink. It was cheaper for them. All this humiliation made me want to stop. I was lying, stealing, losing jobs ..."

Cop On A *Charpoy*

"It was about 10 at night, two of us were walking towards a 'joint'. On the way there was a cop sitting on a *charpoy*. He stopped us. He knew where we were going. The funny part was that the cop knew this other guy, he'd caught him before with syringes but had always let him go. This time he kept us there for

three hours. I was lucky, but the other guy was beaten up with a stick. The cop was basically interested in getting a lot of money out of us. He hit us, slapped us around, till we convinced him that we didn't have much money. We gave him whatever we had. ("A" is undergoing treatment in Delhi.)

The Friendly Cop

"A cop caught me and took me to the police station in Hauz Khas. I was scared. But he took me upstairs and gave me one "pudia" – one gram of heroin and said: "take it" for free. WOW! ("P" is a drug user in treatment in Delhi.)

Inhuman Psychiatrists

"Cops can be good or bad. In my experience worse than the cops are doctors and psychiatrists and counsellors. They are supposed to be having a whole lot of degrees and knowing the entire trade. I've been to a lot of them and I've always wondered why do people analyse us so much. At times you fell that you are really not a normal person. There's something definitely wrong with you. You are said to have personality disorders, other disorders, made to do tests. Then I feel that if I go back to using, I am more normal. I've always been affected by the attitude of people towards an addict, the way he's classified, made into a specimen, knocking him here and there to get answers from him. I think that's the worst thing people can do. Best is to treat him as a normal person with a problem. Everyone has problems, ours is with drugs. Even people trying to help us have no respect for us. We have no dignity. It's really dehumanizing." ("M" is a young user in treatment in Delhi.)

In An Asylum for Using

"I've been picked up by the cops and thrown into jail several times on charges of house breaking, peddling, using… Once I was put in a mental asylum because I was sitting for hours on the steps of the Taj Mahal Hotel in Bombay. The hotel people called the cops saying that this guy's not getting up. I was locked up for *5* days, but nobody turned up to take me out, so they threw me in an asylum. I was there for three months. They give you shocks there without food or water in small wards. It was very very painful." ("M" is in treatment in Delhi.)

Recovery is Possible

"I started on alcohol when I 1was 8 or 9. I used to steal from my father's cupboard. When I went to college I started smoking "green" cigarettes (imported coloured cocktail cigarettes). Then I got introduced to grass. Then I switched over to hashish, then to tablets and smack, the drug of my choice. When I was using,

it was for fun. I felt comfortable I could not move around properly in society, have friends, talk to them. I never thought drugs were a problem with me. I took them because I liked them. My job started getting affected. I used to spend hours trying to get the stuff, and so I couldn't give time to work, I was taking loans. I even started stealing. I changed three jobs. Once I was caught and taken to the police station. I was with a friend and the cops knew him. We had nothing on us, but we were forced to admit that we had and that we bought and sold drugs from a certain place. Once the 'Gypsy' police chased my bike. I fortunately hid in a by-lane. I was badly humiliated in both the incidents. At the police station I'd cried, begged that my career would be spoilt, but they hadn't listened. I'd never thought that drugs were such a problem. For the first time I realized it that day. I wanted to give up drugs. I went to a detox. centre four times. I was there for three weeks to a month each time. They would give me tablets to cut my withdrawal symptoms, then counselling, but it didn't really help me because I still hadn't realized why I was really taking drugs. Recovery started for me only when I saw I had no life left with drugs. I had no job, friends, and family discarded me. I had no money. I could suddenly see my future. I got into Alcoholics Anonymous meetings. Those really helped me get an insight into myself, why I was taking drugs. Seeing and listening to other addicts helped me too. They were a constant reminder of my past and what I was like when I was using. I've been in recovery for four months. I feel great. The fear I was living with morning and night has gone. It's a miracle. I think recovery is possible. I'm slowly getting back to mainstream life. I'm really looking forward to it." ("N" Delhi.)

G's Story

"I'm 25 years old. I've been on drugs for the last 10 years. I wanted to stop, but couldn't because for me there was no life without a high. I even cut my wrist once, but I didn't stop. I was once forced by goondas to go to the Ranchi asylum. But I managed to escape on the way. I was put in Tihar jail 20-25 times on all kinds of charges, including an attempt to murder ..."

Getting Pushed Around

"We arc slaves to drugs, so when we go to pushers (or sellers) they tend to play around with us. Even if they have the stuff and you have the cash there are all kinds of ways – they make you wait, ask you to come later, you request, then end up begging, pleading. Once some pushers who didn't like me got together and set the cops on me. I was locked up under section 151." ("O" came to the Capital from Bombay for treatment and is currently in recovery.)

‘Child Abuse’

“I used to beg them (pushers) like beggars. They would misbehave, abuse. They had small children to sell for them. Even these children used such dirty abuses. And I had to suffer them when any normal person wouldn’t.” (“K” Delhi.)

On the Tracks

“N” from Delhi says: “There were fights waiting ... one day I waited 10-12 hours on the railway tracks (to get stuff from a pusher). Pushers used to abuse us, chase us, harass us, beat us, but take money from us and give us empty “pudias” or adulterated stuff. They always had lots of boys around them to protect them from us.”

Naked Exploitation

“I used to go to this pusher in Sarojini Nagar, a chap called Pinky. This was a long time ago, during 1983-1984, when brown sugar had just hit Delhi. Pinky was a thin reedy looking chap, with a slimy aggressive air about him. One of his customers was a very attractive and beautiful girl. I would see her frequently in his room. Pinky derived a perverse pleasure in humiliating her in front of his cronies. Sometimes, I’d catch glimpses of her, nude on his bed and surrounded by Pinky and his cronies. It was obvious that this girl was forced to be gang-raped in order to support her addiction. Once I plucked up enough guts to ask her whether she wanted any help. But she turned her face away. I remember feeling helpless. I hated myself for not doing anything. I hated Pinky and the disease of addiction that brought about all this.”

Election Addiction

“B” 30, of Varanasi. He gives his account: “I was a student at the BHU at a time when the Student Union elections were going on. One of my friends was a candidate. During the elections, my friends gave me cigarettes to smoke. They had brown sugar rolled in them. After a week, I started getting aches which would go away if I smoked. I had also started to lose my appetite. When I told my friends about this, they admitted that they had been giving me brown sugar. But, by then I was already addicted and I had started spending between 30 to 50 rupees daily on the stuff. I continued to take it for two years because I could not function without it. Then I got myself treated at a hospital. Now I’m okay.” (Saptahik Hindustan 1.12.1991)

From the 'Bitter' Half

36 year old "R" from Varanasi, is on heroin for the last four years. His wife says that it was his friends who made him an addict:

"At first, he would smoke only outside, but his behaviour started to worry me. His sexual performance was becoming very poor. He said he was sick but wouldn't go to a hospital. He started to steal from the shop in which he worked and was thrown out. He sold all my jewellery. We had a small son and I was worried because we had nothing left. He had borrowed money from goondas who forced me to have sex with them in return. When I refused, they threatened to kill my husband. This has been happening for the last five months. We spend Rs. 25.00 daily on his addiction. (Saptahik Hindustan, 1.12.1991)

Sold Out

"S" the young son of a maid servant in Calcutta, smoked smack. He had no source of income so he started selling smack on the streets. "Sometimes policemen could see I was selling dope, but I wasn't scared. I was told they would do nothing." "When I graduated to chasing, peddling brown sugar wasn't enough." He borrowed money from his mother, selling off whatever little the family had. When he finally asked for help, there were no vacant beds at the free detox. centre. He was directed to a hospital where pethidine is given out. But after attending the outdoor clinic for a week, "S" never returned. (The Telegraph Magazine: 24.11. 1991)

Chasing On The Streets

"T" 23 and mother of a six year old son, 'chases' every morning immediately after making up. Her husband also uses, so they spend all their money on heroin, selling off their things, taking desperate loans. "T" can't pay for her drugs anymore. So she is on the streets every night; prostitution is the only way "T" can survive the next morning. (The Telegraph Magazine: 24.11.1991)

A Star's Story

While he was at boarding school at Sanawar, Sanjay Dutt gathered marijuana growing wild on the hill sides and rolled his own 'joints'. Then he went on to brown sugar and heroin. "I have done everything ... free basing, cocaine, main lining of heroin. Blowing Rs.l,200 a day on drugs. Initially, it felt really good ... but I lost 8 years of my life." Dutt was speaking at Combat, the International Conference on Drug Abuse held in Calcutta in December 1991. Dutt scored his stuff from peddlers in Bombay, from outside Bandra police station,

while policemen just watched. According to him, "Most of our cops and government officials are corrupt. With their pay, that is only natural. And to do big-time drug trafficking, you need the help of senior politicians." He feels that the government does not realise the importance of the drug problem." (The Telegraph: 2.12.1991)

Life After Drugs

When I first came into recovery, I thought, GREAT. Now, that I've given up drugs and drinking, my problems would be over. Everything would solve itself. I would be this fresh new man rebounding back into my job, back into the mainstream of existence. The reality is that it didn't quite work out that way because that's when my problems, my character defects began to surface. I was no longer numbing myself, no longer shunting my feelings in the deep freeze. The first thing that I was conscious of was a whole range of feelings. Stuff like anger, joy, guilt, shame – feelings I didn't quite know how to deal with or even understand. They were all kind of piling on. I was amazed, I said "OH WOW, what is happening to me ..!" Also my own character defects my sense of impatience, intolerance, my rigidity, my arrogance, grandiosure, time management, and the works. I realized the world wasn't going to run according to my whims that I needed to develop new skills of behaving and coping and dealing in my inter-personal relationships. It wasn't the big things that were bothersome and it's the same even today. It's the day to day aspect of life and living. The minute to minute routine, the getting up in the morning, the structuring of a day without drugs and booze. Earlier all I did was drink or dope me down. Now it meant filling that vacuum. It was a question of living with myself and all those thoughts that seemed to jostle and fight with each other. It was the knowledge that though I had a wide social circle, and still have, that people didn't really know me. I moved around a lot. But didn't make any friends. I'd always been living behind a facade and disguise, unable to demonstrate my feelings. Even now, I have difficulty in showing my feelings particularly when I am vulnerable and it embarrasses the hell out of me.

Magic and miracles are definitely possible in recovery. But there is no magic situation, no easy softer way. It means hard work, following a programme of recovery. Nobody else can do it for you. Only you can do it for yourself. Addiction is a disease.

When I learnt that addiction was a disease and that I wasn't a mad or a bad man, who had to learn how to be good but a sick man getting healthy. I felt a curious sense of relief. I no longer had to blame or hold myself responsible for all that my disease made me do. The lying, cheating, stealing, thieving, and

manipulating. It is nice to know that I am not responsible for my disease but yes, I am certainly responsible for my recovery and accountable for the consequences.

As an addict I do not have a past. When I look at my past it is one big dusty maze of drugs, drugs and more drugs. I also do not have a future. All I have is today, and I want to make the most of it. Once I didn't even have today. In my new lease of life in this rare second chance to live, I am deeply grateful. ("A" is in recovery in Delhi)

The above examples serve as a graphic illustration of the disease of chemical dependence and the painful ignorance of its nature and process. There are the spouses of drug dependents to whom information on how to cope with dependency is not available. And there are many others like them who are thus forced to live with the stigmas, shame and guilt attached to this disease. Then there are the dependents who start by believing that it will never happen to them. In fact a large number of recovering and active drug dependents said 'I can never become an addict.' Yet they all ended up getting 'hooked'. Most people do not realise that it is not just the psyche or the will power which decides the tendency to become a dependent. Psyche cannot overcome the pharmacology of the drug. If a person tries heroin, it can hook him however great his will power. It is a pity that the Law enforcement agencies and the Medical profession, who can contribute to the recovery processes are in fact doing exactly just the opposite.

During the course of preparing this report ABVA came to know of the following centres for detoxification and rehabilitation from the recovering dependents.

SAHARA HOUSE
E- 453, Greater Kailash-II
New Delhi 110 048,
Phone: 6421593.

ITK HOSPITAL
TT Ranganthan Clinical Research Foundation,
54, 4th Main Road,
Indira Nagar,
Madras 600 020,
Phone:418361/417528.

