
INDIA

1. EXECUTIVE SUMMARY

Drug Trafficking: India is wedged between the world's two largest areas of illicit opium production, the Golden Crescent and the Golden Triangle. This proximity has traditionally been viewed as a source of vulnerability, since it has made India both a destination and a transit route for opiates produced in these regions. This fact continues to be important in defining drug trafficking trends in the subcontinent. However, the extent to which heroin seized in the country can be sourced to the diversion of licit opium grown in the country is a matter which continues to be debated.

Drug abuse: In 2004, UNODC and the Ministry of Social Justice and Empowerment, jointly release the National Survey on the Extent, Pattern and Trends of Drug Abuse in India, the first of its kind. It showed that the number of chronic substance-dependent individuals were as follows: 10 million (alcohol), 2.3 million (cannabis) and 0.5 million (opiates). The survey not only points to the problem of India's population having twice the global (and Asian) average prevalence of illicit opiate consumption, but also shows that the treatment resources available are not commensurate with the 'burden of work' (number of dependent drug users) requiring immediate treatment.

Drug-driven HIV/AIDS: India is home to one of the largest HIV/AIDS epidemics in the world. In this context, there is rising concern about the large number of IDUs and the attendant risk of HIV. Sentinel surveillance data from 2003 indicates a rise from 7.4% to 14.4% in HIV prevalence amongst injecting drug users in New Delhi. In 2 of the 6 states now into a 'generalized' epidemic, there is a strong IDU-HIV link. There is also rising concern about the drug abuse/HIV nexus between IDUs, female sex workers, their partners, the non-substance using partners of IDUs and the so-called "general population". The link is strong and is seen as one cause of the 'feminization of the epidemic' in India.

Licit pharmaceutical diversion: In India, currently, injecting drug use is more closely linked to the abuse of licit opiate pharmaceuticals than to illicit drugs. India is a large manufacturer of pharmaceuticals. The law regulates their production and sale, but there is no uniformity in the monitoring of compliance with the law. This contributes to an increase in the abuse of pharmaceutical drugs. The smuggling of pharmaceuticals from India, especially codeine-based cough syrups, dextropropoxyphene and injectable buprenorphine, is a major concern for India's neighbours, particularly Bangladesh, Nepal and Sri Lanka. Other pharmaceuticals that are also commonly diverted for abuse within India as well as for smuggling include diazepam and nitrazepam.

Illicit cultivation: A small amount of illicit opium cultivation takes place in India – primarily in Himachal Pradesh, Kashmir, Uttaranchal and Arunachal Pradesh. Indian authorities discovered new areas under illicit opium poppy cultivation in Karnataka recently (about 40 km from Bangalore) and took prompt action to destroy the illicit crop. It is

extremely difficult to estimate the extent of illicit cultivation. Kashmir and Himachal Pradesh have emerged as sources of cannabis resin or Hashish seized in the country. Hashish is also being smuggled into India from Nepal across the land border in the states of Bihar and Uttar Pradesh, from where it finds its way to Delhi and Mumbai.

Licit cultivation: India is the only country currently producing licit opium gum for domestic medical and scientific purposes as well as for export under the terms of the 1961 Single Convention. However, an unknown portion of India's licit opium crop (1,061mt in 2004) is diverted into illicit channels and then converted into heroin, usually close to source.

Amphetamine-Type Stimulants (ATS): Amphetamines are also a growing concern for Indian authorities, both as trafficked substances and in terms of abuse. India has embarked upon successful control efforts in this regard. In May 2003 Indian authorities (with cooperation from the US and China) dismantled their first clandestine laboratory (in Kolkata) which had been established to manufacture ephedrine. Nationals of China and Myanmar had established the illegal laboratory. In June 2004, officers of the Indian Directorate of Revenue Intelligence identified and seized a clandestine laboratory involved in the illicit manufacture of MDMA, methaqualone powder and a tablet-making unit.

Money Laundering: The Prevention of Money Laundering Act entered into force in 2005. This act strengthens the already-robust provisions of the 1985 NDPS Act in terms of money laundering.

Precursors: India has a well-developed chemical industry, which produces substantial quantities of acetic anhydride, ephedrine, pseudo-ephedrine, potassium permanganate and many other precursor chemicals. In spite of precursor control legislation and procedures being in place, several cases of diversions of significant quantities of precursor chemicals have occurred in recent years. The growing threat of traffickers establishing ATS laboratories in the region, and availability of ephedrine and pseudo-ephedrine in India is of grave concern to Indian law enforcement authorities.

Crime: Crimes against women are a matter of serious concern in India. Women in the country suffer due to a lack of awareness of their rights, illiteracy and oppressive practices and customs. A sizable number of crimes against women go unreported due to the social stigma attached to them.

Human trafficking: The issue of trafficking in human beings – and especially in women and children – is increasingly of concern in India. India serves both as a source and destination country for trafficked persons. It is also a transit country. Many women and girls arriving in India are intended for forced labour and sexual exploitation. The Indian NGO establishment, which is involved in trafficking issues, is extremely energetic and active.

Corruption: According to Transparency International, the corruption perception index (CPI) for India is 2.8, placing it 83rd in the year 2003 in a ranking of 133 countries. In 2004 India scored 2.8 again and ranked 90th among 146 countries. Underground "Hawala" banking is the typically-used alternative remittance system in India. The system is known to also meet a number of crime-related objectives such as bribery and tax evasion.

2. MAJOR CHARACTERISTICS OF THE COUNTRY RELEVANT TO THE DRUG AND CRIME PROBLEM

India contains 17% of the world's people, yet it accounts for only 2% of its GDP and 1% of its trade. Poverty remains pervasive – India is still home to 260-290 million poor. Per capita income growth has been slow and there is a great unevenness in the distribution of income. These conditions, together with the geographic location of India between the world's two largest producers of illicit opium, and the breakdown of traditional social capital resulting, in part, from large-scale rural-to-urban migration and its attendant modernization influences, have all contributed to the rise in drug abuse in recent years. Nonetheless, the fact that most (70%) Indians still live in the countryside adds to the importance of recent findings about the extent of substance abuse (including injecting drug use) in the rural areas. The process of industrialisation has itself contributed new and cheaper pharmaceutical drugs widely abused by the poor and unemployed. At the same time, recent rapid economic growth (in the region of 8%) has created pockets of affluence which propel a market for the sorts of “designer drugs” more commonly consumed in western countries. The fact that India is the world's largest producer of licit opium gum opium has, despite strict controls, meant that some portion of this product is liable to diversion by unscrupulous farmers adding to the availability of drugs on the market.

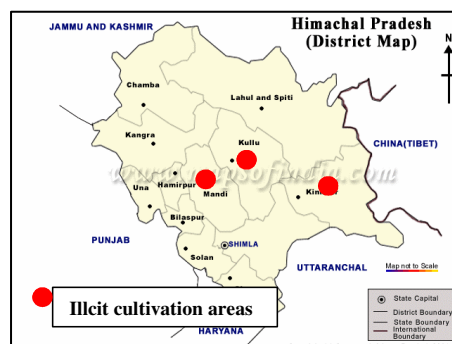
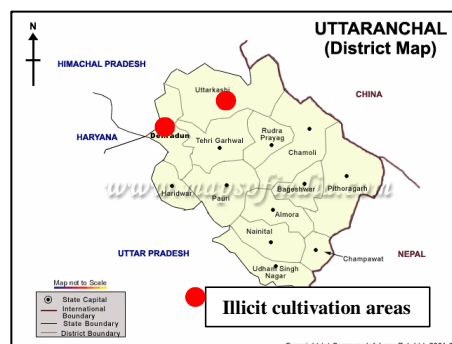
3. DRUG SITUATION

3(a) Production and cultivation

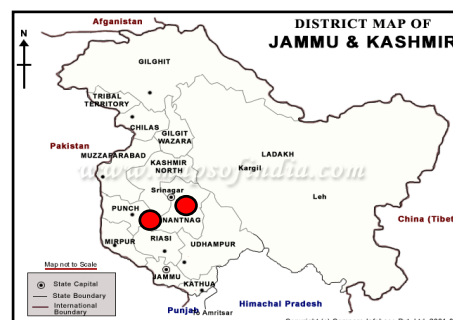
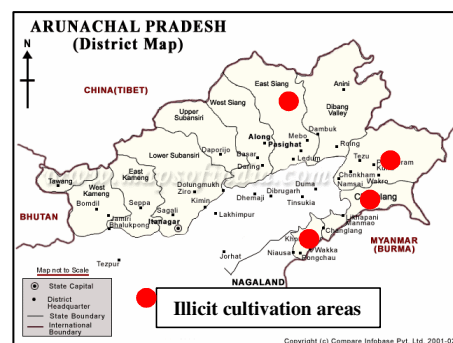
Illicit Cultivation

For centuries, opium has been cultivated in the north-eastern states of India for medical use by both people and livestock. It is also used in festivals and celebrations in these areas as well as Rajasthan. Most areas have now curtailed this practice, but it remains prevalent in remote areas, such as in the east of Arunachal Pradesh.

Illicit cultivation of opium poppy still occurs in India. It has been argued that illicit cultivation of opium poppy in the north east became commercial when the tribal population came into contact with timber merchants from the plains in the late 1980s. There is very little economic activity in these districts, and agricultural practices are essentially still subsistence-based. Opium is often the only marketable commodity produced, and it has the added advantage of being collected at the farm gate by traders or wholesalers – an option not normally available for other agricultural products.



Though it is extremely difficult to estimate the extent of illicit cultivation, according to a UNODC-sponsored study in 2001 which received logistical support from the Central Bureau of Narcotics (CBN), some production of opium was reported in Arunachal Pradesh (in the Upper Siang, Lohit, Changlang districts and Khonsa circle of Tirap district), Uttaranchal (Uttarkashi and Dheradun districts) and in Himachal Pradesh (Kulu, Mandi and Kalpa districts). Certain quantities are reportedly also produced in Jammu & Kashmir, Bihar and West Bengal (NCB 2002). Reports in 2004 cited experimental cultivation in Karnataka.



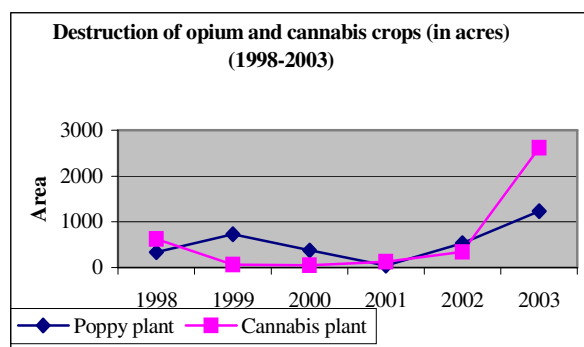
The market dynamics of illicit opium cultivation have been studied in some depth in Arunachal Pradesh. In order to determine the extent of illicit cultivation of opium poppy, a survey was carried out with logistical support from the CBN in three districts of Arunachal Pradesh. The survey covered 86 villages out of 506 on the three districts Upper Siang, Tirap and Changlang. Out of 86 villages 52 were observed to be growing opium. The main findings of the survey are as follows: (a) the majority of the cultivators had only started opium growing in 1999; (b) the size of the plots varied between 50sq.m and 12ha.; and (c) the average yield is approximately 5-8kg/ha. On this basis, it was estimated that cultivation in Arunachal Pradesh could reach 1,000ha, and that about half of this amount was accounted for in Lohit district. CBN destroyed 248, 153 and 218 hectares of illicit poppy during 1999, 2000 and 2002 respectively in Upper Siang, Lohit, Tirap and Changlang districts of Arunachal Pradesh. It also destroyed 9 hectares of illicit opium in Kullu during 2001 in association with Himachal Pradesh police.

Destruction of narcotic drug yielding plants in India

		1998	1999	2000	2001	2002	2003
Poppy plant	Area (in acres)	333	729	379	45	539	1,234
Cannabis plant	Area (in acres)	627	66	50	1,23	n/a	2,620

Source: NCB 2004.

The extent of such cultivation is very limited in comparison with the quantity of licit opium cultivation in India. Nonetheless, in line with its obligations under the international drug control treaties, India has stepped up its efforts to destroy illicit opium (see graph and table on this page).



Cannabis is also illicitly cultivated in the states of Jammu & Kashmir, Himachal Pradesh, Uttar Pradesh, Andhra Pradesh, Tamil Nadu, Kerala and Manipur. Every year, 80 to 100 tonnes of ganja (cannabis herb), both indigenous and smuggled is seized by the

enforcement agencies (NCB 2002). Judged on the basis of seizures, most of the cannabis cultivation in India occurs in the north east (NCB 2004).