CHEMICAL ADDICTION INFORMATION MANAGEMENT (CAIM) FOUNDATION
318, 15th Cross Road CAIM,
Sada Shiv Nagar, 12 km Bannerghatta,

Bangalore 560 080 Hulimavo Village,
Bangalore - 76.
Phone: 640075.

KRIPA FOUNDATION
81A, Chapel Road,
Mount Carmel Church,
Bandra (West)
Bombay 400 050.
Delhi Phone: 37922898/3792898.

Most of ABVA's documentation and personalized testimonies are of individuals who are either following a recovery programme or are undergoing treatment in various centres in India. That they are mainly people from the middle or upper income groups is possibly an indication of the fact that treatment of or information about the disease has failed to reach the slum dwellers and the poorer classes in a significant way. In any case, few families from these groups could afford expensive detoxification and psychiatric treatment. The obvious shortage of stories from women dependents could also be a comment on the status of women in our society in general, and in particular on the social and moral stigma that prevent women dependents from seeking help and getting into recovery. As Dr. Satrujit Dasgupta, a psychiatrist at a detox. centre in Calcutta points out: "Very few patients of mine are women. But then, women in our society are expendable. Parents bring their sons to me, they don't bring their daughters." (The Telegraph Magazine: 24.11.1991)

SOCIETAL ATTITUDES

The response to AIDS in India has involved relentless harassment and denial of human rights of people with AIDS and people allegedly spreading it. ABVA has consistently taken a public stand that the protection of human rights is an integral component of effective AIDS prevention and strategy. ABVA, while preparing this report wrote to 75 organizations and prominent citizens from different walks of life in Delhi, Bombay and Madras with a set of questions (see appendix) to help them voice their opinion and in the process help in developing an understanding of society's views on drug users.

Drug abuse in Churachandapur and Imphal districts in particular and in the whole of Manipur state in general has become a matter of very serious concern. ABVA wanted these prominent citizens and activists to give their opinion on the issue. ABVA members expressed willingness to meet them if they desired.

Only eleven replies were received. It is surprising that some of the most active fighters for human rights have chosen to remain silent on this issue.

Who cares?

Almost all the respondents to the questionnaire have expressed fear that the politicians, bureaucrats and government agencies are insensitive to the issue. These fears appear to be true as none of the parliamentarians, bureaucrats and heads of various health institutions, to whom ABVA wrote, found the issue of drug abuse worth their attention.

Five out of eleven responses consider drug dependence as a disease. Shankar Chowdhury of the Centre For Community Medicine - AIIMS says "it is a condition of dependence". Vinay Bhardwaj of Mahila Dakshata Samiti states "it is a consciously acquired habit." According to Fr TK John of Vidyajyoti, it is a "bad habit".

Paul G, the Acting Director of Indian Social Institute, says that "Addiction is a disease. Once acquired it needs socialized curative treatment. However, more important is the overall socio-economic and political environment that favours drug addiction." He further adds that " ... the social and work environment along with the economic condition of the victim seems to be a most important factor leading to addiction. The family has much to contribute. But one should remember that the home atmosphere is itself very much subjected to the pressures exercised upon it by the prevailing socio-economic, political and cultural conditions. In a period of rapid social transformation involving breakdown of the

family and social structures as well as of the value system, drug addiction, along with many other social problems is bound to find its way into society. The way this breakdown affects various sections of society is largely determined by the nature of the elite which is in power and 'guides' the transformation. In the specific questions on drug addiction, public opinion, legislation and its implementation, concrete behavior towards addicts, all reflect the attitudes and interests of the elites in power. There is therefore a political aspect to the problem of addiction."

In talking about a cure for addiction, Paul G says "there is a cure for addiction. However, merely curative treatment does not solve the problem of addiction. It is the entire socio-economic and political environment which has to be remedied. To him "The current treatment/rehabilitation facilities in existence, though successful in some individual cases, are not adequate to deal with the problem. It is obvious from the very fact that addiction is spreading very fast all over the country. In such a situation the worse thing the State can do is to bring in the repressive apparatus against the victims while leaving at large the mafia, the big traffickers who have links with the political 'elites'. This is what happens all over the world, including India. The social welfare and health department can play a role. However, the effectiveness of the role will depend on the overall socio-economic and political factors mentioned previously."

Paul G clearly states that "it is not the victims that should be put behind bars but the big traffickers and the mafia. The distinction between the two has to be made very clear. Victims need the help of society. This help is due to them in strict justice. The traffickers must be dealt with ruthlessly. They (drug-dependents) certainly should not be jailed." "I view drug addicts," says Paul, "as victims of a system and of groups having enormous financial and vested interests in alliance with political elites. They are victims of exploitation and gross injustices. This is the crux of the problem. Ultimately, drug addiction can be greatly reduced only by the creation of countervailing forces of a political nature to oppose the vested interests of drug industry, the mafia and the politicians. The remedy has to be evolved within such a broad political framework."

Fr TK John from Vidyajyoti Institute of Religious Studies, based on his interview with Fr S Arul, SJ, who works amongst drug dependents in Manipur, quotes "There is a cure for addiction. Medically, I don't know how to cure. It is good to pay attention to the reasons for the widespread use of drugs in Manipur. The society in Manipur is facing a rapid change from a primitive set-up to a modern society. Entertainment is restricted to video parlours. Proximity to the border and the involvement of the army, government and the insurgents in peddling ensures a steady supply of drugs. A lot of money is available to the people. There is no control over children. Churachandpur is really bad. Perhaps

prevention is better than cure. Not satisfied with the current treatment/rehabilitation facilities in existence he says that addicts need counselling which can, motivate them, give meaning to their life and it should be value based." He continues "Drug addiction should not be a part of any ministry. Government Organizations are very corrupt because a lot of money is involved. Only non-government organizations can do a better job. There is no reason to put them (drug dependents) behind bars. The interest and wish of the patient has to be considered first. Isolation should be on the strict advise of the doctor. Detention has to be the last resort. Whether it is isolation or detention, the patient has to get necessary medical attention."

He continues further "I view drug dependents with sensitivity. I blame the system for this problem. We need to provide a system or atmosphere which can take care of them." "All these are very complicated in Manipur. Politicians, bureaucrats and government agencies are very much involved in this."

Jyotsna Chatterji, Director of Joint Women's Programme could see a connection between marketing, production and drug/alcohol intake in the country. "I see the linkage but politicians bureaucrats and government agencies are basically insensitive to the issue." While commenting on the role of the Welfare Ministry, Health Ministry and Law enforcement agencies, she says: "It should be a joint effort of all ministries." She is emphatic that the drug users and HIV positive persons should not be put behind bars. She feels "they should be treated with sensitivity and understanding." "A multi-disciplinary team of experts should help them."

Ankur, a voluntary group involved in education work in slums of Delhi, responded to the ABVA questionnaire through its Director, Jaya Shrivastava. She states "Drug addiction should be a subject under welfare and health ministries rather than Law Enforcement Agencies. Current facilities (for treatment and rehabilitation of the person dependent on drugs) are very inadequate and given the attitudes of society, do not produce desired result."

"Since drug dependence is neither a disease nor a crime," says Jaya Shrivastava, "it is cruel and absurd to put drug users behind bars. It is negation of human rights. Drug users suspected to be HIV Positive should not be detained or jailed in any case. However, some isolation may be required." Drug addicts have to be viewed with sensitivity, continues Jaya. "The government agencies can play a healthy role if the required political will and attitudinal changes are there. But firstly they need to be educated and all sorts of prejudices have to be washed off before one can expect anything."

Vinay Bhardwaj wrote to ABVA on behalf of Mahila Dakshata Samiti. He says: “Addicts cannot be dealt with as criminals or law breakers. They should be treated with compassion and consideration and certainly not harshly.” According to him “The current treatment and rehabilitation facilities in existence do not promote the desired results.” “When rehabilitation agency says they have a success rate, they are presenting an incomplete picture. What they actually mean is that they are trying their best to give treatment to the affected persons. It can be taken with a pinch of salt only. At its best, it is an inadequate picture.”

Shankar Chowdhury of the Centre for Community Medicine AIIMS while commenting on this question of whether desired results have come from the current treatment and rehabilitation facilities in existence, says: “I don’t think so, but that may be due to limited experience in the field.” He further explains that he does not believe in everything said by the rehabilitation agencies about their success claims in treating the drug dependent persons. Authorities and policy makers in power should at least pay some attention to the following statements given by him. “Drug addicts should never be put behind bars. We have addicts behind the bars because of short sighted policy and lack of sensitivity of the concerned authorities. He further states “HIV positive people whether they are drug addicts or college students or rich land lords, should neither be isolated nor detained or jailed. The issue can be dealt with if there is a political will to curb the menace of drug trafficking.”

Professor Chhatrapati Singh of the Indian Law Institute returned the questionnaire to the group with brief one-word answers written on it and suggested that the questionnaire requires more careful designing. He wants the drug addicts to be dealt with sensitivity and says ‘no’ to the isolation, detention or jailing of IV drug users suspected to be HIV positive. Professor Singh at one point has commented that he “needs space to write.”

Three persons from The Spastics Society of Northern India were sensitive to respond to the questionnaire. However, the management of The Society was silent.

People’s Rights Organization invited ABVA to a personal dialogue on the issue. PRO stands for the human rights of people including persons with AIDS and HIV Drug Users. PRO promised legal assistance for getting drug users released from jails in Manipur.

Conclusions

ABVA, while trying to understand the society’s attitudes learnt that many well-meaning and broad-minded individuals and organizations did not consider

the issue of drugs or for that matter AIDS to be of any relevance to the human rights movement. Apparently such realizations take time to crystallize. ABVA members felt that right thinking people associated with important institutions can at least attempt to influence the policy makers in India.

The group members were surprised at the response sent in by Fr TK John calling tribal societies as primitive. Are tribal cultures 'primitive' just because they do not conform to the modern (western) norms?

In this search for developing an understanding of social attitudes ABVA learnt that there is a recovery from addiction and that the drug dependent persons should be viewed with sensitivity. At least, no one wanted it to be dealt with by the law enforcement agency. Everyone was unanimous in agreeing that a drug dependent person should be dealt with humanely, with understanding and respect. They must be protected against police brutality, since they are victims of a social system.

Lastly, ABVA has clearly felt that the remedy to the problem of drug abuse can be evolved only within a broad political frame-work since the drug mafia as also the system has a vested interest in promoting alcohol and drug business in the society.

AIDS AND THE IV DRUG USER

Global Perspectives

In the West AIDS and AIDS related policy is not as recent as it is to us in India. Developments in the West relating to this are therefore pertinent to us, particularly as policies adopted in the West may have a significant impact on policies here. The AIDS Bill which was finally withdrawn last year was in fact inspired by American legislation on AIDS. Experiences in the West need to be understood in the right perspective before transferring them to the Indian socio-political situation.

Intravenous drug use has been identified as a high risk method of HIV transmission. The sharing of unsterilized needles increases the risk of transmission substantially if one of the partners is HIV positive. Drug prevention policy in the USA and Europe has emphasized the need for the education of drug users about HIV related risk behavior, the provision of sterile injecting equipment and the increasing emphasis on outreach work. Clinical practitioners who have been trained to guide drug-users to abstinence, have had to reorient their work increasingly towards encouraging pro-active, harm minimization and risk reduction.

The use of outreach workers who work within the drug using community, has taken on increasing importance in the West. There is a stress on building relationships with drug users and devising appropriate strategies for working with them. “Bleach and teach” programmes are also a part of their work. (This involves the cleaning of injection equipment with bleaching powder and water.) However, at the same time as a study by Power R et al highlights, along with this strategy there has been an increasing emphasis on a reduction in supply, exemplified by the “war on drugs” and “zero-tolerance”. As a result, more and more money is being pumped into drug policing.

The role of drug legislation and enforcement strategies has been critically reviewed in the past few years (Harding T, 1990). The United Kingdom, the Netherlands and Switzerland have active needle exchange programmes in an attempt to limit the spread of HIV. “Although Italy has had availability of injecting equipment through shops and pharmacies throughout the 1980s, HIV has spread among drug users who inject themselves. Germany, France and Belgium have relied more on the promotion of syringe cleaning techniques, but also have retail outlets.” (Farrel M and Strang J: British Medical Journal, Volume 304, p.491, 1992).