Licit Cultivation

India is the only country currently producing licit opium gum for medical and scientific purposes for domestic needs and for export under the terms of the 1961 Single Convention.⁵

Opium poppy is cultivated in three states of India – Madhya Pradesh, Rajasthan and Uttar Pradesh – in the following 22 districts:

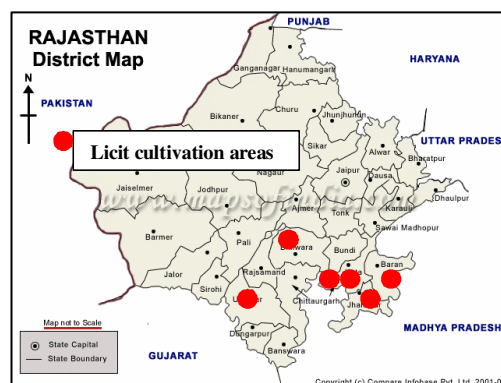
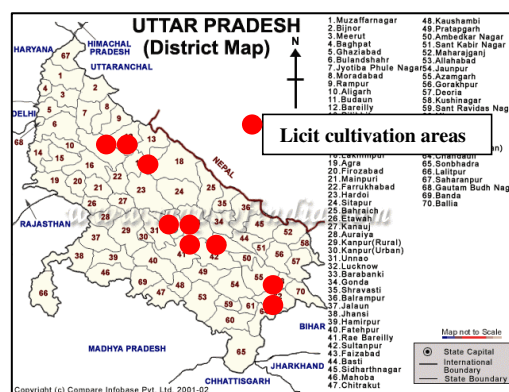
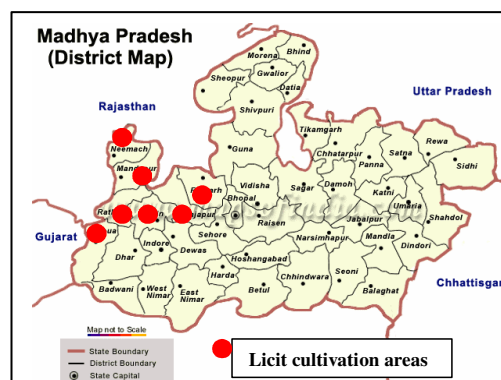
Madhya Pradesh: Mandsaur, Neemuch, Ratlam, Ujjain, Jhabua, Shajapur, and Rajgarh.

Rajasthan: Kota, Baran, Jhalawar, Chittorgarh, Udaipur and Bhilwara.

Uttar Pradesh: Barabanki, Faizabad, Ghazipur, Mau, Lucknow, Raibareilly, Bareilly, Shahjahanpur and Budaun.

The Central Bureau of Narcotics, based in Gwalior, implements a stringent licensing system in India. The crop is generally sown in November and harvested in March-April. Opium is used to extract alkaloids such as morphine, thebaine and codeine. After the extraction of the opium, the pods are crushed and the poppy seeds are extracted and can be used as condiments in Indian cooking.

The sale of poppy seeds forms a significant proportion of the income from the licit opium crop. The crushed pods left after extraction of the seeds are referred to as poppy straw. This poppy straw contains a small concentration of morphine residue. The state governments in India regulate the sale of poppy straw for medical and scientific purposes. Trafficking and abuse of poppy straw is a common problem in some north-western states of India.



⁵ The other countries which authorize licit opium gum production are the Democratic Republic of Korea (only for domestic purposes), and Japan (only in small quantities to maintain the technology). China produced licit opium for medical purposes until the end of 2001. While the country appears to have stopped such production it maintains estimates for opium production. There are 11 other countries that cultivate opium poppy for the extraction of alkaloids. These are: Australia, China, Czech Republic (where poppy-straw as an opiate raw material is only obtained as a by-product), France, Hungary, Slovakia, Spain, the former Yugoslav Republic of Macedonia, Turkey, the United Kingdom and Serbia and Montenegro (where poppy-straw as an opiate raw material is only obtained as a by-product). There are 6 more which cultivate only for horticultural or culinary purposes: Austria, Estonia, Germany, Netherlands, Poland, Ukraine, but they harvest the produce using means which do not involve the process of lancing and obtaining gum, thereby minimizing the risk of having opium diverted into illicit channels.

Raw opium is a viscous product with considerable moisture content. Opium tendered by the farmers at the time of procurement normally comprises of 55-60% solids; the remainder is moisture. For the sake of uniformity, all production figures of opium in India are calculated using a consistency ratio of 70 degrees i.e., comprising 70% solids and 30% moisture).⁶ The extent of licit cultivation of opium poppy in recent years is given below.

Licit cultivation (licensed area in hectares)

Year of harvest	1997	1998	1999	2000	2001	2002	2003	2004
Opium poppy	29,799	30,714	33,459	35,270	26,683	22,847	20,410	21,141

Source: CBN 2004, and correspondence with CBN in September 2005.

Licit production (metric tons at 70 degrees consistency)

Year of harvest	1997	1998	1999	2000	2001	2002	2003	2004
Opium produced at 70 degrees consistency	1,271	335	1,382	1,705	995	1,055	684	1,061

Source: CBN 2003, and correspondence with CBN in September 2005.

Number of licensed cultivators for the 2003-2004 growing season

Name of unit	No. of cultivators licensed	No. of cultivators			
		Did not sow	Who actually cultivated	Uprooted	Tendered opium
Madhya Pradesh	48,207	783	47,424	871	46,553
Rajasthan	44,695	2,273	44,422	491	43,931
Uttar Pradesh	10,795	77	10,718	2,647	8,071
Total	105,697	3,133	102,564	4,009	98,555

Source: CBN 2004.

Licensed cultivation/harvested area (in units) for the 2003-2004 growing season

Name of unit	Area licensed in hectares	Area utilized (in hectares)				Quant-ity of opium at 70° consistency	Average at 70° consistency
		Not sown+ unutilized	Measured	Uprooted	Harvested		
Madhya Pradesh	9,642	877	8,765	200	8,565	500	58.39
Rajasthan	9,339	768	8,571	110	8,461	506	59.83
Uttar Pradesh	2,160	22	2,138	573	1,565	55	42.27
Total	21,141	1,667	19,474	883	18,591	1,061	57.07

Source: CBN 2004.

The opium is thereafter dried and, for export, the consistency is increased to 90 degrees, i.e., 90% solids and 10% moisture. Most of the opium produced in India is destined for export. The quantities of opium exported in the recent past are contained in the table below.

⁶ Since all opium is first tested at the collection centres, in the case of farmers who produce low-consistency opium (e.g., 50 degrees consistency), a smaller amount would be recorded as their total. As an example, if a farmer produces 14 kg of opium of 50 degrees consistency, it will be reckoned as 10 kg (14 x 50 / 70).

Recent Opium Exports (in metric tons at 90 degrees consistency)

Year	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03
Opium exported	735	528	650	574	495	495

Source: CBN 2003.

The 2005 crop: According to provisional data from the Central Bureau of Narcotics, the total quantity of opium harvested in 2005 (March – April) declined by more than half to 439 metric tons. This was the result of a conscious decision by the union government to reduce the number of hectares under cultivation. The number of hectares harvested in 2005 was 7,833, down from 21,141 in 2004. The number of cultivators who actually tendered opium was 79,016, down from the 2004 total of 98,555. The average yield declined minimally from 57.07 to 56.04 kgs per hectare at 70 degrees consistency.⁷

Diversion: Although an elaborate system of regulatory and preventive controls has been established to prevent the diversion of opium, certain quantities do flow into illicit channels. This is evidenced by seizures in and near the poppy-cultivating areas⁸, although the extent of diversion is almost impossible to determine. One obvious incentive for unscrupulous farmers is the higher price offered by the illicit market (ranging from Rs.5,000 per kg during the crop season in April, to between Rs.15,000 - 20,000 in December/January). This can be compared with the government's official procurement prices, which generally vary from Rs.720 – Rs.2,100 per kg depending on the quantity of opium tendered per hectare.

Market studies also lend indirect support to the notion that the illicit manufacturing of some quantum of heroin within India results from diverted product. For example, a UNODC study of the illicit drug markets of Delhi (UNODC ROSA 2001) estimated, on the basis of respondents, that a significant portion of the heroin available on the city's streets originated from opium poppy cultivated in India. To reduce the risk of diversion, attempts have been made to ensure that the product is not left with the cultivators for a significant amount of time following the conclusion of the lancing and extraction of the opium. In an effort to further reduce the risk, the CBN has also initiated a project to estimate the licit opium poppy cultivation area through satellite imagery.

3(b) Manufacture

Opium / heroin: The number of heroin manufacturing facilities ('labs') detected during the past few years are as follows:

Year	1999	2000	2001	2002	2003
'Labs'	3	5	6	7	3

(Source: National Drug Enforcement Statistics as on 30 Nov 2004 compiled by the Narcotics Control Bureau, India)

Methaqualone: Methaqualone is a depressant used in combination with diphenhydramine (or, alternatively, diazepam) in the manufacture of Mandrax®. Methaqualone is not typically abused in India. It is illicitly produced in India and exported for consumption (both oral and smoked in combination with cannabis as 'white pipe') in South Africa, a country with which India has strong, historical, cultural and trading links. The NCB notes that the illicit

⁷ Source: correspondence between CBN and UNODC in September 2005.

⁸ For example the Annual Report of the Narcotics Control Bureau indicates that during the year 2003 39% of national seizures of opium occurred in the three states licitly cultivating opium (NCB 2004).

manufacturing of this drug, which was limited mainly to Maharashtra and Gujarat, could take place in pharmaceutical establishments in other parts of the country. Illicit manufacturing facilities have, in recent years, been discovered in Hyderabad, South Gujarat, Rajasthan and Eastern Uttar Pradesh. In some cases it was observed that these illicit operations had been financed and controlled by non-residents based outside India. The principal destination for the end product remains South Africa.

Substitute chemicals: One recent trend detected during certain investigations has been the use of acetyl chloride as a substitute chemical for Acetic Anhydride, which is controlled under the NDPS Act. The use of such chemicals will render the location and identification of illicit manufacturers increasingly difficult.

Amphetamine type stimulants: Although India produces many precursors used for illicit manufacture of amphetamines, until recently, illicit ATS factories had not been discovered. The precursors for ATS, especially ephedrine and pseudo-ephedrine, tended to be smuggled out to Myanmar for ATS manufacture there. A change in trend was however observed as a result of the successful dismantlement on 17 May 2003 of an illicit ATS laboratory in Kolkata and the seizure of 24 kg of ephedrine. The facility, involving Myanmar, Chinese and Indian nationals, had yet to start production. The raid was the result of a successful joint global operation by the Indian Narcotics Control Bureau, and authorities from China and the United States. On 5 June 2004, officers of the Directorate of Revenue Intelligence dismantled another factory in South India, which was manufacturing ecstasy (MDMA – Methylene DioxyMethyl Amphetamine) as well as methaqualone. Methamphetamine was also seized in the operation. Considering the relative ease of availability of ATS precursors in India and the growing demand for ATS in the world, especially SE Asia, the pattern is of concern.

Other Licit Drugs

India is a large manufacturer of pharmaceuticals. Its approximately 25,000 manufacturers account for about 10% of the total quantity of pharmaceuticals produced in the world. While the law requires all drugs with abuse potential to be sold only on prescription, there are reports of significant diversion (INCB 2003). Proxyvon® (a preparation of dextropropoxyphene), buprenorphine, Phensidyl® (a codeine based cough syrup), diazepam, nitrazepam and lorazepam are the most commonly abused pharmaceuticals (NCB 2002). In India, currently, injecting drug use is more closely linked to the abuse of licit opiate pharmaceuticals than to illicit drugs. A related problem is the issue entrance of spurious drugs into the marketplace.

3(c) Trafficking

India is wedged between the world's two largest areas of illicit opium production, the Golden Crescent and the Golden Triangle. This proximity has traditionally been viewed as a source of vulnerability, since it has made India both a destination and a transit route for opiates produced in these regions. However, the question of precisely how much of the heroin consumed in India is attributable to opium diverted from licit production continues to be debated. In addition, Nepal is also a traditional source of cannabis, both herbal (marijuana) and resinous (hashish). As is typical of all countries, an assessment of the work of law enforcement in seizing quantities of drugs and making related arrests provides the basis upon which an analysis of drug trafficking patterns can be made. The table below depicts a series for the past seven and a half years.

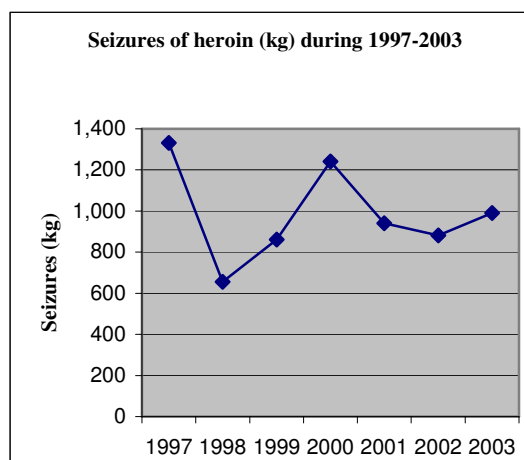
Drug Seizures in India (in kg)

Drugs		1997	1998	1999	2000	2001	2002	2003	2004 (up to October)
Heroin	Seizures	1,332	655	861	1,241	940	881	991	856
	cases	2,990	3,095	2,937	2,845	3,893	4,432	5,578	2087
Cocaine	Seizures	24	1	1	0.35	2	2	3	1
	cases	6	6	4	5	10	5	11	4
Opium	Seizures	3,316	2,031	1,635	2,677	2,533	1,835	1,720	1616
	cases	1,333	954	927	1,255	1,205	1164	905	451
Morphine	Seizures	128	19	36	39	26	66	109	48
	cases	75	56	125	142	146	148	266	137
Cannabis	Seizures	80,866	68,221	40,113	96,218	86,933	88,491	79,483	105,097
	cases	7,062	6,018	6,518	6,071	7,615	4,172	9,389	2004
Cannabis resin/ hashish	Seizures	3,281	10,106	3,391	5,041	5,664	3,010	3,013	4,012
	cases	2,223	2,193	2,500	2,078	2,117	2,038	1,739	883
Methaqualone	Seizures	1,740	2,257	474	1,095	2,024	7,458	345	1614
	cases	207	114	8	31	8	7	6	3
Acetic anhydride (litres)	Seizures	8,311	6,197	2,963	1,337	8,589	3,288	857	2663
	cases	12	9	7	14	8	4	6	7
Ephedrine	Seizures	8,311	1,051	2,134	426	930	126	3,234	1,000
	cases	12	14	51	8	5	4	8	2

Source: National Drug Enforcement Statistics, NCB as well as NCB Annual Reports.

Heroin:

The trafficking of heroin on a commercial scale dates back to the 1970s when the traditional Balkan routes were disturbed by geopolitical developments. Drug traffickers started using India as a transit country for heroin originating in South West Asia. They were assisted in this regard by pre-existing networks of smugglers operating on the Indo-Pakistan border engaged in gold and other commodity smuggling. The opening up of the CIS route for SW Asian heroin rendered India less attractive as a transit route and the annual seizures of heroin during the past few years have declined to hover around one metric tonne.



In relation to global trends, this average annual Indian seizure of one metric tonne is relatively modest when compared with the approximately 50 metric tons seized annually across the world (UNODC 2004). India has nonetheless witnessed a marginal increase in heroin seizures during the year 2003. Seizures increased from 881 kg during 2002 to 991 kg during 2003 (NCB 2004).

Main routes: The data indicates that the areas most vulnerable to drug trafficking are the north western states bordering Pakistan as well as Maharashtra (whose capital is Mumbai), Delhi and the Tamil Nadu coast which constitute the exit routes. A new trend has been detected during the past 18 months that includes the movement of heroin from the northern population belt eastwards and out of South Asia via Bangladesh. It has been suggested that

this movement can be explained by the strengthening of controls imposed upon the export of heroin via the Tamil Nadu route.

It is recognized that unscrupulous farmers divert part of the licitly produced opium and this is converted into heroin. Heroin trafficked in India originates from three main sources: (a) South West Asia, (b) South East Asia and (c) indigenously produced heroin from diverted opium. South West Asia, which has traditionally been the primary source, accounting for 37% of the total heroin seizures during 1998. The share of SW Asian heroin in total Indian seizures has been gradually declining and accounted for a mere 4% of the total heroin seized during 2003 (NCB 2003). South East Asian heroin always accounted for only around 1% of the total seizures (NCB Annual Reports, various years).

The absence of a heroin signature programme in India causes difficulty in ascertaining with absolute certainty the provenance of much of the heroin seized. In cases where specific packaging, marks and numbers are still present it is possible to identify provenance. However, once the product passes through several hands, these identifying marks may be lost because of possible substitution and adulteration of the original seized drug.

Year	1996	1997	1998	1999	2000	2001	2002	2003
Total heroin seized (kg)	1,257	1,332	655	861	1,241	940	881	991
SW Asian %age	64	48	37	38	39	20	5	4
SE Asian % age	1	1	1	1	1	1	1	1
Unknown %age	35	51	62	61	60	79	94	95
Total quantity (kg)	1,257	1,332	655	861	1,241	940	881	991
SW Asian qty. (kg)	802	640	240	326	483	185	45	39

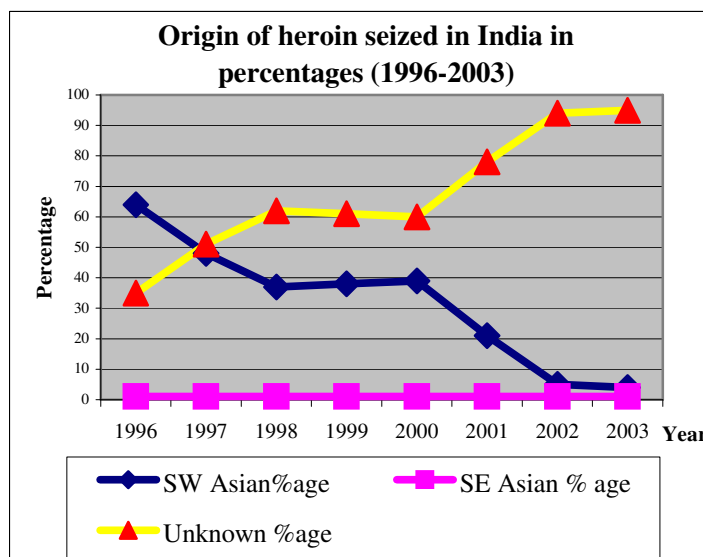
Source: NCB Annual Reports, various.

South West Asia: South West Asia has traditionally been considered the main source of heroin in India but its quantum has fluctuated significantly in response to the level of tension associated with activities on the Indo-Pakistan border. For example, during 1998, 1999 and 2000 over 35% of the heroin seized in India was deemed to have originated in South West Asia (NCB 2002). This figure declined to 20% in 2001 and to 4% during 2003 (NCB 2003). Security concerns between India and Pakistan and consequent military build-up appear to have been the cause of the reduced trafficking. The net effect was a significant fall during these years both in the total quantity of seizures and the proportion of South West Asian heroin involved in total seizures. Most of the seizures of South West Asian heroin have taken place in states close to the border – namely Rajasthan, Punjab and Jammu & Kashmir.

South East Asia: Total heroin seizures in the north-eastern states totalled only 8 kg in 2002 (or 1%) compared with 12kg in 2001. Trafficking volumes of heroin entering India mainly from the Myanmar border are significantly lower than the volumes of product that enter the country from Pakistan. Moreover, while heroin from Afghanistan and Pakistan is reported to mainly transit India to overseas destinations, there are no reports that the heroin trafficked into north east India is either to other parts of the country or smuggled abroad. Such product tends to be consumed mainly in the north-eastern states themselves. The purity of heroin trafficked in from Myanmar tends to be high (heroin number 4). The NCB reports that the problems of interdiction in the north-east relate to “the existence of traditional cross-border ethnic links, lack of restrictions on movement, inhospitable terrain and the problem of insurgency”. (NCB 2002)

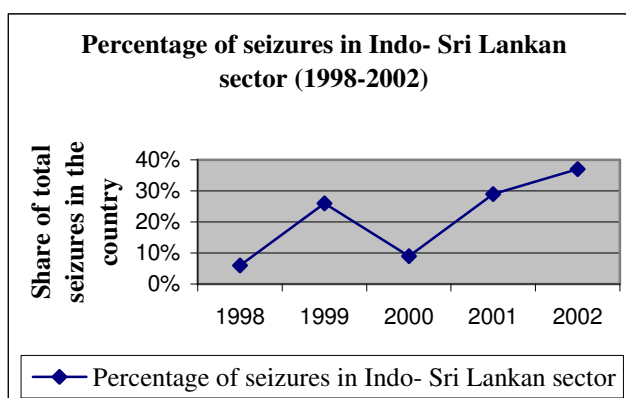
Locally manufactured heroin:

Notwithstanding the caveat above regarding the absence of a signature programme and in spite of the strict controls exercised by the CBN, an unknown quantity of opium is believed to be diverted into illicit channels. According to NCB figures, approximately 4% of the heroin seized during 2003 was sourced in South West Asia and 1% in South East Asia. The origin of the remaining heroin seized could not be determined with complete accuracy.



Nonetheless, according to the NCB, while “a major percentage of [...] diverted opium is intended for local consumption of [opium] addicts in the country [...] some of it also appears to get processed into heroin in makeshift clandestine laboratories” (NCB 2002). An analysis of the seizures on a state-by-state basis shows that the three opium-cultivating states – Rajasthan, Madhya Pradesh and Uttar Pradesh – accounted for nearly 50% of total seizures. Most of the heroin laboratories dismantled in India are also located near to the opium cultivating areas.

Indo-Sri Lankan sector: Seizure statistics as well as information from other sources have demonstrated the rapid increase in the use of the Tamil Nadu coastline around Tuticorin as a staging point for heroin shipments to Sri Lanka. The Tamil Nadu route has become the most significant drug trafficking route out of India in recent years. According to the NCB,



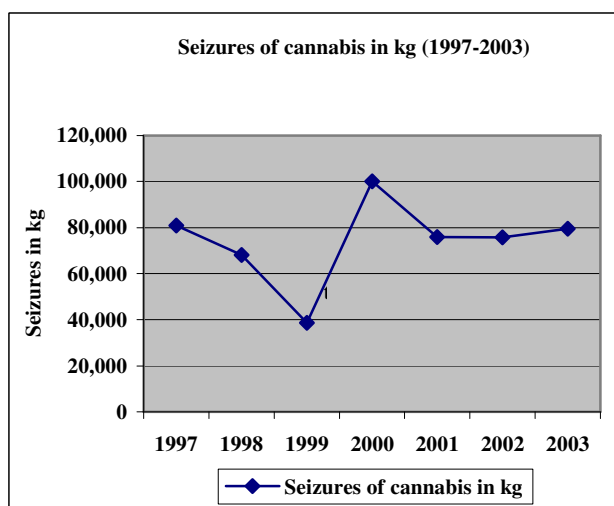
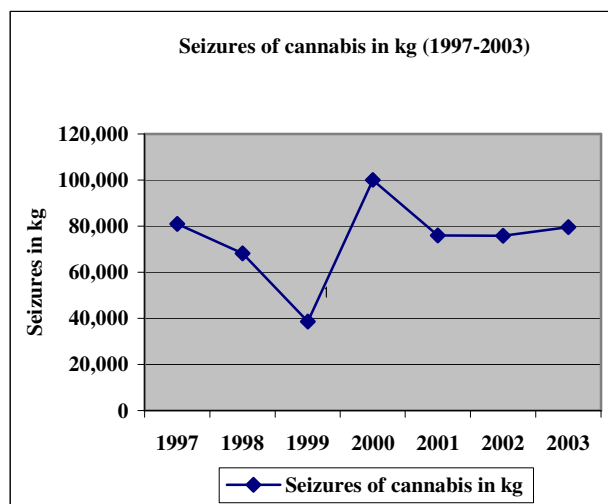
“geographical proximity and ethnic links contribute to smuggling between coastal southern India, especially the southern Coromandel coast and the north western coast of Sri Lanka by sea, mainly by small craft” (NCB 2002). Of the total seizures of heroin, only 6% was seized in the Indo-Sri Lankan sector during 1998. This figure increased to 29% during 2001, and 37% during 2002.

Heroin has traditionally been smuggled out to destinations in the west primarily through Mumbai and Delhi. The two new routes developed over the past few years, viz., the Indo-Sri Lankan sector and Indo-Bangladesh sector especially the former continues to grow in significance. In September 2005, New Delhi witnessed its largest seizure (18kg) of a combination of heroin and cocaine smuggled in by West African nationals from Kabul en via New Delhi en route to Addis Ababa.

Cannabis:

On average, Indian law enforcement agencies seize between 80-100 mt of cannabis each year. In 2003, the figure was 79 metric tons of hashish (*charas*) and herbal cannabis (*ganja*) compared with 88 metric tons in 2002 and 87 metric tons in 2001. In India, herbal cannabis constitutes the majority of seizures of illicit drugs in volume terms. In 2003, the north-east as a whole accounted for 34% of all cannabis seized throughout the country (NCB 2004).

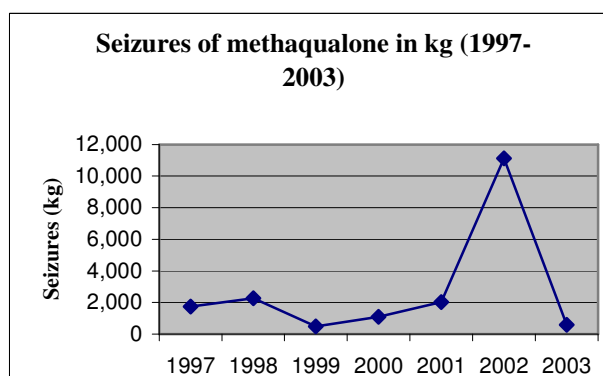
Cannabis is widely cultivated along the states of Manipur and Meghalaya. It is reported that the militant organizations in the region have developed a form of patronage with the narcotic smuggling groups in exchange for money.