In the United States, legislation that outlaws the possession of drug paraphernalia has often made it difficult to provide a widespread availability of clean syringes. Rates of syringe sharing in cities such as Chicago and San Francisco where legal sterile syringes are unavailable are known to be higher than in the Netherland and the UK where syringes are freely available. (Power et al: s263, 1990)

In Britain, the increased use of the Police and Criminal Evidence Act 1984, to "stop and search" drug users has made them more suspicious of outreach workers and has hampered such community oriented work. This has also further pushed the drug scene underground and has made contact with target populations difficult and frustrating, according to a study by the Pompidon Group (Pompidon Group, 1987 Multi City Study of Drug Misuse in Amsterdam, Dublin, Hamburg, London, Paris, Rome, Stockholm and Council of Europe.)

In Scotland, the common law offense of 'reckless conduct' was used against shopkeepers to prevent the sale of solvents to juveniles and may be extended to pharmacists providing syringes for drug injectors. This has caused concern among those advocating a policy of "harm minimization."

Further, in Britain a recent White Paper on Crime, Justice and Protecting the Community proposes a close working relationship with drug agencies, such as those selling sterile syringes, in order to keep offenders out of prison. While this is a step in the right direction, if people are forced into treatment this will work against HIV policy, argues Power et al. The risk is also that drug agencies may be seen to be too closely aligned with the judiciary and this will alienate potential clients. The imposition of stiffer penalties for drug possession and compulsory treatment in Italy in 1990 are known to have hampered AIDS prevention activities, while the proposed reforms of the National Health Service (NHS) in the UK will not only make drug users unattractive as potential patients, but will also threaten small non-statutory services supported by the NHS that have excellent records of providing outreach work among drug users. Preventive legislation has thus not often had a positive effect on HIV prevention efforts. The Inner London Probation service has, learning from this fact, adopted a harm minimization policy and has tacitly tolerated the continuing drug use among clients although they are obliged to report this. A similar policy is being followed by the police in the Netherlands (Farrel M and Strang: British Medical Journal, Volume 304 p489, 1992).

Punitive action against drug users has only pushed them underground. This has resulted in discussions on the need for decriminalizing and legalising illicit drugs in the hope that this will prevent HIV positive drug users from going underground. Unless the drug market is placed on a legitimate basis, the spread

of AIDS/HIV can never be tackled adequately. There is a need to change the focus from the street drug user and the user dealers to the major drug suppliers for preventive methods.

The policy of "normalization" being adopted at least in part, has had a positive impact such as in Amsterdam where the police separate cannabis markets from other drug markets and in Britain, where some local police forces refer drug users to local agencies through referral schemes, or even have syringe-exchange facilities on their premises. This global drug policy thrust on supply side reductions has had, however, serious repercussions on drug producing countries, almost all of which are 'South' Countries. Such a strategy attacks the economic infrastructure of such countries thus making the provision of HIV prevention strategies all the more difficult (MacGregor S, British Journal of Addictions: 85:863-872, 1990).

Supply side restriction policies are known to have introduced injectable heroin to Thailand because of the anti-opium laws in 1959. Indigenous opium smoking thus paved the way for injectable heroin. The shift of illicit production and heroin refining activities to the Golden Triangle area, which also stretches across to North East India, because of successful law enforcement strategies, such as the termination of the 'French Connection' in the Mediterranean, has shifted the terrain of drug problems to many poor drug producing countries. (Vichai, P, Future Outlook of Drug Dependence in Thailand, Institute of Health Research Bangkok, 1988). Another result of such supply-side pressures has been the decreasing purity of street heroin which may also have encouraged heroin smokers to shift to heroin injections. (Pearson, G The New Heroin Users, 1987)

AIDS

Today AIDS is the most significant health crisis of the 20th century. It was first documented amongst groups which have since then been classified as 'high risk' groups; these are gay men, women in prostitution, professional blood donors and intravenous drug users. The fact that these groups were already marginalized and stigmatized has resulted in the framing of society's responses in harsh moralistic terms. The human rights abuses on these groups are being increasingly documented and publicised across the world.

What is AIDS?

AIDS, which stands for Acquired Immunodeficiency Syndrome, is a disease which can destroy the immune system in the body. This system is the body's main defence against infection. People with AIDS can get serious and sometimes fatal diseases which do not usually affect people with healthy immune

systems. The initial symptoms may be the occurrence, over several months, of weight loss, fever, night sweats, skin rashes, diarrheoa, tiredness or swollen nodes (in the neck, underarm or groin). Multiple infections such as shingles, thrush, herpes and tuberculosis may supervene. Some people may get pneumonia, caused by Pneumocysti carinii or a formerly rare skin cancer – Kaposi's sarcoma. At a very advanced stage, HIV may also attack the nervous system and cause brain damage.

It is commonly believed that AIDS is caused by a virus called "HIV" which stands for "Human Immunodeficiency Virus." The virus is transmitted when an infected person's blood, semen or vaginal fluid enters another person's body. The most common way of spreading the virus is during unprotected, penetrative sex (that is penetrative sex without a condom), or when people are given infected blood or share used needles to inject drugs. HIV can also be transmitted from an infected mother to her foetus during pregnancy.

There have been no recorded cases of HIV transmission by casual contact such as hugging, kissing, mutual masturbation, sharing household objects, staying near a person with HIV infection who sneezes or coughs.

What is the HIV test?

When HIV enters the body, the body produces substances to fight the infection called antibodies in the blood in response to the virus. The HIV test simply looks at a small sample of blood to see whether these antibodies are present in the sample. The HIV test should not be called the AIDS test as it does not detect whether a person has AIDS – it can only tell whether the person who has provided that sample of blood has produced the antibodies in response to the virus that is believed to cause AIDS.

What does HIV negative mean?

A person is HIV negative if s/he has not developed antibodies to the virus. However, an HIV negative test result does not guarantee that a person is virus-free. The body can take between 6 weeks to a year after infection with the virus to produce these antibodies. If a person takes an HIV test after they have been infected, but before the body has had enough time to produce antibodies, that person will test HIV negative. Tests on recently infected persons can therefore give false negative results. A negative result therefore does not mean that a person cannot transmit the virus to someone else. It is therefore vital that people who think that they are HIV negative as well as people who think (or know) that they are HIV positive, practise safer sex in order to avoid the risk of infecting others.

What does HIV positive mean?

If at some point in their life, persons are exposed to HIV infection, then, in due course or time they test positive for the antibodies against the virus. Such persons who have the antibody to the virus are known as HIV positive. Being HIV positive does not mean that the person has AIDS or will certainly develop AIDS in their future. Some persons may remain healthy for a very long time. Others may develop AIDS anywhere from three years to more than ten years after they were infected with the virus. Other people may develop AIDS Related Complex (ARC) which is a condition with some AIDS symptoms but without any of the major infections that are associated with an AIDS illness. At present there is no way of knowing who will develop AIDS as a result of HIV infection.

Being HIV positive does not mean that a person is immune to the virus. Unfortunately, antibodies to HIV, unlike most of the antibodies that are produced seem to provide no protection against HIV or AIDS. In all cases of persons having tested positive a second test – the Western Blot – should be performed to confirm the presence of the antibodies.

In a very small percentage of cases people will test positive even though they have not been infected with the virus. This is known as a false positive test. This could be a result of an error in the test itself or if the person had been taking certain drugs. In such circumstances, a second test will usually show that the person is HIV Negative. In a very small number of cases the body does not produce any antibodies at all. This is known as silent infection. Consequently, a person may test negative for HIV antibodies though he has HIV infection.

Transmission issues

It must be emphasized that there are no bio-medical or physiological factors which make some groups rather than others more prone to HIV infection. The concept of "High Risk Groups" in the context of AIDS irresponsibly suggests that AIDS affects only defined groups to which the majority of people do not belong. The only meaningful factor is what you do and not who you are, that is, have unsafe or safe sex, or share or be injected with unsterilized reused needles, or be given infected blood or blood-products.

As a study on heterosexual heroin users points out, (S Kane HIV, Heroin and Heterosexual Relations, Social Science and Medicine, 32 (9):1037-1050, 1991) "both in high and low seroprevalence groups, consistent and careful condom use is a far more effective method of reducing risk of HIV infection than reducing the number of partners … must emphasize the safeness of sex not the diversity of partners or casualness ..."

The study thus criticizes the weakness of public health models that rely on distinguishing high risk groups from a general population, or somehow not at risk of HIV infection.

Today the spread of HIV is as much a part of the risks of unsafe sexual and other practices of the mainstream heterosexual population as of any other groups.

What is safer drug use?

1. Use sterile disposable needles.

2. Never allow anyone else to use the needle and syringe you are using.

3. If you use the same needle repeatedly, boil the needle for 20 minutes and use bleach to clean it.

In India needles can be purchased from any pharmacist's shop without any prescription.

What is safe sex? What is safer sex?

As HIV is present in semen, blood, cervical and vaginal secretions and as it has been shown to be transmitted during sex which involves penetration of the anus or vagina, **safe sex** is any sexual activity which does not involve penetration. **Safer sex** on the other hand is sex which provides protection against the possibility of infection, through the use of condoms for example (Peter Agglton et al. AIDS: Scientific and Social Issues, 1989.). Reuse of condoms once used is not safe.

PART II

PART II

A Report of a Two Member Fact-Finding Team On The Plight of Intravenous Drug-Users And HIV Positive Persons in Manipur

The Background

In February 1992, ABVA constituted a two member team comprising Jagdish Bhardwaje (Delhi) and Dr. PS Sahni (Delhi). The primary task of the team was to collect facts about IV Drug Users/ AIDS Patients/ HIV Positive persons and their treatment at the hands of Manipur administration. This was in the light of reports that HIV +ve persons and intravenous drug users were being detained in jails. The team also wished to investigate if any discrimination of HIV positive persons was being made at Hospitals, Universities, and at the work place. The team left for Manipur on 29.2.1992 and returned back to Delhi on 15.3.1992 visiting Dimapur (Nagaland), Guwahati (Assam) and Calcutta (West Bengal).

The team reached Manipur while it was facing a popular non-violent movement to get Manipuri language included in the 8th schedule of the Indian Constitution. (People had already boycotted the Republic Day Celebrations this year to protest against this). Political parties, students' organizations and women's groups had given a call for boycotting Hindi movies and newspapers as also the use of Hindi in all educational institutions and offices. A demand for replacement of Assam Rifles had also been clubbed along with the language issue. There was no elected government in Manipur as the assembly had been dissolved.

ABVA feels that an understanding of the demographic, geographic and political features of Manipur is important to comprehend the widespread use of drugs there. This may help in understanding as also putting in proper perspective the large scale use of drugs there and the widespread use of torture and state oppression allegedly inflicted on the masses over the last four decades. Could this have any bearing on the problem of drug use? ABVA hopes that the report will stimulate discussion, debate and further exploration on this aspect of the problem. Manipur is situated in the extreme North East of India. There are eight districts – lmphal, Thoubal, Bishnupur, Churachandpur, Chandel, Ukhrul, Senapati and Tamenglong. The last five districts are in a hilly region. It is difficult to reach the interiors due to poor road communications. Though the first railway line in India was opened in 1853 (between Bombay and Thane) till today there is no railway line in Manipur. Population of Manipur is 18,26,714 as per 1991 Census. It comes to 0.45 % of India's total population. The distribution of population in the three valley districts is based on agricultural economy in the rural areas and socio-economic development programmes in the Urban area. The literacy rate of

60.96% is much higher than the all India average of 52.11%. As on 30.1.1989 there were 2,51,926 applicants in the live register of Employment Exchanges. In one District, Bishnupur alone, over 21,000 persons are seeking jobs.

Manipur is industrially backward. There are no large scale industries. Handloom weaving is the single largest industry. The State is a late starter in major and medium irrigation.