Hashish is produced indigenously and both herbal cannabis and hashish are also smuggled in from Nepal by trucks and passenger vehicles. Nepalese hashish is reported to constitute approximately 40% of the total seizures (NCB 2002). Movement across the Indo-Nepalese border tends to be relatively free without any passport or visa restrictions. Among the Indian states, while Gujarat and Maharashtra remain the key transit states, Kashmir has emerged as a significant source of hashish. In the very recent past, some seizures of cannabis have been sourced to Bhutan.

Methaqualone: Seizures of methaqualone declined considerably during 2003 to 593 kg. During the previous two years, 2002 (11,130 kg) and 2001 (1,984 kg) seizures of methaqualone had increased sharply over the quantity seized in 2000 (1,095 kg). Although seizures were made in all parts of the country, most were concentrated in Mumbai.

The pattern of seizures during the last three years, as well as information on organized criminal groups involved in its production, suggests that there is a need to review earlier assessments that the illicit production of methaqualone in India has been eliminated. There are clear indications of a revival of illicit production particularly in the vicinity of Mumbai. An important factor in the



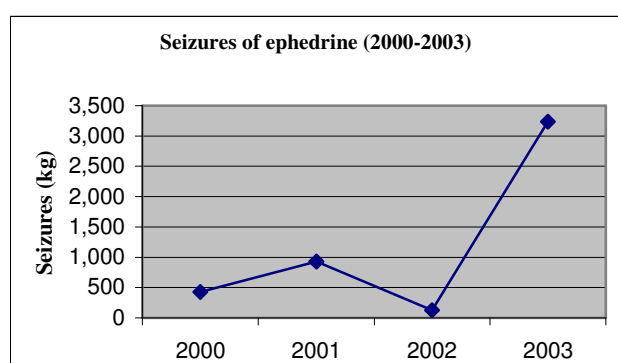
clandestine manufacture of methaqualone in the Mumbai area is the closure of a number of small-scale pharmaceutical units. Some former employees of these units who possess the necessary expertise have reportedly been lending their technical skills to illicit methaqualone manufacturers. In some cases it was found that these illicit operations were financed and controlled by non-residents based outside India, particularly the United Arab Emirates. Illicit facilities have been detected and shut down in Uttar Pradesh, Rajasthan, Gujarat and Andhra Pradesh.

The principal destination for the end product remains South Africa. Another feature, which has been reported through some investigations, is the use of acetyl chloride as a substitute chemical for acetic anhydride which is controlled under the NDPS Act. The use of such chemicals will render the location and identification of illicit manufacturers increasingly difficult. Authorities in India are cooperating with the International Narcotics Control Board in this regard.

Amphetamine Type Stimulants (ATS):

The volume of trafficking of ATS and the quantum of abuse has increased in India in recent years. Since 2000, small consignments have been entering India principally from across the Indo-Myanmar border. For example, during the year 2000, 0.09 kg and 2,839 tablets of amphetamines were seized. The

quantity increased to 9,336 tablets in 2001 and 9,926 tablets during 2002. While ATS are smuggled from Myanmar into north-eastern states of India, ephedrine and pseudo-ephedrine – the precursors for their manufacture – are smuggled from India to Myanmar. It has not been established whether this process is part of a barter arrangement.



In December 1999, India imposed controls on ephedrine and pseudo-ephedrine under the NDPS Act. It is interesting to note that seizures of ephedrine in India after a significant fall in 2000 to 426 kg rose again to 930 kg in 2001, fell to 126 kg in 2002, and again increased to 3,234 kg in 2003. The overall trend appears to be one of increased trafficking and consumption.

During 2003, authorities of Narcotics Control Bureau – in coordination with Chinese and US authorities – foiled an attempt to establish an ATS manufacturing facility in Kolkata. During 2004, officers of DGRI dismantled an ecstasy manufacturing facility and another facility for tableting the drug in South India. Thus, attempts to manufacture ATS within India appear to have surfaced. This is a matter of concern because India is a major producer of the ATS precursors ephedrine and pseudo-ephedrine.

Cocaine: Seizures of cocaine have remained steady – but not statistically significant – at about 2kg during 2001, 2002 and 2003 (National Drug Enforcement Statistics compiled by NCB). Cocaine appears to be smuggled in primarily to meet the demand of the more affluent drug users in India's metropolitan areas. There are increasing press reports of cocaine as a drug of choice among this group. Cocaine users are the third most common users of treatment services in Maharashtra (UNODC ROSA and MSJE 2002).

Pharmaceutical preparations: The illicit trafficking of pharmaceuticals both within and outside the country takes place on a large scale, mainly to Bangladesh, Myanmar, Nepal, Pakistan (via Dubai) and CIS countries (NCB 2002). Authorities in Bangladesh report concern over the volume of pharmaceutical preparations like cough syrups and painkillers, which are smuggled into that country from India. For example, during 2002, law enforcement authorities on the Indian side of the border seized 300,000 bottles of Phensidyl® (NCB 2002). A similar problem is being observed, though not on the same scale, regarding the smuggling of painkillers and cough syrups into Nepal.

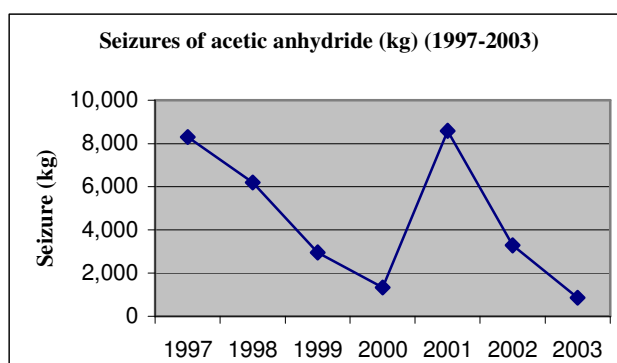
Drug trafficking in the north-east of India: Most of the problem substance abuse in the north-eastern states of India relates to alcohol, cannabis (commonly referred to as ‘ganja’), heroin Number 4 and Spasmoproxyvon®.⁹ The latter two are of particular concern, as they both tend to involve the practice of injecting. Heroin Number 4 enters the country across the border from Myanmar. While there are joint cross-border meetings with Myanmar aimed at improving cross-border cooperation, these are not held regularly in all states. The heroin commonly referred to as ‘brown sugar’ enters the north-east states from their respective borders with other Indian states. There have been no large seizures of heroin in the north-east of India. Some opium is seized (usually it is wet opium imported from Myanmar). Most of the bulk seizures are accounted for by cannabis. Some states in the northeast impose tight controls on the availability of SP. Ephedrine, a precursor for the manufacture of ATS also moves move into Myanmar from India.

3(d) Diversion of drugs and precursors

The diversion of precursor chemicals from licit channels takes place in spite of strict controls exercised by law enforcement agencies.

Acetic anhydride (AA): Acetic Anhydride is a precursor to the production of heroin and methaqualone. India produces approximately 45,000 mt of acetic anhydride each year for use in its pharmaceutical and dye industries. Strict controls have been imposed on this chemical under the NDPS Act, Export Import Policy as well as the Customs Act.

There are 11 manufacturers of acetic anhydride in India with an annual output of 30,000 to 40,000 tons for various industrial and pharmaceutical uses. Acetic anhydride is subject to a special customs regime, according to which its storage and transportation within 100 km of the Indo-Myanmar border and 50 km of the Indo-Pakistan border are subject to special controls. Traffickers have tried alternative methods such as exporting acetic anhydride in misdeclared sea cargo consignments using Dubai as a transshipment point. Acetic anhydride has continued to be seized by local law enforcement authorities. The acetic anhydride seized had been intended for use mainly in the illicit manufacture of low-grade heroin in India (INCB 2004).

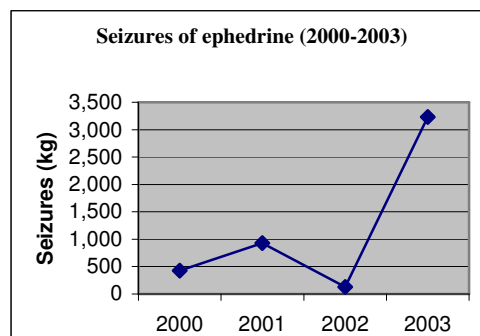


⁹ Spasmoproxyvon is an analgesic containing dextropropoxyphene, a narcotic drug regulated under the 1961 UN Convention - more generally referred to as ‘SP’.

Seizures of acetic anhydride during the past few years are depicted in the graph on this page. There has been a decline in seizures between 1997 and 2000. However, in 2001 the seizures jumped up to 8,589 kg to come down again to 3,288 kg in 2002 and down further to 857 kg during 2003.

There has been a decline in the smuggling of acetic anhydride across the Indo-Pakistan border, the traditional favourite route. Neither India nor Pakistan has reported seizures of acetic anhydride along the border in recent times. Most of the diverted acetic anhydride appears destined to manufacture either methaqualone or heroin within the country. There have been attempts, some successful, to export acetic anhydride clandestinely from India in maritime cargo consignments (NCB 2000).

However, the most common method of diversion is pilferage by drivers of tankers carrying acetic anhydride. This acetic anhydride is further accumulated by illicit traders and supplied to illicit drug manufacturers.



Ephedrine: Ephedrine is a precursor to the production of amphetamine-type stimulants (ATS). India produces over 500 mt of ephedrine and pseudo-ephedrine annually. The seizures of ephedrine during the past few years are as follows:

Year	2000	2001	2002	2003
Seizures (kg)	426	930	126	3,234

Source: National Drug Enforcement Statistics compiled by NCB India.

These figures indicate a gradual increase in the seizures of ephedrine in the long-term. Both substances have been declared controlled substances under the NDPS Act in December 1999. Consequently, all manufacturers, traders and consumers of these chemicals are required to maintain records and comply with other restrictions under the NDPS Act. Despite these controls, diversion and trafficking appears to be on the increase.

Anthranilic acid: Anthranilic acid is the precursor used for illicit manufacture of methaqualone. It has been brought under control under the NDPS Act. In almost all illicit methaqualone facilities within the country, anthranilic acid is used.

3(e) Drug prices

As per reports available, the approximate prices of various narcotics drugs in the illicit Indian market are given below. All prices are as per NCB Annual Report 2002.

Pharmaceutical preparations

Pharmaceutical preparations containing narcotic drugs and psychotropic substances are often diverted for abuse; these tend to fetch a price of 400% to 500% in excess of their licit market price. A strip (8 capsules) of Spasmoproxyvon costs Rs.50 (US\$1.04) while its licit price is Rs.11 (US\$0.22) (average daily dose = 20 capsules). Benzodiazapines such as Nitrazepam and Diazepam are also diverted for abuse. A strip of these costs Rs.70-80 (US\$1.45-1.66) while their licit price is Rs.12 (US\$0.25)

Heroin

The illicit market price of heroin in India varies with the region, the level of purity and the stage in the marketing chain. On average, wholesale heroin prices in India are reported to be in the region of Rs. 200,000 per kg (US\$4,500). Street prices in north east India are as follows: half a gram of heroin number 4 costs Rs.600-800 (US\$12.50-16.66); half a gram of brown sugar costs Rs. 250-350 (US\$5.20-7.29). By comparison with prices in other countries, the wholesale price of heroin can start from US\$25,000 per kg.

Hashish

The wholesale price of hashish in India is approximately Rs.13,500 (US\$300 per kg) on average, although the price varies significantly throughout the country. The price at street level can reach Rs.35,000 (US\$729). In the US, the price can fetch US\$2,500 per kg.

Herbal cannabis (ganja)

Wholesale price of herbal cannabis can be as low as Rs.400 (\$9) per kg near to source areas. Nearer the main consumption centres it can fetch prices between Rs. 2,000-3,000 (\$44-66). In some cities, street prices up to Rs. 4,000- 6,000 (US\$83-125) per kg. Internationally, wholesale prices for herbal cannabis tend to range around \$2,300 per kg.

Precursors

The licit price of acetic anhydride in India is about Rs.50 (US\$1) per litre. The illicit price varies depending on the stage in the chain of illicit supply. Illicit drug manufacturers may pay up to Rs.1,000 (US\$20) per litre.

3(f) Demand

Although many studies examining the issue of substance use in India have been published in the scientific literature, few published studies have addressed the issue of the epidemiology of substance use disorders in the country. While some treatment-setting-based studies have been published, there is a relative dearth of studies from the community setting. The latest information on drug demand in India comes from the national survey of drug abuse in India released under the title of “The Extent, Pattern and Trends of drug abuse in India” (UNODC ROSA and MSJE 2004).