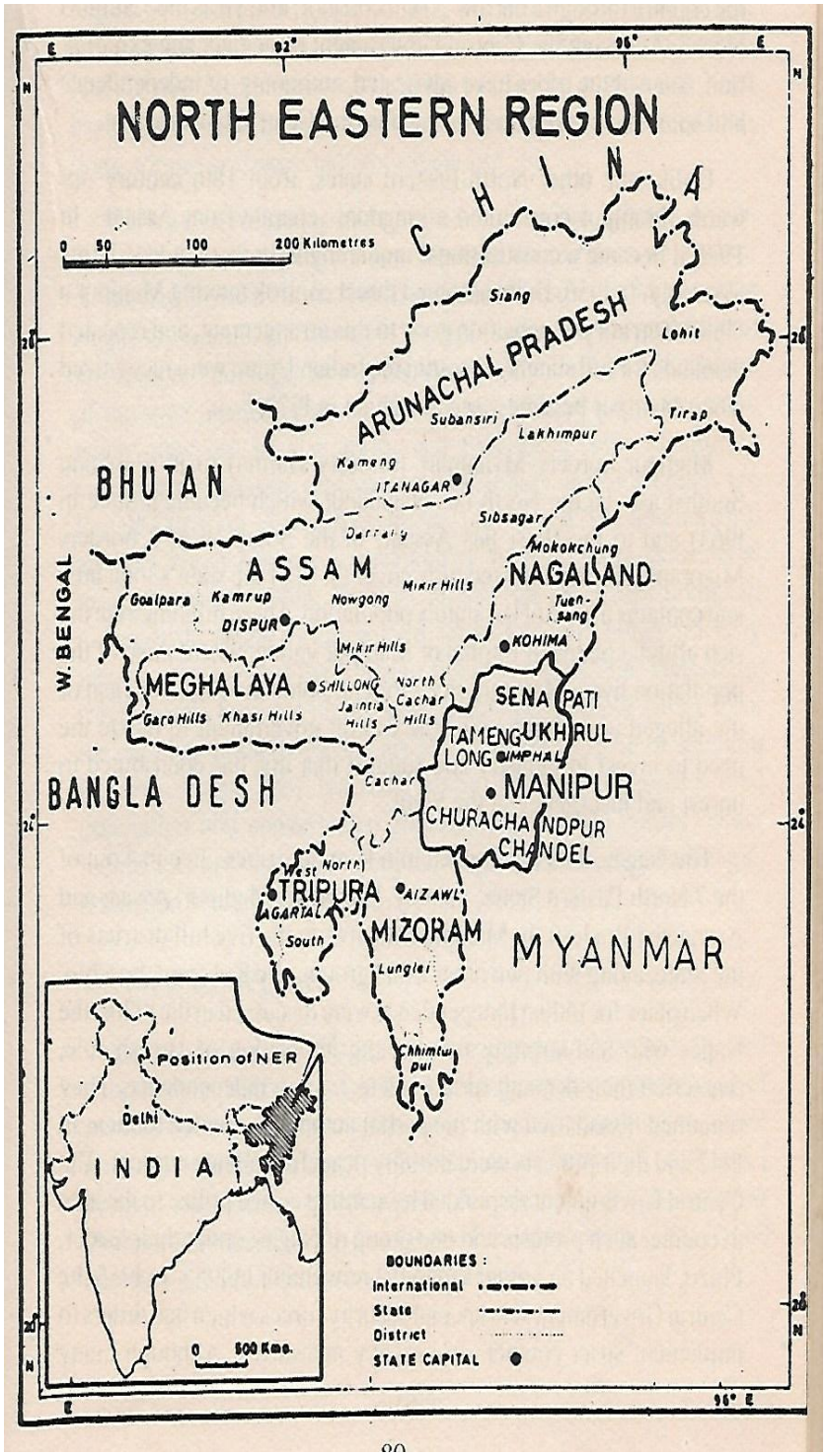
The per capita income is Rs. 2382 in comparison with the all India average of Rs. 2596 (1985-86). Out of the total population, 800,000 are below the poverty line.

GEOGRAPHICAL & POLITICAL CONTEXT

More than 220 hill tribes live in seven Indian states in the quarter million square kilometer region of North-East India: Assam, Nagaland, Manipur, Arunachal Pradesh, Meghalaya, Mizoram and Tripura. They feel ethnically, economically and socially different from inhabitants of other parts of India, from whom the North-East is nearly cut off by Bangladesh. The area is connected with the rest of the country through a narrow 20 km corridor, known as the "Siliguri Neck". Accusing the Central Government of neglect and exploitation, some of the tribes have advocated, autonomy, or independence and some have taken up arms against the Central Government.

Unlike the other North-Eastern states, from 18th century onwards, Manipur constituted a kingdom separate from Assam. In 1948 it became a constitutional monarchy with its own legislative assembly. In 1956, Delhi assumed direct control, making Manipur a Union Territory. Opposition grew to this arrangement, and repeated demands for full statehood within the Indian Union were recognized when Manipur became a separate state in 1972.

Manipur borders Myanmar (formerly Burma) to its East and South-East. To the North lies Nagaland (which became a State in 1963) and to the West lies Assam. In the South West it borders Mizoram. Thickly forested hills cover 90% of the state's total area and contains a third of the state's population. These hills encircle the rich alluvial plains of Imphal or Manipur valley, where most of the population lives. Many are rice farmers. Some have been critical of the alleged unwillingness of the central government to tackle the need to invest in industry and suggest that this has contributed to unrest and insurgency in the State.



The Nagas, who are divided into 16 major tribes, live in 4 out of the 7 North Eastern States, namely, Nagaland, Manipur, Assam and Arunachal Pradesh. In Manipur they live in the five hill districts of the State, along with two other tribal groups, the Kuki and the Chin. When plans for Indian Independence were discussed in the 1920s, the Nagas who had strongly resisted the imposition of British rule, reasserted their demand for complete independence. They remained dissatisfied with the partial autonomy granted to them in 1947 and their protests were initially peaceful and non-violent. The Central Government responded by

sending armed police to the area to counter such protests and one group of Nagas, under their leader, Phizo, launched an armed separatist movement in 1955. ln 1956 the Central Government sent special security forces which had orders to implement strict counter -insurgency measures . Although many Nagas oppose the use of arms, security forces have suspected several arms supported insurrection. Counter- insurgency operations carried out over the years have been accompanied by reports that Naga tribal groups have been indiscriminately subjected to illegal detentions, torture and extra judicial executions.

Majority of Nagas, considered to be of eastern Tibetan origin, live in Nagaland but others live in neighbouring areas in Assam, Arunachal Pradesh and the Hill Districts of Manipur. In Manipur the Nagas are a minority and form twenty percent of the state's total population. The Nagas mainly inhabit the four northern hill districts of the state, namely Ukhrul, Tamenglong, Chandel and Senapati, where they are in a majority and practice a form of shifting cultivation. Because of Colonial missionary activities they are largely Christian, although not all have converted. The Southern hill area of Churanchandpur is inhabited by the Kuki tribes, considered to be of Chinese descent. During Colonial rule the British attempted to control the Nagas by following a 'divide and rule' policy whereby they apparently used the Kukis to fight the Nagas. The Meteis, the tribal people from the plain's who inhabit the Manipur valley form the majority in the State and are also considered to be of southern Chinese origin. They represent about 70 % of the State's total population and converted to Hinduism in the 17 Century. Other inhabitants are Muslims, Pangols, migrants from Nepal, Bengal, Bihar and Uttar Pradesh.

Armed Insurgency

Of the various non-Naga insurgent groups in Manipur, the left wing People's Liberation Army, campaigning for independence of the entire North-Eastern region, has been particularly active. Other armed groups are the People's Revolutionary Party of Kangleipak (Prepak) demanding independence for Manipur, the Kangleipak Communist Party (KCP), The United Liberation Front (UNLF) and the Manipur Revolutionary Party (MRP).

The Forces Involved

Since the Naga-inhabited hill districts were declared "disturbed" in 1972, a number of special security forces have operated and still operate, in Manipur. These include the Border Security Force, The Central Reserve Police Force and the Assam Rifles. In the early 1880's the Sikh Regiment was also posted to Manipur. All have been given special powers under the Armed Forces Special Powers Act and are directly responsible to the Central Government.

The Assam Rifles are responsible to the Central Government Home Ministry and the Ministry of Defense. The top officers of the Assam Rifles are always seconded from the regular army. In 1986 they were given a particularly powerful position in Manipur as they took over operational command of defence forces in the State from the regular army.

Role of Assam Rifles

It is the oldest paramilitary force in the country, services in North-Eastern region during the last 154 years. Besides carrying out its task relating to a) Security and vigilance of India's international borders in sensitive parts of North-East region, b) Conduct of counterinsurgency prone area of Arunachal Pradesh, Nagaland, Manipur and Mizoram, c) assistance to civil administration in maintenance of law and order during situations beyond control of state police. AR has also made a significant contribution in extending civil administration in the hitherto un-administered areas of this region. The force was also deployed in Sri-Lanka in operation 'Pawan'.

The force has about 52,475 men and is headed by DG with headquarters at Shillong. Bulk of the force is operating under army command. ("India 1990" Ministry of Information and Broadcasting, Government of India)

Killings And Counter Killings: As Per the Annual Report 1990-1991, Government of India, Ministry of Home Affairs

"In 54 incidents of violence committed by the NSCN in Manipur, 35 persons were killed, the PLA indulged in 81 acts of violence in which 31 persons lost their lives. The operation of the security forces against the extremists resulted in the arrest of 86 persons belonging to NSCN and 81 belonging to PLA. The pressure of security forces also resulted in the surrender of PLA extremists"

"In Nagaland 6 NSCN extremists were also killed in encounters with the security forces."

The Armed Forces' Special Powers

In areas declared "disturbed" under section 3 of the Act, security forces have sweeping powers to arrest people on suspicion without warrant, and to shoot, to fire on sight. The Security Forces have immunity from prosecution.

Moreover, although the Assam Rifles are only supposed to act "in aid of the civil power", they have in fact exercised absolute powers in certain areas

outside any form of control by state officials responsible for maintaining law and order and upholding basic safeguards. Superintendents of Police, were themselves detained by the Assam Rifles. In a memorandum written shortly after the Oinam incident to the then Home Minister of India, the then State Government of Manipur concluded that: "The Civil law has, unfortunately, ceased to operate in Senapati district of Manipur due to excesses committed by the Assam Rifles with complete disregard shown to the Civil Administration. The Assam Rifles are running a parallel administration in the area. The Deputy Commissioner and Superintendent of Police were wrongfully confined, humiliated and prevented from discharging their official duties by their security forces. We can hardly afford to term the entire population as antinational as is being projected by the Assam Rifles."

Effect of Torture

In 1958 the Armed Forces (Assam and Manipur)Special Powers Act was enacted, giving the Governor of Assam or Chief Commissioner powers to declare an area "disturbed" if the whole or the part of these states is "in such a disturbed or dangerous condition that the use of armed forces in aid of civil power is necessary." Different areas of Assam and Manipur were declared "disturbed" under these provisions at various times. After the division of Assam, the Act was amended in 1972 making it applicable to all 7 North-East Indian states and Union Territories including Manipur. The Amendment also empowered the Central Government to declare an area "disturbed" without consulting the State Government. After the amendment, the Government, through the Ministry of Defence, immediately used these powers to declare the Naga- inhabited hill areas in northern Manipur namely: Senapati, Ukhrul and Tamenglong District – "disturbed areas" under the Act. (Categorizations enacted from Amnesty International India "Operation Blue-Bird" a case study of torture and extra judicial executions in Manipur 1990).

Extracts from POST TORTURE – STATE of MENTAL HEALTH: A Report of a Medical Study on the Delayed Effects of Torture on Nagas in Manipur brought out by Drug Action Forum, West Bengal, in July 1990:

The study was carried out on some of the village people from the Naga hills of Manipur who had been tortured 22 months previously by the security forces. For the first time, a medical study of this nature has been carried out on a large number of tortured victims who are living in an apparently democratic country which has no constitutional provision for martial law.

The high percentage of psychological disorder and physical disability documented among the victims is merely the tip of the iceberg of morbidity

prevalent in the areas under the Armed Forces' Special Powers Act. The study, carried out under a condition of stress because of the continued threat posed by the security forces, had to be limited to those who were tortured victims and could not be extended to other members of the family forced to witness the torture. For the first time, there is a document to highlight the existence of such a problem the extent of which has hitherto been unsuspected.

Characteristics of The Study Population

As with the whole of Naga population they belong to closed communities with a well supported social system. Although the popular myth is that the Nagas continue to exhibit their warring way of old style living, even today, the reality is that they are a peace loving people in their community. Because of their self-sustaining economy and a highly evolved system of mutual support, the stresses of "modem" life are missing in these hill communities. As pointed out by the interpreters, the crime rate, addiction to alcohol and narcotics are fairly low and when present, are generally dealt with by the local tribe-based social organizations. It is important to note that in the local language there is no equivalent word for "depression", "boredom" and the villages in this area have no history of suicide. It was also pointed out that before the current "disaster", frustration was an unusual phenomenon.

Introduction

It is well known that following any disaster, (natural or manmade), the effect on the mental health of the survivors becomes an important component of 'disaster effect'. The literature points to the universality of reactions in terms of the manifestations as well as the magnitude. Post Traumatic Stress Disorder (PTSD); is one such important manifestation which characteristically develops following a psychologically traumatic event that is generally "outside the range of usual human experience which most normal people would find overwhelming."

This disorder is well described in survivors of several disasters and has in fact been shown to increase over a period of time as in the case of prisoners of war, World War II, who exhibited it even after a lapse of forty years.

It is also well known that "manufactured" disasters as compared to natural disasters regularly produce a higher prevalence of PTSD. Torture of a person by "fellow" human beings can well fit into the category of "manufactured" disaster and could be described as an event falling outside the range of "normal human experience".

Background to the Study

As reported in the press on July 9, 1987, the Assam Rifles Camp at Oinam Village in Manipur's Senapati District was attacked by certain unknown persons believed to be members of the NSCN and in that attack 9 jawans were killed and three others were seriously injured. The raiders walked off with a large quantity of arms and ammunition. On July 11, 1987 the Assam Rifles launched "Operation Blue-Bird" to recover the arms and ammunition.

While carrying out the 'Operation Blue Bird' the Assam Rifles completely sealed off the area with their forces from July to September 1987 and imposed curfew in the area for four months. Hundreds of villagers of all age and sex including pregnant women and sick were detained in the interrogation camps by the paramilitary forces.

Due to the excesses committed by the Assam Rifles (AR) it was reported that many people including six babies died. Men were subjected to third degree methods of interrogation, women and children were not spared. Houses were dismantled, agricultural crops were destroyed, private properties were confiscated while AR carried out house to house search.

Various reports from press and Government sources revealed that 20 or more villages surrounding Oinam experienced a "War-time" situation for six months. They experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone. Accepting all these constraints of sample frame and size, the cause effect relationship of their illness can very well be established from the study itself. The study team in three different places found significant similarities in 'symptoms' among the sufferers. There is an unquestionable relationship with the type and nature of torture with their symptoms, like recurrent distressing dreams of the event, falling and staying asleep, recurrent and intrusive painful recollection of the torture. Barking of dogs, sounds resembling gun shots, sight of olive green dress or even the colour, sound of jeeps, sound of helicopters, sounds of children running downhill simulating marching troops, still disturbed these victims with vivid memories of torture and intense psychological distress.

It is found from the study that the percentage of victims still suffering from recurrent dreams of torture (38.61%) and disturbed sleep (66.33%) is fairly high. Major groups of people are still having the problem of maintaining social relationships with other members of the family and village. They are incapable of enjoying village festivals, food, sex, and even friendships (54.44%). A good number of victims have lost their self-confidence and developed a sense of foreshortened future (37.62%).

The results of the present study show that individuals who are subjected to torture and their family members who are often forced to witness the torture have developed serious mental health problems. On the whole, the study team had to work under stress and with several constraints in following scientific procedures freely.

If this was the situation that the study team had to face after 22 months of the episode, one can well imagine the constant stress the local population faces. PTSD has been shown to increase over a period of time especially when the agents of stress continue to be present. The constant fear that the continuous threats from the security personnel produces, together with the continued state of injustice, can only increase the psychiatric problems in this population in the years to come. Lack of medical and other facilities aggravate the stressful situation. This was very noticeable among the tortured victims of the study population.

Based on this study a further elaborate investigation should be undertaken after ensuring that the study constraints are removed as far as possible.

Findings

The team discussed the matter with a supporter of Tangkhul Naga Youth Council (TNYC) based in Ukhrul District of Manipur on 4.3.1992. The team was provided with a report entitled "A Critical Study on Drug Addiction and HIV/AIDS Epidemic in Manipur – North-eastern Region, India." The Report prepared by K Thanshok of TNYC, records: "Manipur as such, serves as an important trading centre for the North-Western Burma area identified as the part of the famous Golden Triangle. The temporary shifting of the headquarters of the Drug Baron Khun Sa also called Chang Chif to Tammu (a Burmese town just 2 kms from Moreh, Manipur town) in 1982 followed the military operation launched by the Thailand against his empire. This brought the traditional trade routes between Manipur and Burma to serve as important outlets of opium. It is in this background that the problem of drug dependency and HIV infection/ AIDS have to be considered.

It is alarming to note that there is little possibility of checking the heroin-peddlers from across the border, given the fact that the border between the two countries is left virtually open except for the thick forests and the difficult terrain and a few BSF posts on some of the important routes.

Peddling within the State has also been going on with little resistance from the State Enforcement Agencies. It can be safely assumed that the huge amounts

of money in the narcotic trade has either co-opted or stifled the enforcement agencies and the political leaders to be a strong link between the peddlers and large number of leading politicians and officers of Manipur.

In this context it is to be noted that the enforcement agencies have seized only 15.1 kgs of heroin in the state in 1988-89 and only two persons – petty peddlers have been charge-sheeted. The Manipur Governor, Mr. Chintamani Panigrahi speaking at a public meeting at Churachandpur on 27th October 1989 said that Manipur today needs 6 kgs of heroin powder daily to feed the habit of the addicts which is worth Rs 6 crore in the international market.

The state is also faced with the danger of promotion HIV and AIDS infection from another quarter. The drug dependent under the custody of the state are lodged together in the Jail without proper arrangements such as Treatment, Detoxification, Counselling, Rehabilitation and After Care.

Number of Drug Dependents in Imphal Central Jail

1986	1987	1988	1989	1990
Male Female	Male Female	Male Female	Male Female	Male Female
683 + 23	725 + 4	818 + 33	1538 + 42	913 + 23
Total: 706	729	851	1580	936

The Problem of Prostitution

Till now there is no history of professional and open prostitution in Manipur society. On the other hand, modern society seeks entertainment of various kinds. As a part of this entertainment, screening of films in video parlours is widely practiced.

The growing concern among the people at the utter failure of the government to meet the challenge has given way to the emergence of the Insurgent organizations. This situation has raised an important issue of extremely urgent nature, whereas these organizations' commitment and competence in effectively dealing with the identified known drug dependent and peddlers by eliminating or incapacitating them physically cannot be questioned, this may bring the danger of drug dependents and HIV infected persons and persons with AIDS, going underground and resorting to increasing use of contaminated needles and syringes or sharing among them thereby accelerating the spread of HIV infection and AIDS.

On 4.3.92 the team met senior doctors at the Regional Medical College, Imphal involved in the ICMR Surveillance Programme. The government doctors said: "We are aware that since 1985 hundreds of IV drug users have been detained at the two jails of Imphal – The Central Jail and the Sajiwa sub-jail at Khabes, 10 kms from Imphal. RMC is an autonomous institute funded by 6 states of NEC (excluding Assam).

"The surveillance Centre for AIDS at the RMC started functioning in September 1986. Since its inception till February 1992, the centre has screened 8233 individuals with high risk behaviour and detected 1428 as HIV positive. 96 % of these were IV Drug Users. There are an estimated 20,000 IV Drug Users in Manipur and upto 50 % of these could be HIV positive. They have been subjected to HIV testing by government doctors initially without any pre- and post-test counselling. The first HIV +ve case was found in January 1990.

- An HIV positive person was admitted at RMC about 6 months back, but the medical staff went on a strike, and refused to treat the patient. It was their unfounded fear of handling such cases.

- At the Jawaharlal Nehru (New Civil) Hospital facilities for AIDS patients exist but invariably treatment is refused to them. Most doctors are not prepared to treat HIV positive or AIDS patients unless bio-safety measures are available.

  There have been four documented deaths of full-blown AIDS cases, but many more may have died unreported.

- The Administration used to refer fresh recruits/serving personnel in government services for HIV testing, we were asked to do these blood tests (ELISA at RMC itself, followed by Western Blot for which samples were sent to NICED, (National Institute of Cholera And Enteric Disease - Calcutta) and to send back their HIV Reports to the Department concerned. Those found HIV positive were subsequently thrown out of job. It was only when one security personnel (who had lost his job) threatened to move the Court, because his HIV report had been leaked to his officials. We had debated the issue and decided not to disclose HIV reports to other government departments. This could create legal and ethical problems for us doctors. We threatened to stop doing the tests if people found to be HIV +ve are thrown out of a job. At one stage, the speaker of Manipur Assembly was pressurizing the Medical Establishment to let the list of HIV positive persons be placed in the Assembly. However, we resisted the pressure. Making such a list public could have disastrous consequences for the persons concerned.

Initially, the newspapers were prominently carrying the identity (name, age, address, even photo) of HIV positive and IV Drug Users. It resulted in the lynching of one person in Churachandpur and public flogging of 18 persons in the same district. Newspapers also indulged in disinformation campaign. One of the most popular daily Suyen Lanpad, in its issue of 31.12.91 carried the headline: "Certificate necessary before marriage" thereby implying that prospective brides and grooms should be subjected to HIV tests before getting married! "Meeyam, News Journal", a daily, also carried a similar item. Such reports can only strengthen the stigma against HIV positive persons."

The team then drew the attention of these doctors to the reports appearing in the national press to the effect: "AIDS infects 646 babies in Manipur" (The Telegraph, 30.1.1992). This paper had attributed the comment to the Manipur Governor, Mr Chintamani Panigrahi, while inaugurating an AIDS Conference held in Imphal in January 1992. The doctors at RMC stated that this was gross misreporting by a national daily and there was not an iota of truth in it. "Since we are doing the HIV tests, we would have known it," stressed the doctors.

ABVA would like to stress that the media should not disclose the identity of drug users and HIV positive persons, neither should they have articles pertaining to them carried in a sensational form.

The team visited KRIPA Foundation Centre for IV Drug Users at Koiren (Near BSF), Imphal on 4.3.1992. They talked to the social worker (a former drug user himself); the medical officer, Dr Roy, a socially committed and motivated doctor, who not only works at the center but also stays there 24 hours, and shares meals with IV drug users. As he puts it "I'm living with HIV positive persons equipped with correct and authentic knowledge. It's safe." HIV testing should be done only with the consent of the IV drug-user. There should be no coercion. Mass education is very important, and it should be stressed that any citizen is at risk. Also some sense of liability should be infused in every citizen. At our centre, the inmates go through several steps.

– Primary Care (de-addiction) patients are detoxified.

– Assessment

– Secondary Care (Rehabilitation) - average stay 144 days.

The 24 hours are broken up into work/study, sleep, leisure/ exercise and life fulfilling activities. Each patient works on adopting the philosophy of AA/NA before leaving treatment.

– Tertiary Care (Follow-up)

– Extended Care

Kripa Foundation Recovery Programme draws its inspiration from the multi-disciplinary treatment of the Minnesota Model and of Hazelden. USA."

The team had a group discussion with the 18 odd male inmates present at the time. One of the recovering drug users spoke at length to us. "We, the drug users know that all drug users need not become HIV positive, all those who become HIV positive, need not get AIDS. Society thinks that AIDS spreads from drug users, society must understand that this disease may be spread by anyone. Why does society sanction killing of AIDS patients or their detention in jail! Why don't people understand that AIDS patients are like cancer and TB patients? There should be place for us in society. Some scientists have found a new drug AZT, it doesn't really cure what you call AIDS, but we came to learn it can prolong life. There is hope for us to live like normal persons. We, the drug-users, gays, prostitute – why don't we groups teach society the real facts about HIV and AIDS? Even 'they' may be carrying HIV who do not use drugs; such people can also infect their wives. This way the disease may spread to thousands of people. So far I have not tested for HIV. I actually don't want to have sex with others without condoms; my self-esteem is not down. I want to help persons like me. I'm sure one day, like cancer and TB. AIDS will become curable. That is our hope".