Summary findings of the National Survey released in 2004

This survey, jointly released in June 2004 by the Ministry of Social Justice and Empowerment and UNODC, contains a multi-modality approach whose main advantage is to ensure crosschecking, triangulation and multiple indicators in order to provide the most accurate picture of drug abuse trends. The National Survey has four major components.

- National Household Survey of Drug and Alcohol Abuse (NHS)
- Drug Abuse Monitoring System (DAMS)
- Rapid Assessment Survey of Drug Abuse (RAS), and
- Focused Thematic Studies:
 - Drug Abuse among Women
 - Burden on Women due to Drug Abuse by Family Members
 - Drug Abuse among Rural Population
 - Availability and Consumption of Drugs in Border Areas

- Drug Abuse among Prison Population

The **NHS** was carried out between March 2000 and November 2001 on a randomly selected nationally representative sample (males only, 12 to 60 years) across the country. Altogether, 40,697 males were interviewed and data on various socio-demographic and drug use parameters was collected. Alcohol, cannabis and opiates were found to be the three most common drugs of use. The prevalence of current use (i.e., use within the preceding month) was as follows:

- Alcohol - 21.4%
- Cannabis - 3.0%
- Opiates - 0.7%
- Any illicit drug - 3.6%
- IDU - 0.1%

Based on the above data, it can be projected that currently in India, there are approximately:

- 62.5 million alcohol users
- 8.7 million cannabis users
- 2 million opiate users

It was observed that among current alcohol users, 17% were dependent users. Correspondingly, 26% of current cannabis users and 22% of current opiate users were dependent users. These figures translate to 10 million alcohol-dependent individuals, 2.3 million cannabis-dependent and 0.5 million opiate-dependent individuals. This can be considered as the 'volume of work' for India in terms of providing treatment services.

In the **DAMS** component (UNODC ROSA and MSJE 2002), data was obtained from patients seeking help in various drug abuse treatment centres. A total of 203 centres participated. The four most commonly abused substances were alcohol, cannabis, heroin, and opium. Alcohol was reported by 43.9% of treatment seekers. This was followed by opiates as a group (26.0%) and cannabis (11.6%). About 14% of individuals reported injecting drug use (IDU).

In the **RAS** component (UNODC ROSA and MSJE 2002a), information was collected from drug users on the streets of 14 cities in the country.¹⁰ Some Key Informants (KIs) were also interviewed. Out of 4,648 drug users interviewed, 371 (8%) were women. Opiates (heroin, buprenorphine and propoxyphene) and cannabis were the major drugs abused. The highest proportion (35.6%) of subjects was currently (i.e., within the last one month) using heroin followed by other opiates (propoxyphene, opium, buprenorphine, and pentazocine) at 28.6%. About 22% were using cannabis, about 5% were alcohol users and 3.7% had used sedatives and hypnotics. Nearly half had injected drugs at some time in their life (43%).

Through **Focussed Thematic Studies**, it was found that drug abuse does exist among women in India and women also bear significant burden due to drug abuse by their family members. Drug abuse was also reported in rural areas, border areas and prisons.

¹⁰ In the five cities - Chennai, Delhi, Imphal, Kolkata and Mumbai- another RSA was also conducted prior to the national survey and has been reported in Dorabjee and Samson (2000).

The nature of drug use in India

- *Rural versus urban background:* In this NHS, 51.6% of the subjects came from a rural background and the remaining 48.4% were from urban India. They resembled each other on most of the parameters. The monthly income was slightly higher among the subjects from an urban background. People from an urban background more often reported heroin abuse, injecting drug use (IDU) and needle sharing. In contrast, users of other opiates and cannabis were generally from a rural background. A marginally higher percentage of urban users had been introduced to drug use earlier, i.e. before the age of 20 years (42% versus 34%).
- *'Ever use' versus 'current use':* It was observed that many 'ever users' were 'current users'. The proportion of 'current users' as part of 'ever users' was around 80% for alcohol, 70% for cannabis and 65% for opiates. Thus, drug use, once initiated, appears to continue in a majority of cases.
- *Youth (DAMS):* Among treatment seekers (the DAMS component), there were several young subjects. Overall, about 5% of total treatment seekers in various states were below 20 years of age. It was noted that young people reporting for treatment were more often users of propoxyphene, heroin and cannabis.
- *Youth (RAS):* A total of 368 out of 2,831 subjects were below the age of 20 years. In addition it was seen that the mean age of initiation to drug use was around 19 years. The data from Chennai described drug abuse by street children, who used a variety of substance including inhalants, cannabis, alcohol and heroin. Some of these children were involved in drug dealing.
- *Reasons for drug use:* Common reasons given for drug use were curiosity, experimentation, being in the company of drug users and to experience the effects. By and large, the reasons were similar regardless of the substance being used.
- *Treatment-seeking (DAMS):* Very few current users of these drugs contemplated treatment for drug use. Only a small minority did actually seek help. Among alcohol users, only 2% actually sought help. Four percent of cannabis users and about 18% of opiate users reported that they had visited treatment centres to quit drug taking, although there were significant regional variations within the country. However, a large number of IDUs (73%) had reported for treatment.
- *Treatment-seeking (RAS):* Overall, about one-third had attempted to reduce drug consumption in the preceding six months. However, only a minority (27%) had ever reported to any organisation for help and an even smaller percentage (12%) was currently receiving treatment. Some were not even aware of the availability of treatment facilities. Some others reported that they faced difficulty in obtaining help for treatment from the established treatment centres. Amongst those who reported for treatment, the level of satisfaction was not high. The available responses suggested that certain factors – lack of infrastructure, cost of treatment, lack of facilities and indifferent attitude of staff – which discouraged them from undergoing treatment.
- *Implications:* The data shows that a large number of current users require help to prevent them from progressing towards regular or dependent use, and as a result, interventions

should be planned for these subjects. However, the dependent users (addicts), varying between 17% and 26% of current users would need treatment most urgently. This number (0.5-10.6 million, of alcohol, cannabis, opiate and sedative/hypnotic users) might constitute the estimated caseload burden for India at present.

Injecting Drug Use (IDU)

The most significant recent shift in drug use patterns in India is the move from smoking or chasing to IDU. Heroin, buprenorphine (Tidigesic® / Tamgesic®) and dextropropoxyphene (Spasmaproxyvon®) are the drugs that are commonly injected in India. HIV prevalence among drug users in India demonstrates considerable heterogeneity. There are high levels in some areas particularly in certain parts of North East India (e.g., the state of Manipur with a reported HIV prevalence of up to 60% in some districts). High prevalence also occurs in many cities with a concentrated IDU population (e.g. Chennai and New Delhi). Low prevalence is observed in other urban areas such as Mumbai and Calcutta.

Information on IDU is available from several components of the survey. These include the National Household Survey (NHS), the Drug Abuse Monitoring System (DAMS), the Rapid Assessment Survey (RAS), and four of the Focused Thematic Studies, namely: Drug abuse among Women, Drug abuse among Rural Population, Availability and Consumption of drugs in the Border Areas and Drug abuse among Prison Population.

- *Proportion of IDUs:* The proportion of IDUs varied between 0.1% (in NHS) and 43% (in RAS). In the RAS, the highest prevalence of IDU was reported from Imphal (80%) followed by Chennai (43%) and Kolkata (38%). In the RAS, the age of IDU initiation varied between 15 and 28 years. There was a gap of 2-10 years before shifting to injecting practices. In the DAMS component, 14.3% reported 'ever' using drugs through the injecting route and 9.4% could be called 'current' IDUs.
- *Profile of IDUs:* IDUs were present among all sections of the population. However, the prevalence was higher depending upon the setting and population sub-group. It was definitely higher in the urban sample and more so among those recruited from the street (non-seekers of treatment). Finally, even among the rural sample, though prevalence was low, IDUs were detected. IDUs among women, though rare, were also reported.
- *Drugs being injected:* The common drugs of abuse by means of injecting were propoxyphene, heroin and buprenorphine. IDUs were often poly drug users and the abuse of pharmaceutical products was popular with them.
- *Reasons for injecting:* Common reasons cited for injecting drugs were 'non-availability of heroin (brown sugar)', 'injections are less expensive', 'better and quicker high' and 'peer-influence'. The data also suggested that non-availability of heroin and easy over-the-counter availability of injectable pharmaceutical products such as pentazocine and buprenorphine led to a transition towards injecting. This should be seen in the context of a lack of availability of traditional drugs of abuse.
- *'Reverse switch':* Although it was observed that most IDUs had shifted from non-injecting to an injecting route, some others had also reported a 'reverse switch' i.e.

shifting to a non-injecting route from injecting practices. Many drug users reverted to smoking because of blocked veins, health hazards, increased awareness, availability of “good-quality” heroin and treatment.

Multiple adverse consequences and risk behaviours related to IDU were also found. These are described under ‘Costs and Consequences’.

Substance use in prisons

In India, 70% of prison inmates are ‘under trials’ (in remand), moving in and out of the prison settings until they are convicted or discharged. Although India has a low prison population (29 prisoners per 100, 000 inhabitants), it suffers from prison overcrowding: prisons are generally 30% overfilled (ICPS 2004). This may facilitate the spread of diseases, including HIV/AIDS. Drug dependent individuals comprise about 8% of admissions in Tihar Jail, New Delhi, one of Asia’s largest jails. The majority of these are primarily heroin users who inhale, although IDUs have also been reported in sizeable numbers (UNODC ROSA and MSJE 2002b). Most are long-duration drug users (more than five years) and some have histories of multiple arrests. Since the universal mandate of prisons is rehabilitation of convicts and safe custody of remand prisoners, the prison staff is more interested in the safe custody of the latter. The long judicial process increases the exposure of prisoners in remand to the risk of drug abuse.

Drug addiction treatment and rehabilitation are carried out in Delhi Prisons. With an increase in the number of medical officers at present, Delhi Prison was able to take over the detoxification of drug users from an NGO working since 1989. Currently, there are 3 detoxification centres with 72 detoxification beds, 60 for adult males and 12 for adolescents. Following detoxification, the adult males are rehabilitated in therapeutic communities run by AASRA, an NGO that houses about 800 drug dependent prisoners. The end results of the programme are still evolving. The prison environment has become conducive to rehabilitation and it is now possible to conduct rehabilitation programmes with wide range of disciplines. Gradually, a positive change in the mindset of the prison staff has occurred for the treatment and rehabilitation of drug dependents in the prison environment since 1993.

Various studies have shown that the severity of drug use and the vulnerability to consequences of drug use increase among inmates especially if no services address the needs of this group.

Substance use among street children

Street children are those for whom “the street” has become the home rather than “the family”. In such situations, there is no protection, supervision or direction from responsible adults (HRW 1996). According to some estimates, India has the largest number of working children in the world (Simmhan 2004), as well as the largest number of street children in the world (HRW 1996). According to one dated estimate, at least 18 million children lived or worked on the streets of urban India in 1996 (HRW 1996). The recent estimate is that about 47.2 million homeless and runaway adolescents are roaming on the streets of India (Khurana et al 2004). Street children are a group known to be generally vulnerable to drug abuse. A review of drug abuse among children in India (Tripathi and Lal 1999) stated that common drugs of abuse among children and adolescents in India were tobacco and alcohol, while the use of illicit drugs like cannabis and heroin were also reported. Of concern was the finding, in the

same study, of a high prevalence of drug use and even IDU among street children and working children. Street children have been found to be involved in crime, prostitution, gang-related violence and drug trafficking (Das 2003).

A study examining high-risk behaviours among street children in Bangalore reported that 50% of street children who abused drugs also practiced unsafe sex (BOSCO 1999). In another study from the same city (Ramkrishna et al 2003), 121 street boys were interviewed. The median age was 16 years. Drug and alcohol use was common. Half the boys inhaled “solution” (typewriter correcting fluid), and nearly half (46%) consumed alcohol. About 61% boys were sexually active. Anal sex, which is usually a boy-to-boy activity, was the most commonly reported sexual behaviour, followed by vaginal sex. A commonly observed feature of substance abuse by children and adolescents in India is the abuse of inhalants (Waraich et al 2003, Basu et al 2004). In a recently published study (Pagare et al 2004) 115 male street children aged 6 to 16 years were interviewed in New Delhi. More than half (57.4%) of the subjects had indulged in substance use before coming to the observation home. The agents consumed were nicotine (44.5%), inhalants (24.3%), alcohol (21.8%) and cannabis (26.4%). Substance use was found to be significantly associated with domestic violence, maltreatment of the child, nuclear families, running away from home, and the working status of the child.

Recent findings on drug consumption from small-scale studies

Since the research was done for the National Survey during 2000-2001, a number of smaller studies have been undertaken most of whose findings essentially serve to confirm the overall trends depicted in the National Survey. A synopsis of this work is given below.