On 5.3.92 - The team visited 'Gamnwam Christian Home' at Churachandpur District, Manipur. A highly committed husband and wife team runs the 'Drug Addicts, Counselling and Rehabilitations Centre' without any government support. The team talked to the Founder, Director Mr. Paokholian Dousel and the General Administrator Mrs. D Zenkhoman; the attending nurse, two recovering drug users explained the functioning of the centre.

"Drug users admitted at the centre undergo spiritual healing but no detoxification with medicines is undertaken here. The withdrawal symptoms are painful and may take upto 5 weeks to disappear. Patients have to stay here for three years before they are completely well. During the phase of withdrawal symptoms, patients are hand-cuffed and put in fetters. In fact, parents themselves insist for hand-cuffing and give their consent for the same. We ourselves were chained during our recovery and now we are normal. Patients want it this way However, some patients do try to run away from the Centre, initially because the urge to take drugs is there. We have community support and participation. Presently there are 31 inmates (male and female). Testing for HIV is done with

consent 60 % of the inmates are HIV positive. About the success rate, 30% of our former inmates do return back to us for treatment all over again. We don't ask for financial help from the government, but do not refuse it either. Help without strings is alright. We must also add that we resent the manner in which the media had sensationalized the functioning of our centre printing photographs of inmates in chains and fetters in some national dailies."

The team was taken around the centre and saw a drug user in fetters. The team noticed that persons suffering from mental disorders were lodged in the same centre along with the drug users. About our persistent query as to whether use of condoms is suggested to HIV +ve drug users, once they are back with their families the reply was ambiguous. There appeared to be a taboo on condom use.

On 5.3.1992 evening the team met the government doctors at Jawaharlal Nehru Hospital. Elaborating on the lack of facilities as also on the discrimination faced by HIV positive persons in the hospital, workplace, and educational institutes they said; "we started surveillance work in October 1990. Till 31.1.1992, 125 persons have been found to be HIV positive out of the 2088 tested. Though an AIDS unit is proposed, it is not functioning. ELISA tests are done here; but for the confirmatory tests (Western Blot) for HIV infection we have to send samples to Calcutta. Samples collected in a particular month are sent to Calcutta in the first week of the following month and it may take two to three months in all before the person can be pronounced as HIV positive or negative."

"In the casualty department several intravenous drug users come following road accidents. If we notice that their veins are thickened (because of frequent injections of drugs) we suspect them to be HIV positive. Both the doctors and the paramedical staff show unwillingness to handle such cases. Once a treating surgeon admitted an accident case suspected to be HIV positive, but decided not to inform the HIV status of the person to the attending nurses."

"No known HIV positive person has been operated in the main operation theater. An HIV positive person who was admitted with the history of vomiting blood was refused surgery and sent away to a private nursing home, with the suggestion that he should not reveal his HIV status. Another suspected HIV positive pregnant nurse was reluctantly admitted; after the delivery she was found to be HIV negative!"

"Students from Manipur going to other parts of India for higher studies are asked to produce HIV negative certificates prior to admission. Are Manipuris not Indians? Is Manipur not part of India? Four Manipuri students needing admission came to Jawaharlal Nehru Hospital for HIV testing, and under verbal instructions,

from the Director of Health Services they were tested and found to be HIV negative. Certificates indicating their HIV negative status were issued to them."

"One lady home guard who married a third time after being divorced twice was labeled as a prostitute. Her monthly pay withheld. Later she was found to be HIV negative. About four months back around 300 persons from the Manipur Police Training School were forcibly subjected to HIV testing at the request of Manipur Police Training School Chief. Those found HIV positive lost their jobs." The government doctor further elaborated "We realized that we ourselves could be sued in a Court of Law and therefore insisted that HIV testing should be done only with consent. We recall two instances of HIV positive patients needing surgery (for incision and drainage of abdominal and arm abscess) in the main operation theater being sent to the minor operation theater for surgery."

"There is a lack of clear cut policy by the Administration. We do not have proper facilities like gloves, disposable syringes. Besides, there should be a risk allowance for health care workers." ABVA feels that there is a need to provide facilities for Western Blot in Manipur itself where the need is much more than in Calcutta.

The team met the Joint Director, Health Services, Manipur on 6.3.1992. He informed the team: "I am unofficially aware that few Manipur students going to other States for higher education have been asked to produce HIV negative certificates; you may go to Surveillance Centres at RMC and Jawaharlal Nehru Hospital for details. If we get an official complaint against this discrimination, we'll act."

"Presently there is no government rehabilitation centre for IV drug users. (Under section 71 of the NDPS Act, l985, the State Government is obliged to establish a Rehabilitation Centre for identification and rehabilitation of drug users.) No case of job discrimination has come to our notice, we are against discrimination. As far as keeping IV drug users at Sajiwa Jail is concerned, I'll say it is no more a jail."

The team met a senior and responsible person at the Department of Psychiatry, Regional Medical College on 6.3.1992 and recorded his observations. "This department of Psychiatry used to cater to 20-30 drug users a day in 1983-84. The number started decreasing by 1985. Now very few turn up. In fact, on Saturday – when counselling to HIV positive persons is provided – no one turns up in the OPD because of social ostracism and fear. A significant incident occurred in 1985. The Medical Register containing the record of IV drug users (name, age, address, occupation) was lost. Soon after this the police started

scooping down on IV drug users." (To a query whether the police or a police agent could have got the Medical Register lifted, he smiled.)

"Presently, there are few IV drug users in the Central Jail, most of them have been shifted to the Sajiwa sub-jail, which houses over 200 IV drug users. There may be about 5-6 female HIV and IV drug users in the Central Jail. IV drug users are not necessarily arrested under the NDPS Act; arrests could be on charges of petty thefts; many are not even brought before the Magistrates. In any case, the police was arresting them even before the NDPS Act came into existence. Many IV drug users are arrested from their homes! The problem for the police is how to book them for the theft. Normally they are detained for 2-3 months. A team from RMC and IMA was extending counselling facilities for the inmates at Central Jail. After 3 months when group counselling of inmates was started, the concerned staff received a letter asking them to discontinue their services. No reasons were assigned."

Presently most drug users are under-ground, partly because of fear of the police and partly because of social ostracism. Hardly a few hundred are in jails or rehabilitation centres. Thousands and thousands of them are under-ground because of fear of the police. The social attitude of the family is negative and authorities are surrendering to parents. An attempt was made to get the elderly citizens to form associations, but with no success. Parents are withdrawn from the problem!

Regarding the discrimination faced by the Manipur students when they go to other States for higher studies, we are aware of it and have discussed it in our Department meetings. It is equally true that medical personnel have refused to treat HIV positive persons.

ABVA strongly condemns the detention of drug users in jails; and the discrimination faced by HIV and IV drug users in hospitals, educational institutions and workplaces.

The team visited the Old District Hospital in the afternoon of 6.3.1992 and talked to Dr. LS Singh. When enquired whether an AIDS Unit existed at the hospital, he categorically said NO. In fact, he said that such a Unit is to be established at the JN Hospital. Doctors at the JN Hospital had informed the team on 5.3.1992 that no AIDS Unit was functioning there. Surprisingly a write-up by the Director of Health Services, Manipur appearing in 'Manipur Today', 26.1.1992 special issue and brought by the Department of Information and Public Relations, Government of Manipur, states categorically: "One six bedded AIDS ward is set up in the Old District Hospital, Imphal." The team failed to see such a Unit in Imphal, and nobody appears to be aware of its existence.!

The team finally met the Secretary Health, Manipur on 7.3.1992 in the afternoon after several futile attempts and having to wait for five hours. He stated: "I'm not aware of students from Manipur going to other States being asked to produce HIV negative certificates, I do agree that there should be no discrimination. I have no knowledge of any job discrimination against police personnel found to be HIV positive." The team was surprised to hear from him that: "Isolation of HIV positive persons is desirable so that other patients may not get infected." Not surprising then that hundreds of IV drug users are detained in jails in Manipur, even if this policy evidently seems to be counter-productive. The Secretary, Health, stated that the AIDS Unit is functioning. When the team told him that it could not be traced in the whole of Imphal, he took the stand that more funds and staff are needed for its running.

The team visited the Central Jail, Sajiwa at Khabesoi, Manipur on 7.3.1992 in the morning. The jail occupies an area of about 100 acres, with a 30' high boundary wall and heavily guarded by armed personnel. It was formerly used to detain lunatics (ganja-smokers). Presently, it houses drug users, lunatics and undertrials, and convicts for other crimes. All inmates, including drug users have to abide by the common jail rules and regulations like head-count of all inmates done at the end of the day and then locked up in their respective quarters.

The jail official briefed us "Out of the 612 jail inmates as on 7.3.1992, 320 are here because of drug-related offenses. 95 are drug peddlers and 225 drug users. 28 of the drug users are known to be HIV positive. Over 90 % of those involved in drug related offenses are drug users from Churachandpur District. Presently for IVDU we have no detoxification programme. The only counselling available is spiritual. Even within the jail the HIV positive males are kept separately in one hall. Such is the fear that the jail guards have started asking for risk allowance. Many a time HIV positive inmates of the jail when taken to other hospitals have been refused treatment."

In fact, as the team was discussing the issue, a young inmate HIV positive IV drug user was brought as he had sustained an injury over his elbow. "If we send him to a hospital now, the doctor there will refuse to treat him." 222 drug users have been arrested under Sections 109-110. Criminal Procedures Code (CrPC). They are produced before a Magistrate and are sent here. It is implied they are drug users. When released, they have to sign a bond for good behaviour for 6 months. The period of detention may be for several months to 3 years. (Section 109 – Security for good behaviour from vagrants and suspected persons. Section 110 – Security for good behaviour from habitual offenders CrPC). Example

a) is by habit a robber, house-breaker, thief [or forger] or

b) is by habit a receiver of stolen property knowing the same to have been stolen, or

c) habitually protects or harbours thieves or aids in the concealment or disposal of stolen property, or

d) habitually commits, or attempts to commit, or abets the commission of the offense of kidnaping, abduction, extortion, cheating or mischief, or any offense punishable under Chapter XII of the Indian Penal Code, or under section 489B, 489C or section 489D of that Code, or

e) habitually commits, or attempts to commit, or abets the commission of offenses involving a breach of the peace, or

f) is so desperate and dangerous as to render his being at large without security hazardous to the community. The 95 drug peddlers in Central Jail have been booked under the NDPS Act. Three inmates have been booked under the Illicit Trafficking Act (Amendment NDPS Act)."

"Some of the drug users leaving the jail are subsequently not traceable. Possibly they may be committing suicide. In fact one HIV positive had died in our jail itself. I suspect many more may have died."

"I agree that there should be an agency which should look after the drug users, who should be housed in a rehabilitation centre, rather than a jail. Such a kind of step is needed. Jail environment is not conducive for their reformation. Also, lunatics lodged in our jail should preferably be admitted in a mental asylum. The higher authorities and NGOs gloss over the problem. I feel that at one level there is no stigma attached to drug users. There is social acceptance out of helplessness. I attended the marriage ceremony of a VIP's son, an IV drug user. A doctor was in attendance with a syringe and drug ready in case the bridegroom had any withdrawal symptoms."

The team was taken round the jail and could talk to the inmates. The team was surprised to see about 50 odd inmates labeled as lunatics; housed in a section of the jail. A young male (a volley-ball player before he took to drugs) was found to be HIV positive. He was in detention for one year. On enquiry he showed his keenness to come out of jail. A young girl, an IV drug user and HIV positive, was caught by the police, and was in jail as an undertrial for one year. She had been booked under section 21 NDPS Act.

ABVA feels that since drug dependency is a disease, the question of detaining drug users should not arise. It would be unthinkable to detain a malaria or a typhoid patient. ABVA strongly condemns the detention of IV drug users in jails as it is irrational, illegal and unscientific. It is ridiculous to separate them further even within the jail premises.