Kumar and Basu (2000) reviewed the prevalence of substance abuse among medical students and doctors in India and reported that the frequent use of alcohol/drugs among medical students was up to 56% while ‘ever’ use was up to 81%. Common drugs abused were alcohol, tranquillizers and opioids. Reasons cited for drug use included, “to relieve stress”, “to feel good” and “heightened sexual experience” (particularly for opium).

A cross-sectional survey was carried out at two points of time with an interval of one year in a representative sample of the general population in Delhi (Mohan et al 2002). Matched data for two points of time was available for 5,414 males and 4,898 females. In the total sample, the annual incidence rates (per 100 persons) among males for any drug use, alcohol, tobacco, cannabis and opiate were 5.9, 4.2, 4.9, 0.02 and 0.04 respectively. This was one of the rare studies, which examined incidence (proportion of new cases) as opposed to other such studies, which tend to examine only prevalence (proportion of all cases).

Another study (Mohan et al 2003) examined a methodological issue related to substance use epidemiology. A survey of 500 households in a New Delhi urban slum compared reports of substance use in the family as provided by an informant who was the head of the household with reports provided by the individuals themselves. Information from the two sources was compared for 1,132 people above the age of 15 years. The agreement regarding the presence of symptoms and classification of dependence for the use of alcohol, tobacco and opiates ranged from good to excellent. The authors concluded that interviewing the head of the household provided useful estimates of drug use and dependence for substances associated with observable physiologic withdrawal syndromes. This method was described as less costly and quicker to perform than traditional self-report methodologies.

The same group of researchers (Mohan et al 2001), reporting a survey of 72 colonies in five types of housing clusters in Delhi, obtained drug use information from 6,004 heads of households. The prevalence of tobacco, alcohol, cannabis and opiate use among males was 27.6%, 12.6%, 0.3% and 0.4% respectively. De et al (2003) attempted to apply age-at-onset typology in a sample comprising 80 people seeking treatment for opium addiction. The early onset group (the mean age at onset was 21 years) was characterized by a significantly younger current age, more urban and unemployed subjects, younger ages at the onset of opiate use and dependence, a higher severity of opiate use, a higher lifetime use of sedatives and tobacco, younger ages at the onset of dependence on alcohol and cannabis, higher sensation seeking, and higher global psychopathology in terms of MPQ (Multidimensional Personality Questionnaire)¹¹. The late onset group (mean age at onset 27 years) was distinctively different within these parameters. The authors concluded that the age at onset typology in opiate dependence appeared to be feasible and to have some similarities to age at onset typology in alcoholism.

Recent findings in North East India

According to sources used for the National Survey, (UNODC ROSA and MSJE 2002, UNODC ROSA and MSJE 2002a and UNODC ROSA and MSJE 2004), alcohol is the drug most commonly used in all the states except Mizoram. However, alcohol users are those who most commonly present for treatment at the treatment services in Assam and Meghalaya. Moreover, although alcohol is not readily available in Manipur, Mizoram and Nagaland¹², alcohol users are the second highest users of services in these states. In Manipur, Mizoram and Nagaland, opiate users are the most common users of services. Significantly, users of propoxyphene (a drug not available in the injectable form) are the highest users of services in Mizoram and Nagaland (although these two states are not contiguous). Use of propoxyphene (diluted to inject) is associated with a higher risk of abscesses, increasing the morbidity of drug users. Users of inhalants in Manipur and users of codeine-based cough syrups in Mizoram are the third most significant users of services. Cannabis users are the second largest users of services in Assam and Meghalaya.

Chaturvedi et al (2003) interviewed a sample of 1,831 people (age 10 years and above) about their drug use habits, if any, and types of substance used, in Meghalaya and upper Assam. The prevalence of substance use was 29.4% tobacco, 12.5% alcohol, and 4.9% opium. Opium and cannabis users were mainly confined in Assam close to the Arunachal Pradesh border, indicating a regional influence. Mean ages for substance use initiation were: 18.5 years for tobacco, 21.8 years for alcohol, and 25.8 years for opium.

North East India HIV/AIDS Network reported a profile of drug users from selected areas¹³ of North East India (NEIHAN 2003). Using the stratified random sampling method, a set of 865 respondents were identified and interviewed. The data was reported separately for all states.

¹¹ Multidimensional Personality Questionnaire: An instrument routinely used by psychologists to make personality assessment.

¹² Due to the restricted alcohol licencing system in these traditionally conservative Christian dominated states.

¹³ The states in which the study was conducted were: Meghalaya, Assam, Nagaland, Manipur and Mizoram. In all, data was collected from 10 sites, spread over these five states.

From Meghalaya, out of 258 respondents only one-third were married, and just over half were unemployed. A large majority had witnessed the onset of drug use below 20 years. About 40% were IDUs. The rest were heroin smokers or alcohol, cannabis and pharmaceutical tablet users. From Assam, out of 125 respondents 29% were married. The majority (73%) had started drug use below the age of 16 years. About two-thirds were IDUs. From Nagaland, out of 191 respondents, just less than a quarter were married. About 55% were unemployed, and a large majority (82%) started below the age of 20 years. All were IDUs, most (about 90%) of them injected Spasmoproxyvon. From Manipur, out of 205 respondents, about one-third were married and about one-third were unemployed. About 41% had started using drugs below 18 years of age. An overwhelming majority (90%) were IDUs, most of whom injected heroin. From Mizoram, of the 86 respondents, 94% were IDUs.

An epidemiological study was carried out to assess the prevalence and pattern of use of various substances in Arunachal Pradesh, India (Chaturvedi and Mahanta 2004). A representative sample of 5,135 people aged 10 years or older was interviewed. Overall, the prevalence of substance use was about 31% tobacco, 30% alcohol and 4.8% opium, which varied across location, gender, race, age, education, and occupation. Poly-drug abuse and high opium use prevalence was described as alarming by the authors. In recent times, attempts have been made to conduct localized RSAs in India as well.

From the state of Assam, (again, in the North East India) Sarin (2004) reported a qualitative assessment of IDU. This RSA involved KIs with law enforcement officials, service providers as well as in depth interviews with IDUs. Spasmoproxyvon, heroin and Fortwin® were the drugs most commonly injected. While injectable heroin is reportedly being smuggled from Manipur and Nagaland, the pharmaceuticals are purchased locally in the black market, often at higher prices. Chasing heroin was described as almost always a precursor to IDU. A general impression, reported from KIs as well as discussion with IDUs was that, IDU prevalence had peaked in mid-1990s and is now decreasing.

3(g) Costs and consequences

Drug abuse has been found to be associated with significant adverse consequences to the individual, his/her family and by extension, to the whole society. In the National Survey, current drug users reported several hazards. Commonest among these were generalised weakness of the body, followed by the inability to visit friends / relatives and the inability to perform as husband or father. Additionally, some complained of depression, anxiety, memory loss, coughs and difficulty in breathing and poor sexual performance. Other adverse consequences related to drug use in the survey include the fact that between 6% and 49% of users report reported drug-related arrest and between 24% and 66% reported drug-related violence. Unprotected sex practices with partners other than spouses were quite common including sex with sex workers, which varied between 4% and 24%.

Injecting Drug Users

- *High-risk behaviour:* The IDUs were engaged in several high-risk behaviours. Needle sharing was common among them as was indirect sharing (e.g., sharing of cotton swab, filter and spoons etc.). Most did not clean the needles and syringes. Many used only water to clean.
- *Sexual behaviour:* In addition to injecting drug use and sharing of needles, high-risk behaviours also included unsafe sex. Among IDUs there was an increased reporting

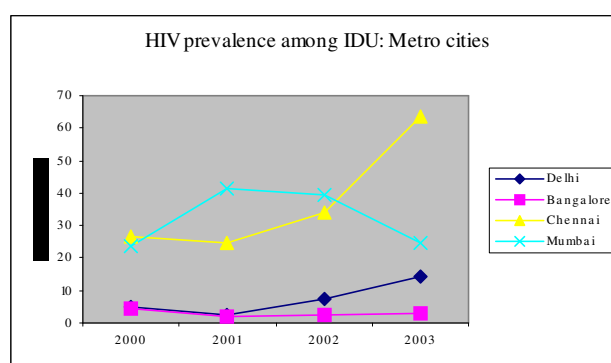
of sex with sex workers (40%-66%). A few subjects in Chennai, Imphal, Amritsar and Hyderabad had been tested for HIV and the proportion varied between 7% (Chennai) and 47% (Hyderabad). An even smaller proportion was aware of their HIV test report. The risk perception regarding acquiring HIV/AIDS was low among IDUs.

- *Consequences:* In addition to the common domestic, social, economic, legal and health consequences of drug abuse, IDUs suffered from many health consequences such as abscesses in superficial veins, subcutaneous tissues and muscles, septicaemia, HIV infection and Hepatitis B and Hepatitis C infections.

The burden on women by drug abusing male family members

The sample in one of the Focused Thematic Studies was based on interviews of subjects who were living with an affected close family member who was a current regular (daily or near daily) user of drug(s) other than exclusive alcohol and / or tobacco. The women themselves were not regular users of any dependence producing substances. The subjects were recruited from eight urban centres namely Bangalore, Chandigarh, Chennai, Delhi, Imphal, Pune, Solan & Shimla and Thiruvananthapuram, as well as from various settings such as treatment centres, the community or the workplace. The data was obtained from 179 women having affected family members from eight sites and 143 key informants from these sites.

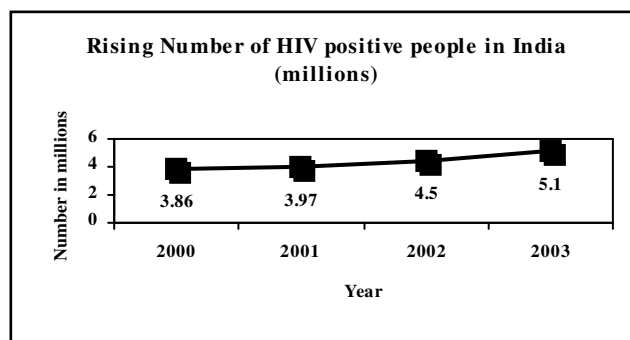
- *Drugs abused by the male family members:* About 41% were current users of heroin and about 52% reported abuse of psychotropic drugs (buprenorphine, propoxyphene, barbiturates, minor tranquillizers, other sedatives and cough syrups). Many were poly-drug users. A large proportion of them (67%) had been using these intoxicants for more than five years and about 41% were currently undergoing treatment for drug abuse.
- *Burden on women:* The study found that across all sites, drug use was considered a predominantly male phenomenon and the impact of male drug abuse on women was generally economic, followed by stigmatisation, emotional and a whole range of relationship difficulties and neglect of children who were in turn more prone to child labour or delinquency. Domestic violence, crime and increased trafficking were recognised as possible outcomes of individual drug use. The family burden, especially on the woman, of caring for drug users was also substantial. Besides the economic burden, women were seen as making adjustments at the cost of their own welfare, growth and development. The lack of social support systems served to aggravate their economic, social and emotional burden.
- One of the major burdens the women faced was that of stigma – blame for the drug use of the family member, blame for hiding the issue from others and blame for not getting timely treatment. The woman thus became the victim of not only the drug user but also the society at large.
- Women continued to look after the drug using family member despite continued addiction and



in the process suffered from constant worry and depression. These women were often subjected to violence and lived in a hostile environment. Most domestic violence reported in the study was directed at women and took place in the context of demands for money to sustain the habit. To prevent further violence, the woman usually conceded and provided the money, creating a vicious cycle of violence as an effective mode of extracting money.

HIV/AIDS

Although India continues to be a low prevalence country with an overall prevalence rate of less than 1% among the adult population, the absolute number of people affected is high. It is estimated by the National AIDS Control Organisation (NACO) that there were 5.1 million HIV-infected persons in India as of October 2003 compared with 4.5 million in 2002, 3.97 million by the end of 2001 and 3.86 million in 2000,

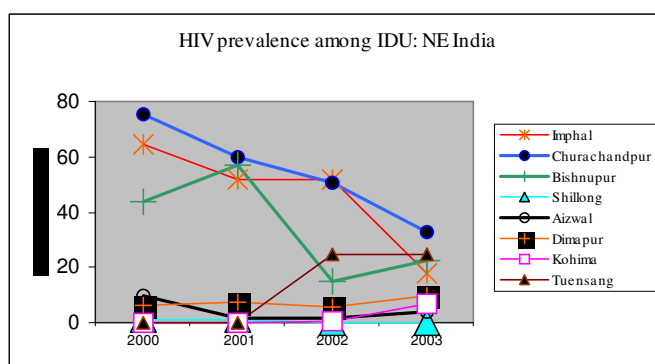


Source: NACO 2004a

indicating a steadily increasing rate of infection (NACO 2004a). Antenatal data (which is used as a proxy for HIV prevalence among the general population¹⁴) from states such as Maharashtra, Tamil Nadu, Andhra Pradesh, Karnataka, Manipur and Nagaland indicate above 1% prevalence, while in states such as Gujarat and Goa, prevalence figures have crossed 5% in the high-risk group (though less than 1% among pregnant women). This data supports the notion that HIV infection is spreading from high-risk groups to low-risk groups in the population.