The team, talked to an eminent social worker and writer of Manipur whose house in Manipur had been searched during the "combing operations" by the paramilitary forces. This person said: "Since 1985 the police officials in Imphal have become rich overnight, they own palatial residentia1 complexes. This is linked to their involvement in the drug trade. Even the paramilitary forces (BSF) have their hands in the pie, the politicians are part of this too. About two years back, a State Minister in Manipur was killed at his residence at Churachandpur for possible links with the drug business. The whole issue had become a major scandal at that time. Even army vehicles have been used for drug trafficking. Manipuris – belonging neither to the Aryan or Dravidian races – are also facing a crisis of identity. Is that a co-factor responsible for the high incidence of drug-use?"

Discrimination of Manipuris

The team met five doctors of Guwahati Medical College (GMC) on 2.3.1992, morning. One of the doctors, a post-graduate in surgery recalled: "My professor was operating upon a patient of renal stones recently. 1 was assisting him in the surgery. Half way through the procedure, someone in the operation theater pointed out that the patient was a resident of Manipur. Suddenly all hell was let loose. Surgery was stopped, till all of us had worn an extra pair of gloves by way of precaution. The patient was not even known to be HIV positive!"

Another resident doctor recounted: "Last year a patient was admitted in the Psychiatry Ward of our hospital (GMC) for de-addiction. He suffered from loose motions and later tested to be HIV positive. Originally a resident of Birugarhi, Assam, the patient had stayed in Manipur for a while because of his father's posting there. We assumed he must have taken to drugs in Manipur itself. The Psychiatrists shunted him to Infectious Diseases Hospital (IDH) for isolation where he was kept for a month before being thrown away from there also. The patient eventually died at his residence. Meanwhile there was an agitation by the medical staff demanding basic facilities for universal precaution. In panic the attending Psychiatrists got themselves HIV tested, but turned out to be negative. The whole incident was sensationalized by the press."

The team visited Dimapur (Nagaland) on 9.3.1992, and talked to doctors at the civil Hospital. "In 1991, ICMR had taken 54 blood samples from the so-

called high risk groups. 27 were found to be positive. One was a woman in prostitution and 26 were IV drug users. The ICMR had taken the help of police to get blood samples of the women in prostitution from near the Railway Colony.

Dimapur. Drug users are mostly youth from well-to-do families. We had conducted a house to house survey of 200 families, some time back, in a government colony in Dimapur, 114 persons in the age group of 14-40 years were found to be drug users. Drugs are available freely here. Enforcement is difficult."

"Unfortunately, funds marked for AIDS programme are not being used properly. The only organization which has taken a definite stand against drugs is the NSCN. About three months back the NSCN shot dead three drug peddlers. Dimapur being a small town, everyone knows that NSCN was definitely involved."

We hold the Central Government responsible for introducing a culture of corruption in Nagaland politics over the last two decades. There is free flow of money from Delhi during election time. In some elections truck loads of rum were given to villagers; at one time the electorate demanded drugs like Phensydyl and got it in the election. At another time Delhi transported Marutis and two wheelers by plane to our state; next time it could be heroin and brown sugar, which will be given to the electorate."

The team talked to a member of YPWS (Young People's Welfare Society), Dimapur on 9.3.1992 afternoon. YPWS is involved in AIDS awareness work. "Heroin is smuggled in from Burma into District Puensane. Drug smuggling takes place at three areas – Pungro, Thonokuyu and Noklak, where jungle is thick. Involvement of paramilitary and military personnel is there. The Central Intelligence of the Army would be knowing about it. But then drug could well be used to break the movement of our youth."

The team had met the PRO Manipur Government, a gazette officer from Manipur, posted in Delhi. "It should be easy to control the smuggling of drugs into a small state such as Manipur. But what to expect when many of the BSF personnel are themselves chor (thieves). They are supposed to prevent drug-trafficking, but have actually been abetting the crime. During my posting in Delhi I have been questioned a number of times about my nationality! Just because we Manipuris have different facial features, does not mean that we are not Indians. Such discrimination hurts us."

The Role of PLA and NSCN

1. Despite a microscopic population of less than 18,00 000 Manipur had 63 shops selling Indian Made Foreign Liquor (IMFL) and three bonded warehouses. Apart from army and paramilitary canteens, roadside shops sold illicit liquor with a high alcoholic content. Yet the police turned a blind eye to these illegal activities.

2a. Realizing that drugs and liquor were used as a long-term counter insurgency policy, the PLA militants ordered all foreign liquor shops closed since January last year. As the IMFL sales were the only dependable source of government revenue, the administration offered to post armed guards at the shops. However, shopkeepers who feared the wrath of the insurgents, spurned the offer. The government which implemented prohibition overlooking the fact that only a few days ago it had issued another licence for a bonded warehouse, admitted that drinking and drug addiction had been drastically curtailed.

2b. Ironically, the PLA is fighting for the implementation of the constitutional provisions for Prohibition; the State which is supposed to uphold the Indian constitution is actually violating these provisions. In the process, the PLA is being dubbed as anti-national.

3. Screening of obscene English films in cinema halls and lending blue films video cassettes had been a thriving business in Manipur before the insurgents decided to step in. The UNLF and PLA militants raided a number of video libraries confiscating blue films and burning them to cinders.

4. When some die-hards continued to screen blue films, the insurgents shot video parlours' owners and audiences in the legs. Television set and VCPs were smashed beyond repair. These actions have helped the masses immensely since government officials and business sharks are hand in gloves most of the time.

5. Insurgents in Manipur and Nagaland are against killing innocent persons. A killing takes place only when the crime is established and the culprit is given a chance to defend himself.

(Blitz, April, 1992)

NSCN has made in the past, public statements (which have been carried even by the national press) to the effect that drug-users and peddlers and AIDS

patients would be shot dead. Of course drug users are given a chance and sufficient time to reform themselves.

ABVA is against any kind of violence on any individual anywhere in the world. ABVA is convinced that solutions found through peaceful, non-violent means are more likely to be lasting solutions. Violence by the State or by the activists is not the answer. “A bullet for bullet” does not work. What is needed is to work with empathy and understanding.

A social activist and lawyer, who has been taking up human rights violation cases in Manipur and Nagaland, explained the philosophy of NSCN. “Naga society places lots of hope in individual improvement and responsibility; community support is provided to the needy. Such an approach towards self-reform is time-tested. It is in the light of this background that the public pronouncements of NSCN are to be viewed. Many drug users have been able to reform themselves in the process.”

In Manipur, the PLA has adopted a similar stance. In fact the PLA urges the reformed drug users to give public statements in local newspapers (giving their name, age, address and photographs) indicating that they have given up taking drugs! Many ex-drug users do go public. Meanwhile, the state apparatus continues to aid and abet drug trafficking; while it is left to the lot of the insurgents to fight drug trafficking.

The team was able to verify the detention of hundreds of drug-users and/or HIV positive persons in Manipur jails; death and disappearance from within the jails and rehabilitation centres; discrimination faced in hospitals, educational institutions and work place. It was able to record the discrimination faced by drug users/HIV positive persons from Manipur in other parts of the country as well.

The team wishes to thank all those who helped in uncovering the facts pertaining to drug users and/or HIV positive persons in Manipur.

We are grateful to Kusum Gupta (Calcutta) who joined the team in Manipur and for her valuable suggestions.

PART III

PART III

Charter of Demands

ABVA urges the Government of India to take cognizance of the following demands and take urgent steps towards their implementation.

1. Repeal all discriminatory legislation singling out drug users. Decriminalize Chemical dependency.

2. Establish a commission to document and prevent blackmail, extortion, violence and other such actions on drug dependents at the hands of the police, judiciary and the state administration.

3. Encourage the Press Council of India to issue guidelines for respectful, sensitive and representative reporting on drug-dependents.

4. Ensure judgement free health education for all, an education that emphasizes the disease concept of chemical dependence.

5. Terminate all forcible HIV Testing.

6. Ensure availability of voluntary and anonymous HIV Testing.

7. Stop all discrimination against recovering drug dependents, at the work place. For active drug users, ensure adequate treatment.

8. Stop the requirement of certificates regarding HIV and AIDS negativity from students and those desiring to marry (particularly those from North - East).

9. Set up a unit and appoint a sensitive ombudsman to receive and act upon complaints from Drug Users/HIV positive and persons with AIDS.

10. Release all HIV positive persons detained in jails, vigilance homes and under house arrest all over the country and stop further arrests of such persons.

11. Ensure free supply of sterile disposable needles to intravenous drug users so as to prevent the spread of AIDS (This should be done under anonymous settings).

12. Control growth of illicit drug industry and requisites for the manufacture and trade of these drugs – especially AA.

13. Permit Citizen groups to visit jails and mental hospitals so as to promote understanding of the conditions of persons detained there.

14.a. Repeal Article 13 of the Code of Ethics of The Medical Council of India under which Drs refuse treatment to select patients. Take action on doctors or other health personnel who refuse to treat drug-dependents, HIV positive and persons with AIDS.

b. Provide sufficient number of gloves and disposable syringes/needles in all medical centre throughout the country.

15. Establish detoxification and rehabilitation centres as envisaged under the NDPS Act.

16. Deal severely with drug smugglers and drug barons.

17. Investigate the functioning of the existing government funded (220) rehabilitation centres to suggest improvements and ensure effective programmes.

18. Change government policies to de-link funding of treatment centres for chemical dependents with success rates of recovery, so as to prevent false reporting.

19. Constitute a group comprising professionals from various backgrounds (including recovering individuals) to be part of policies/decision making on the specific issue of drugs and chemical dependency.

20. Establish a coordination unit between the Finance, Social Welfare, Health and Chemical Ministries to deal with the problem of drugs and of chemical dependency.

GLOSSARY OF TERMS

Amphetamines (Speed) - Commonly a white or brown powder but can be in pill or capsule form. Usually sniffed or injected. Makes people lively, giggly and over-alert but depression and difficulty with sleep can follow. Heavy use can produce feelings of persecution.

Cannabis (Pot, Dope, Hash, Grass, Shit, Marijuana) - Hard brown resinous material or herbal mixture. Smoked in a reefer or pipe (known as a 'joint') with tobacco. Distinctive "herbal" smell. Users may appear "drunk" and talkative. Risk of accidents when intoxicated.

Cocaine (Coke) - A white powder, commonly sniffed. Can be injected or sometimes smoked. Similar effects to amphetamines but more likely to lead to dependence.

Heroin (Smack, Skag, Snow, Snort, Milk Sugar, Brown Sugar, No4, Thai White, The Indian name is Gardh) - White or speckled brown powder. Usually heated on Aluminium cigarette foil and fumes inhaled. Can be sniffed or injected or smoked. Produces initial alertness followed by drowsiness and "drunken" appearance. Overdose can produce unconsciousness. Regular, frequent use produces dependence. Abstinence in a regular user can result in physical withdrawal symptoms similar to flu.

Magic Mushrooms - Types of mushroom containing a substance like LSD. Grows wild in the UK and the Himalayas. Produce hilarity, over excitement and with high doses, dream-like images. Main risk arises from eating other poisonous mushrooms.

Other Opioids (dikes, 118s) – May include red or white tablets or ampules. Swallowed or injected. Same effects as heroin.

LSD (Acid, Purple Haze, Pink Jesus, Window Pane, Silver Pane, Orange Sunshine, California Blue, Black Widow) - Tiny coloured tablets. Microdots on blotting paper. Small impregnated stamps. Taken by mouth. Produces glazed eyes and sometimes over-excitement. Heavy use can produce acute confusion and ideas of persecution.

Tranquilizers (Downers) - Prescribed tablets and capsules sometimes taken illegally for kicks. Similar effect to alcohol and increased effect when taken with alcohol.

Injecting - Many drugs can be injected. Risks are abscesses, infected veins, blood poisoning, hepatitis and AIDS virus infection.

Mainliner or shooter - A user who injects Heroin into his veins.

Chasing - Inhaling the fumes that emanates when brown sugar, placed on an aluminium foil cigarette wrapper is heated, usually with a match stick or a candle.

Pudia - A small packet containing about a gram of brown sugar.