Wide differences in HIV prevalence rates have been observed in the IDU community in the country (Dorabjee and Samson 2000).

NACO has been periodically collecting data on HIV seroprevalence among high-risk groups, which include IDUs in various sites across the country. The last two figures on this page show the trend of HIV prevalence among IDUs at 12 sites in India over a period of last four years (NACO 2004c).



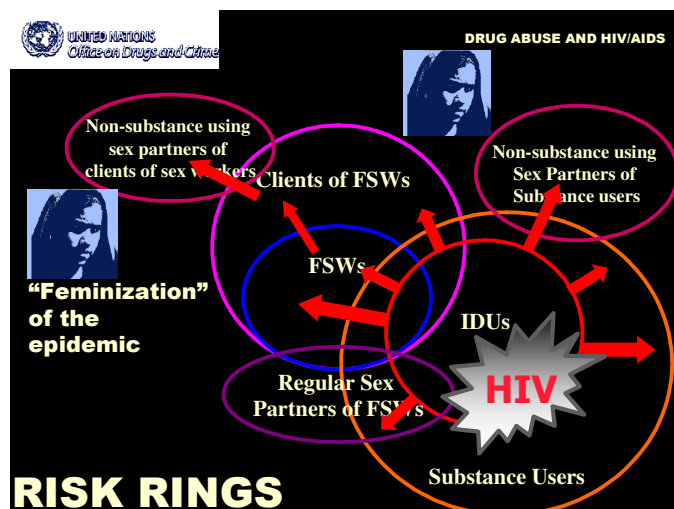
As depicted in these diagrams, while in the rest of the country the HIV prevalence among IDUs shows a steady increase, in the north-east, a gradual reduction can be seen over the past four years, although at sites such as Imphal, Bishnupur and Tuensang, in the northeast it is still high. In many cities with concentrated populations of IDUs, the HIV prevalence is above the critical level of 5%, causing great public health concerns.

¹⁴ Classification of HIV/AIDS epidemic: **‘Low level’**— HIV prevalence less than 5% in any (high-risk) sub-population, **‘Concentrated’** – more than 5% prevalence in any (high-risk) sub-population but less than 1% among pregnant women and **‘Generalised’** – prevalence of more than 1% among pregnant women. (Source: UNAIDS/WHO 2004)

NACO has been conducting sentinel surveillance annually at these specific sites. Interestingly, the National Survey also found IDU at sites where it was not expected. In the RAS component of the national survey, for example, 67% and 87% of the sample was comprised of IDUs in Trivandrum and Jamshedpur, respectively – two places where earlier IDU was not known to be a major pattern of drug use. Other components of the National Survey also reported that IDU is now spreading into smaller towns and rural areas.

Thus, there is a large body of evidence suggesting that not only is the prevalence of risk-behaviours high among drug users, but the prevalence of HIV/AIDS itself has also been found to be variable.

It should be pointed out, however, that it is risky to try to derive national estimates of IDU using the national household survey as a basis. This is because household surveys, in general, tend not to access marginalized populations. Since IDUs are more likely to belong to such groups they are not necessarily captured through such a methodology. As a result, estimates of IDUs based on household surveys tend to produce an underestimation. Thus, although the National Household Survey (NHS) did suggest a lifetime prevalence of IDU among adult males at around 0.1%, it would be inappropriate to use this figure for projecting the absolute numbers of IDUs for the country as a whole. Furthermore, the only data on HIV seropositivity among IDUs comes from sentinel surveillance and certain ethnographic studies and can not therefore be extrapolated on a national basis.



Some information on IDU directly contributing to the development of AIDS cases is available, but it cannot be extrapolated for HIV infection as a whole.

The nature of IDU and the manner in which it can serve as the epicentre for the origin and spread of HIV into the general population has been described in various bodies of research (MAP 2001). The figure entitled 'Risk Rings' reviews the overlapping series of risk rings related to IDU (Hersey 2004). Although precise figures are not easily obtainable, it can nonetheless be concluded that the indirect impact of IDU on the spread of the HIV epidemic is considerable.

Drug - HIV Situation in north-east

Ever since an explosive HIV epidemic was reported among injecting heroin users in certain parts of northeast India in late 1980s, the phenomenon of drug use in this sector has attracted much attention. Although traditionally betel nut, tobacco, cannabis, country liquor and opium were the common drugs of abuse, a shift from traditional usage to non-traditional forms of drug use such as heroin smoking, heroin injecting and injecting dextropropoxyphene (available in capsule form, the powder of which is dissolved in water and injected after filtering it through a cotton wad) took place during the early 1970s to early 1980s. Subsequently it was observed that a considerable proportion of the local youths in northeast India started injecting drugs straight away rather than gradually switching from cannabis abuse to sleeping pills or codeine containing cough syrup to injecting drug use (UNODC ROSA and MSJE 2004b).

In the late 1980s, HIV made inroads among injecting drug users in Manipur, Mizoram and Nagaland – three of the four northeastern states having a common international border with Myanmar. Within the next decade, Manipur and Nagaland moved into a generalized epidemic situation.

Panda et al (2001) examined the interface between drug use and sex work in Imphal, the capital of Manipur. They interviewed 69 women drug users through street-based outreach workers. Thirty-eight women (55%) were injecting drug users. Eighty per cent of the respondents reported having sex with non-regular partners; two-thirds reported sex in exchange for money or drugs. HIV and HBsAg testing, offered to all the study participants, generated data on HIV/AIDS and HBsAg infection. The prevalence of HIV infection in injecting drug users was significantly high (57% compared with 20% among non-injecting drug users), although the prevalence of HBsAg was similar in the two groups (48% versus 56%). The authors recommended an innovative outreach strategy for effective implementation of interventions among women injecting drug users and non-injecting drug users who operate from the streets as sex workers to support their drug habit as well as their livelihood.

Saha et al (2000) evaluated the Hepatitis C virus (HCV) and Hepatitis B virus (HBV) infections among 77 Manipuri couples, among whom all the husbands were both IDUs and HIV positive. This study showed for the first time a high prevalence of HCV (92%) and HBV (100%) infection amongst the HIV positive IDUs in Manipur.

There is increasing evidence that the non-injecting sexual partners of injecting drug users are becoming infected in places like Manipur. In another study (Panda et al 2000) 161 HIV-infected IDUs and their wives were recruited. The HIV status of wives was determined by enzyme-linked immunosorbent assay (ELISA) plus Western blot. Seventy-two wives (45%) were found to be HIV-positive. The following elements were associated with HIV infection of the wife: (a) a sexually transmitted disease (STD) in either member, (b) an estimated duration of HIV in the husband for greater than 8 years, and (c) a history of blood transfusions. Improved control of STDs, condom promotion, and improved blood screening in Manipur were recommended.

3(h) Money laundering

Scope of problem in India

Illicit cultivation, illicit manufacture of drugs, diversion of licit opium, precursors and pharmaceuticals as well as trafficking of the drugs is prevalent in India. All of these activities generate illicit drug money. There appears to be no estimates on the extent of drug money generated in India. Possible illicit uses of this drug money include: (a) own use by traffickers, (b) the financing of terrorism; (c) the buying of political influence.

Sources of drug money in India

- a) In Uttar Pradesh, Madhya Pradesh and Rajasthan unscrupulous farmers divert licitly produced opium.
- b) From precursor trafficking (one litre of acetic anhydride costs about Rs. 50/- in licit market while it fetches up to Rs. 1,000/- in illicit market).
- c) Illicit cultivators of opium and cannabis in Jammu and Kashmir, Himachal Pradesh, Uttaranchal, the north eastern states, Orissa, Andhra Pradesh and Tamil Nadu.

- d) Illicit manufacturers of heroin (primarily in opium growing regions of Uttar Pradesh, Madhya Pradesh and Rajasthan), methaqualone (primarily in and around Mumbai, Hyderabad and Gujarat).
- e) Drug traffickers who smuggle drugs through Mumbai, Delhi, Kolkata and now increasingly through Tuticorin (to Sri Lanka).
- f) Small-scale drug peddlers and the chain of drug traders within the country.

Other sources of “black money” in India:

- a) Evasion of income tax: High rates can encourage income tax evasion resulting in accumulation of black money. Similarly, black money is generated through evasion of other taxes also.
- b) Real estate transactions: The tax on registration of property is called ‘stamp duty’, which is very high in many states in India. This may encourage buyers to show the value of the property as less than its true value. Over a period of time, the under-valuation of properties in the account books can become the norm. In this way, each transaction becomes both a source of black money for the seller and a means of concealing black money to the seller.
- c) Corruption among public servants and politicians as well as in private firms.
- d) Smuggling: Restrictions on imports and high rates of tariffs rendered smuggling very profitable.

Techniques of laundering in India

Aside from the traditional approaches which are employed in India (using businesses with a high cash-transaction rate, over- or under-invoicing of imports, remittances from abroad, etc.) the following techniques are of interest in the Indian context.

- a) Hawala: These are illegal foreign exchange transactions. Any person wanting to convert rupees into foreign exchange or vice versa is legally obliged to go through official banking channels. This exposes the transaction to possible investigation by authorities. Hawala is an illegal foreign exchange transaction that operates on the basis of trust. Once the transaction is completed, accounts pertaining to that transaction are destroyed leaving little trace for the investigator.
- b) Casinos of Nepal: The casinos in Nepal operate only in Indian Rupees. Many casinos issue a fake certificate indicating that the patron has earned an amount of money in the casino in exchange for an underhand fee. The patron simply returns to India and provides the false documentation to the tax authorities. The black money becomes white.
- c) Benami accounts: Money is deposited in fictitious *Benami* accounts and through a series of transfers the money is transferred to the laundered account.

The number of seizures of drugs during the years 1998-2002 and the number of cases where properties have been frozen are as follows:

Year	1998	1999	2000	2001	2002
No. of seizures	12,446	13,029	12,460	15,005	11,472
No. of cases where property has been frozen	36	7	4	2	41
Percentage	0.29	0.05	0.03	0.01	0.36

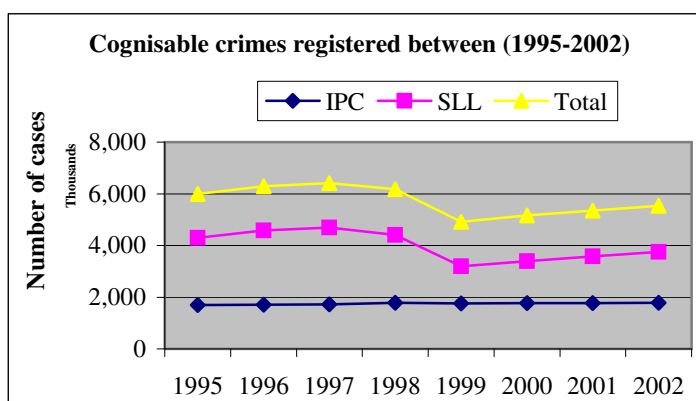
Source: NCB 2002.

Even considering that the majority of seizures tend to be for small quantities of drugs where no financial investigation and asset forfeiture is possible, the number of financial investigations remains limited. This may be explained by the fact that (a) many cases are booked by police who may not be trained in financial investigations and hence there is hesitation in initiating the process and (b) many enforcement officers are not even aware of the provisions for financial investigation and asset forfeiture under the NDPS Act. As noted in Section 5 below, the law is weighted heavily in favour of the investigators and the necessary quasi-judicial procedures in India remain relatively simple.

4. CRIME SITUATION

4(a) Main characteristics

According to the National Crime Records Bureau the total cognisable crime¹⁵ in the country has been steadily increasing. It is noted that this is however keeping pace with the increase in population though at a varying rate over the past 50 years. A review of the available data suggests that organized criminal activities, trafficking in human beings, underground banking and corruption are of particular significance.



According to the report entitled *Crime In India 2002* issued by the National Crime Records Bureau under the Ministry of Home Affairs, a total of 5,531,172 crimes were registered in the year 2002 in India. These comprised 1,780,330 cases under the Indian Penal Code (IPC) and 3,750,842 under Special and Local Laws (SLL). Violent Crimes (221,810 cases) constituted 12.45 percent of the total IPC crimes reported in 2002. Of these, 44.2% of the crimes were violent crimes affecting life (97,966 cases); violent crimes affecting property were 12% (26,706); violent crimes affecting public safety were 36.4% (80,765); and violent crimes against women (rape) were 7.4% (16,373 cases).



A total number of 370,629 property crimes constituting 20.8% of the total cognizable crime under the IPC were reported during the year. As compared with the previous year, this form of crime recorded a decrease of 2.9 percent. The share of these crimes has also been steadily

¹⁵ Cognizable offences are defined as offences which are more serious by nature for which a police officer may arrest a person without a warrant or authorisation from the Court. Non-cognizable offences, by contrast, are simple offences for which the police may not arrest persons unless courts issue arrest warrants.

decreasing during the past four decades, from 67.1% in 1953 to 20.6% in 2000. Over 61,820 economic crimes, constituting 3.47% of the total cognizable crimes under the IPC, were reported in the country in 2002.