Derogatory terms which should not be used:

Afimchi, Charsi, Sharabi, Smackia

Daru – Liquor

Terms used in Alcoholism:

Denial - Chemical dependency is often referred to as a disease of denial. Denial is a psychological process used by chemically dependent people to protect themselves from the reality of their chemical dependency. It is a characteristic feature of addiction which is used unconsciously and automatically without any deliberate or willful deception on the part of the individual. Denial can come in various forms such as simple denial; minimizing, projecting, silence, blaming, diverting, intellectualizing, rationalizing, hostility etc.

Rock Bottom - Rock bottom is a state reached by the chemically dependent individual before he comes into treatment. Rock bottom may vary from person to person. It could be emotional, spiritual, mental, or economical in nature. Treatment centres often precipitate a crisis in the dependent's life through a process of intervention to raise the level of the dependent's rock bottom.

Surrender - Surrender is a term commonly used by AA members to denote a transference of will to a higher power. The higher power can be any one from AA fellowship to a counsellor, a therapy group, sponsor or a spiritual guide.

Powerlessness - The AA term to signify the loss of control experienced by the chemically dependent individual as he progresses into his disease. He begins

to drink or use without intending to and even when he does not want to. This is known as loss of control or powerlessness.

Spiritual Bankruptcy – A condition of mind, body and soul experienced by the chemically dependent individual. It comes about when the individual begins to violate his own value system.

In addition to some of the above mentioned terms which are commonly used The NDPS Act lists all the drugs which come under its purview. The relevant section of the NDPS Act is reproduced below:

The NDPS Act defines narcotic drugs as follows:

"cannabis (hemp)" means-

(a) charas, that is, the separated resin, in whatever form, whether crude or purified; from the cannabis plant and also includes concentrated preparation and resin known as hashish oil or liquid hashish

(b) ganja, that is the flowering or fruiting tops of the cannabis plant (excluding the seeds and leaves when not accompanied by the tops), by – whatever name they may be known or designated; and

(c) any mixture, with or without any natural material, of any of the above forms of cannabis or any drink prepared therefrom:

"cannabis plant" means any plant of the genus cannabis

"coca derivative" means -

(a) crude cocaine, that is any extract of coca leaf which can be used, directly or indirectly, for the manufacture of cocaine

(b) ecgonine and all the derivatives of ecgonine from which it can be recorded;

(c) cocaine, that is methyl ester of benzoyl-ecgonine and its salts; and

(d) all preparations containing more than 0.1 per cent of cocaine;

"coca leaf" means –

(a) any mixture thereof with or without any natural material; but does not include any preparation containing not more than 0.1 percent of cocaine

"coca plant" means the plant of any species of the genus Erythroxylon

"medicinal cannabis", that is medicinal hemp, means any extract or tincture of cannabis (hemp)

"Narcotic drug" means coca leaf, cannabis (hemp) opium, poppy straw and includes all manufactured drugs; "opium" means -

(a) the coagulated juice of the opium poppy; and

(b) any mixture, with or without any natural material of the coagulated juice of the opium poppy, but does not include any preparation containing not more than 0.2 %.

"opium derivative" means -

(a) medicinal opium which has undergone the processes necessary to adapt it for medicinal use in accordance with requirements of the Indian pharmacopoeia or any other pharmacopoeia notified in this behalf by the Central Government, whether in powder form or granulated or otherwise or mixed with neutral materials

(b) prepared opium, that is by product of opium obtained by any series of operations designed to transform opium into an extract suitable for smoking and the dross or other residue remaining after opium is smoked

(c) Phenanthrene alkaloids, namely, morphine, codeine, thebaine and their salts

(d) diacetyl-morphine, that is, the alkaloid also known as diamorphine or heroin and its salts and

(e) all preparations containing more than 0.2 per cent of morphine or containing any diacetyl-morphine

"opium poppy" means -

(a) the plant of the species Papaver somniferum; and

(b) the plant of any other species of Papaver from which opium or any phenanthrene alkaloid can be extracted and which the Central Government may, by notification in the official Gazette, declare to be opium poppy for the purposes of this Act;

"poppy straw" means all parts (except the seeds) of the opium poppy after harvesting whether in their original form or cut, crushed or powdered and whether or not juice has been extracted therefrom;

"poppy straw concentrate" means the material arising when poppy straw has entered into a process for the concentration of its alkaloids;

"psychotropic substance" means any substance, natural or synthetic, or any natural material or any salt or preparation of such substance or material included in the list of psychotropic substances specified in the Schedule;

1. Narcotic Drugs:

   i) Opium
   ii) Morphine
   iii) Heroin
   iv) Ganja
   v) Hashish
   vi) Codeine
   vii) Thebaine
   viii) Cocaine

Poppy strat and any other manufactured drug as defined under Cl. (xi) of Sec 2 of the Act.

2. Psychotropic substances

   i) Mathaqualone
   ii) HC
   iii) Amphetamine and
   iv) Any other psychotropic substances as defined under Cl.(xxiii) of section 2 of the said act.

APPENDIX I

List of Contributors

S.No.	Name	Rs.
1.	Aashita	100.00
2.	Jaya	50.00
3.	Shobha Aggarwal	350.00
4.	Anjana Mehta	100.00
5.	Shanta	100.00
6.	Harinder Singh Bahali	100.00
7.	Dolly Bahali	50.00
8.	Sumitra Bahali Oberoi	50.00
9.	A friend of Dimple	50.00
10.	Ashwini Ailawadi	50.00
11.	JNU(In lieu of guest lecture delivered by ABVA members)	100.00
12.	JS Jassal	100.00
13.	Jaya Shrivastava	200.00
14.	Purabi Roy Choudhury	11.00
15.	Nandita Das	100.00
16.	Sharmila Mahajan	50.00
17.	Sushma Sinha	200.00
18.	Gouri Choudhury	50.00
19.	Mohini Devi	88.00
20.	Nitu Sinha	100.00
21.	Vijay Pratap	50.00
22.	Sunanda Nandi	50.00
23.	Dr Kishwar Shirali	100.00
24.	Sumitra/Sanjay Mitra	30.00
25.	Basanth/Sharmishtha	40.00
26.	Nishal Kaider/Gautami	50.00
27.	Amita/Rajeev Singh	50.00
28.	Kalpana Mohanty	50.00
29.	Gouri/A Sriniwas	122.00
30.	Saleem Kidwai	
31.	Sukirat Anand	
32.	Sunil Dogra	
33.	Manjari Dingwaney	
34.	Tani Sandhu Bhargava	2,600.00
35.	Tarun Bhargava	
36.	Atanu Dey	
37.	Jehangir Jani	
38.	Madhavi Kukreja	

39.	Malini Ghosh	
40.	Kai Friese	500.00
41.	Gunavathi SA	50.00
42.	Paul G	200.00
43.	Sam Rao	50.00
44.	Shalini, SCN	200.00
45.	Anuja	100.00
46.	Sujata	100.00
47.	Dr Jagdish Singh	250.00
48.	Dr G M Bhatia	51.00
49.	Dr Ravi Gupta	500.00
50.	Inder Mohan	195.00
51.	Kaushal Kumar	1,300.00
52.	Dr Shiv Mishra	200.00
53.	Joint Women's Programme	300.00
54.	K V Ramesh	50.00
55.	Asha Ramesh	50.00
56.	Abha & Ratna	100.00
57.	Savita	20.00
58.	Shiv Singh Vayal	50.00
59.	Laxmi Krishnamurty	50.00
60.	Rajesh Talwar	20.00
61.	Modhumita Mojumdar	18.00

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Balance used towards part payment of report printing

Errors and omissions regretted.

The list does not include the amount received by way of sale of the document "Less than Gay – A Report on the status of Homo-Sexuality in India".

APPENDIX II

List of Citizens/Organisations to whom ABVA sent the questionnaire:

1. Jagori
2. All India Democratic Women's Association
3. All India Women's Conference
4. Action India
5. Kali for Women
6. Karmika
7. Ms Jyotsana Chatterji, Joint Women's Programme *
8. Janwadi Mahila Samiti
9. National Federation of Indian Women
10. Nari Raksha Samiti
11. Manushi
12. Mahila Dakshata Samiti *
13. Centre for Women's Development and Studies
14. Ankur *
15. Young Women Christian Association of India
16. Ms Kamla Bhasin
17. Indian Social Institute *
18. Saheli
19. Lt General Jagjit Singh Arora
20. Ms Lalita Ramdas
21. Prof Madhu Dandavate
22. Dr Anandi Lal
23. Dr Saroj Jha, WHO
24. Director, Central Health and Education Bureau
25. Mr Ram Vilas Paswan, MP
26. Mr Shankar Chowdhury, All India Institute of Medical Sciences *
27. Dr TK Malik, LNJP hospital
28. Prof MPS Menon
29. Dr IS Gilada, Indian Health Organisation, Bombay
30. Dr Richa Diwan, Mulana Azad Medical College
31. Mr lnder Mohan
32. Dr Aurobindo Ghosh *
33. Ms Amiya Rao
34. Dr JK Maniar Bombay
35. Dr VP Varshney, Director DHS, Delhi
36. Fr TK John, Vidyajyoti Institute of Religious Studies *
37. Prof Upendra Bakshi
38. Mr Inderjit Gupta
39. Mr Parmanand Katara, Advocate
40. DCP Crime

41. Ms Shyamala Natraj, Madras
42. Mr Justice B.Lentin (Retd.), Bombay
43. Dr Sudhir Kakar
44. Justice VM Tarkunde
45. Mr Atal Behari Vajpayee
46. ACP (Rly Crime)
47. Mr Barry John
48. Mr Ashok Row Kavi, Bombay Dost, Bombay
49. Dr AS Paintal
50. Dr AN Malviya, All India Institute of Medical Sciences
51. Dr GK Vishwakarma, Director General of Health Services
52. Mrs S Chandra, Secretary, Medical
53. President Indian Medical Association
54. Prof Rajini Bakshi, Centre For Study Of Developing Societies
55. Mrs Mita Nundy, Chairman, Spastics Society of Northern India
56. Mr Indu Prakash Singh, Raghuvanshi Niketan
57. Justice Krishna Iyer
58. Swami Agnivesh
59. Prof Veena Das, Delhi School of Economics
60. Mr Dilip Simeon
61. Mr BD Sharma, Ex-commissioner for SC/ST
62. United Nations Development Programme
63. Jagran
64. Director, Institute of Social Studies Trust
65. Mr Chhattrapati Singh *
66. Nishant
67. Voluntary Health Association of India
68. Secretary, Medical Council of India
69. Peoples' Union For Democratic Rights
70. CV Subba Rao
71. Mr YP Chhibbar
72. Director, Centre for Education and Communication
73. Mr Tapan Bose
74. Mr Ravi Nair, Executive Director, South Asia Human Rights and Documentation Centre
75. Prof Kusum Sehgal, Maulana Azad Medical College

*indicates responses received.

APPENDIX III

Questionnaire

1. Do you believe that addiction is a disease?
2. Is it a family disease? An individual disease? or both?
3. Is there a cure for addiction?
4. What kind of treatment is necessary for addicts?
5. Does an addict need counselling? If so what kind?
6. Should drug addiction be a part of the Welfare Ministry? Health Ministry? Law enforcement agencies? Or all?
7. Do the current treatment/rehabilitation facilities in existence promote the desired results?
8. When a treatment in rehabilitation agency says they have a success rate, do you know what they mean by that? Do you believe it?
9. How do you measure success in this area?
10. How should addicts be treated by the law?
11. What is the difference between detoxification, rehabilitation treatment, halfway home and therapeutic community?
12. If drug dependence is a disease, should patients be put behind bars? If not why do we have many drug addicts behind bars? If yes, then why should not typhoid patients, schizophrenic patients be behind bars?
13. Should IV drug users suspected to be HIV positive (for AIDS test) be isolated or detained/jailed?
14. What have your responses to the above queries been based on
    a) Personal interactions with drug users/persons with AIDS/Gays etc.
    b) Popular notions or hearsay knowledge of the above.
    c) Scientific knowledge/written material regarding these issues.
    d) Others - specify.
15. In what way/manner do you view drug addicts?
    with a) Sensitivity
    b) Compassion/Pity
    c) Within a blame frame work
16. a) Do you see a connection between marketing, production and drug/alcohol intake in the country?
    b) What role do you see politicians, bureaucrats and other Government agencies assume in the above process?