The National Capital Territory (NCT), New Delhi reported the highest IPC crime rate¹⁶ at 349.6 in the country as compared with the national average of 169.5. Among the other states, the crime rate was highest in Kerala (322.9), a state in the southern part of India. The total number of cases registered during the period, as can be seen is more or less constant during the period. The National Crime Records Bureau also studied the percent change in the incidence and rate of IPC crime during the decade 1992-2002. The adjacent diagram shows that while the absolute number of cases increased 5.4% during the decade, the incidence declined by 12.9%.

Limitations of the statistics: Crimes may not always be reported and hence statistics do not always depict the full picture. The accessibility, credibility and perceived friendliness of the police as well as the educational levels and awareness of the people determine whether the victim of a crime actually makes the effort to file a complaint with the police. Wherever there are low trust levels of the police, victims either suffer in silence or take direct vigilante action (e.g., retaliation). Either way, the crime does not get recorded. For instance, one of the states best known for high crime rates in India is Bihar. As per the statistics (see table below), it is ranked 26th in criminality while Pondicherry, generally considered to be safe, is ranked number one in terms criminality.

Incidence and rate of Total Cognizable Crimes (IPC) during 2002

Sl. No.	State/UT	Incidence of Total Cognizable Crimes	Percentage Contribution to All-India Total	Estimated mid-Year Population (In Lakhs)	Rate of Total Cognizable Crimes	Rank of Criminality
(1)	(2)	(3)	(4)	(5)	(6)	(7)
STATES:						
1	ANDHRA PRADESH	143,610	8.1	769.15	186.7	14
2	ARUNACHAL PRADESH	2,228	0.1	11.15	199.8	11
3	ASSAM	36,346	2.0	272.47	133.4	22
4	BIHAR	94,040	5.3	851.71	110.4	26
5	CHHATTISGARH	37,950	2.1	213.03	178.1	16
6	GOA	2,440	0.1	13.88	175.8	17
7	GUJARAT	106,675	6.0	517.89	206.0	10
8	HARYANA	40,152	2.3	216.44	185.5	15
9	HIMACHAL PRADESH	12,243	0.7	61.78	198.2	12
10	JAMMU & KASHMIR	19,967	1.1	104.40	191.3	13

¹⁶ The crime rate is the number of crimes committed per 100,000 of the population and is a measure for comparing the crime situation in different regions and countries. The referenced statement indicates that 169.5 crimes are committed per 100,000 population in India while the number is much higher (349.6) in the NCT of New Delhi. It should be noted that the crime rate depicts only cases which are booked by the police. Thus, a state such as Kerala and a Union Territory (Union Territories are regions which are administered directly by the Central Government) such as Pondicherry have very high crime rates while states such as Bihar, where questions of control arise, have much lower rates of crime on paper.

11	JHARKHAND	31,439	1.8	275.43	114.1	25
12	KARNATAKA	113,699	6.4	536.81	211.8	9
13	KERALA	104,200	5.9	322.70	322.9	4
14	MADHYA PRADESH	191,799	10.8	620.72	309.0	6
15	MAHARASHTRA	165,462	9.3	988.26	167.4	18
16	MANIPUR	2,584	0.1	24.43	105.8	27
17	MEGHALAYA	1,664	0.1	23.58	70.6	34
18	MIZORAM	2,820	0.2	9.10	309.9	5
19	NAGALAND	1,114	0.1	20.47	54.4	35
20	ORISSA	47,728	2.7	373.43	127.8	23
21	PUNJAB	28,794	1.6	247.71	116.2	24
22	RAJASTHAN	151,248	8.5	581.25	260.2	8
23	SIKKIM	485	0.0	5.53	87.7	30
24	TAMIL NADU	166,942	9.4	629.43	265.2	7
25	TRIPURA	3,075	0.2	32.47	94.7	28
26	UTTAR PRADESH	146,037	8.2	1708.10	85.5	31
27	UTTARANCHAL	7,976	0.4	86.76	91.9	29
28	WEST BENGAL	58,962	3.3	817.07	72.2	33
	TOTAL (STATES)	1,721,679	96.7	10335.15	166.6	
UNION TERRITORIES						
29	A & N ISLANDS	608	0.0	3.65	166.6	19
30	CHANDIGARH	3,806	0.2	9.32	408.4	2
31	D & N HAVELI	349	0.0	2.28	153.1	21
32	DAMAN & DIU	261	0.0	1.64	159.1	20
33	DELHI	49,137	2.8	143.83	341.6	3
34	LAKSHADWEEP	53	0.0	0.62	85.5	32
35	PONDICHERRY	4,437	0.2	9.91	447.7	1
	TOTAL (UTs)	58,651	3.3	171.25	342.5	
	TOTAL (ALL- INDIA)	1,780,330	100.0	10506.40	169.5	

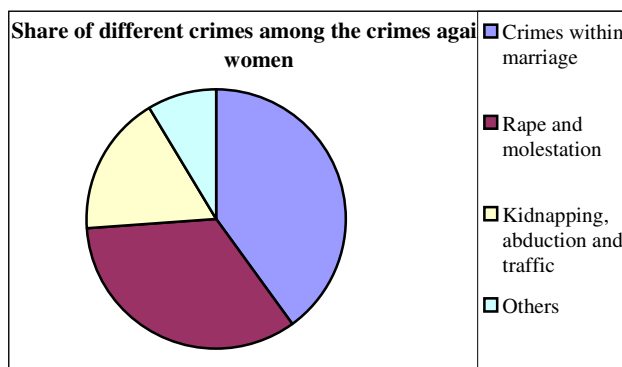
4(b) Trends

Crimes against women: Crimes against women are a matter of serious concern in India.

Women in the country suffer due to a lack of awareness of their rights, illiteracy and oppressive practices and customs. The resultant consequences are many: a consistent imbalance in the sex ratio (in favour of men), high rate of female infanticide, a low literacy rate among girls and women, a high drop out rate of girls from education, relatively lower wage rates. As is evident from the graph shown above, while all crimes have been either decreasing or are more or less constant since 1995, crimes against women have been steadily rising. This could be due to either an absolute increase in the number of crimes against women, or the fact that women are becoming more vocal. Either way, the rising rate of crimes against women is a matter of serious concern. Various kinds of crimes against women during 2002 are as follows:

Type of offence	Cases	% of total crimes against women
Rape	16,373	11.09
Kidnapping and abduction	14,506	9.82
Dowry deaths	6,822	4.62
Cruelty by husbands and relatives	49,237	33.34
Molestation	33,943	22.98
Eve teasing (sexual harassment)	10,155	6.88
Importation of girls	76	0.05
Sati prevention Act	0	0.00
Immoral Traffic Prevention Act	11,242	7.61
Indecent Representation of women (prevention) Act	2,508	1.70
Dowry prohibition Act	2,816	1.91
Total no. of crimes against women	147,678	100

The above crimes can be categorised into the groups depicted as per the pie diagram below. The diagram shows that almost 40% of the reported crimes against women are committed within the family setting (noting that it is also often the case that rape occurs within the family, see below), which adds a social dimension to the problem. The culture of South Asia places great emphasis on the institution of family. It is also an economic entity by itself where the men are often the sole or main breadwinners. Hence, it is important for a woman to ensure that the marriage does not break both for social and economic reasons. If a woman reports to the police against a husband or in-laws she places her marriage at risk. Women suffering domestic abuse face difficulties when going through the legal system. This often compels them to avoid seeking redress from the police. The number of cases of dowry deaths¹⁷ and cases brought under the Dowry Prohibition Act bear testimony to this social pressure on women.¹⁸ Culturally appropriate solutions – which address crimes against women within the marriage, while not destroying the marriage – need



¹⁷ Dowry is an amount, which, traditionally was paid by the bride's parents to the groom at the time of marriage. Since it is considered an inappropriate and exploitative tradition, dowry is prohibited in India. However, the practice of dowry continues in many families and at times it turns exploitative with the husband and in-laws abusing the woman for more dowry sometimes leading to the death of woman including by suicides. Dowry Prohibition Act is heavily loaded against the accused and in favour of the women who complain against harassment for dowry.

¹⁸ The crime figures for 2002 above show that cases booked under the Dowry Prohibition Act were about 2% of the total cases while dowry deaths were double that figure. At first sight it may seem paradoxical that there are more cases brought for dowry deaths than under the Dowry Prohibition Act for harassment. However, this can be explained by the fact that women being harassed for dowry tend to tolerate their treatment to the point of death with very few actually going to the police about it. Hence there are more deaths than cases under the Act.

to be found. These could include counselling by police (following the Delhi police experiment) and family courts, which deal with the problem in-camera, expeditiously, and as far as possible, amicably.

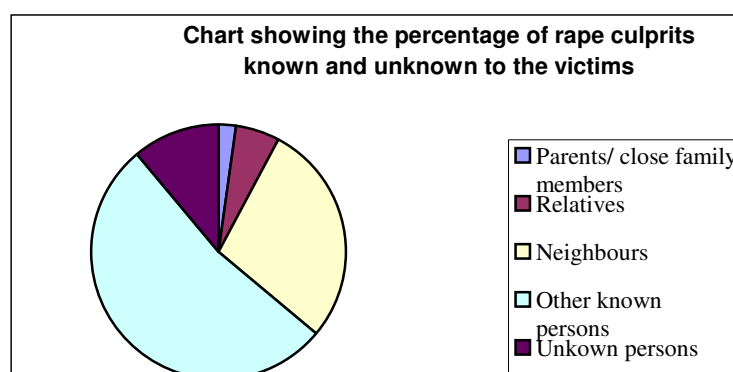
Rape: Of the 16,373 cases of rape booked during 2002, the victims knew the culprits in 14,537 (over 88%). The culprits were close family members, neighbours, relatives or other known persons.

Culprit	Parents/ close family members	Relatives	Neighbours	Other known persons	Unknown persons	Total
Cases	369	924	4,600	8,644	1,836	16,373
Percentage	2.25	5.64	28.10	52.79	11.21	100.00

Underground banking:

Underground banking is an important element of local economies. The alternative remittance system through non-official banking systems is called “Hawala”. Such secret funds are useful in order to meet a number of objectives such as bribery and tax evasion. It is reported that most cases of

money laundering in India relate to an attempt mainly by commercial entities to evade taxes, rather than being related to illicit drug trafficking. It is believed that this underground banking system developed in the 1940s from networks related to people who emigrated from India to Hong Kong, Britain, Canada and the United States. Today, it is estimated that a fee of 15-30% is demanded for the illegal transfer of money across international borders.



4(c) Issues of specific concern

Organized Crime: Organized crime in India is present in large cities and especially in Mumbai which is generally considered the commercial capital and where it is believed that organized criminal groups began to establish themselves from the early 1960s onwards. Its organised criminal gangs are involved in the following kinds of business. While most gangs indulge in many of these activities, they do specialize in certain areas:

- Settlement of business disputes and recovery of dues:** In any business culture where there is a propensity to evade taxes a significant part of all business transactions are usually done in cash. Debtors in such transactions who do not pay their dues cannot be taken to court for obvious reasons. Such disputes tend to be settled and dues recovered by organized criminal gangs through threats backed by credible display of force. Once debt recovery is effected, the criminal gang takes a certain agreed upon percentage of the recovered sum. Even where the business transactions are accounted for and legal, the recovery of dues through the normal judicial process is often slow. In such cases, some businessmen prefer to settle disputes through the use of organized criminal gangs.
- Contract killings:** Contract killings are another important aspect of the business of organized criminal gangs. Colloquially, hiring someone as a contract killer is referred

to giving him 'supari'. The value of the 'supari' depends on the importance of the person to be killed and the difficulty involved in killing. Killing a person who has private guards, for instance, would command a higher amount of 'supari' than one without and similarly, the richer the man, the higher the amount of supari. However, the average cost of a contract killing is too high for the common man on the street to be threatened. Hence, Mumbai is considered quite safe for the ordinary citizens despite the existence of a large network of organized criminal gangs.

- c) **Smuggling:** Smuggling has been a very profitable venture in the underworld thanks to the high rates of customs duties in India. With a view to saving the scarce foreign exchange for essential needs, the Government of India banned import of gold for many years resulting in a significant difference in the national and international prices of this commodity. Gold smuggling, therefore, has become an attractive business. In recent years, the Government of India permitted the import of gold and reduced import tariffs on most commodities. Further, the government has also been encouraging multinational companies to establish their manufacturing facilities in India with the result that electronic goods and other consumer durables are now available in the local market. Smuggling has thus been rendered less and less profitable in recent years and hence organized criminal gangs are gradually shifting to smuggling of drugs both into the country and out of it.
- d) **Extortion:** Extortion from businessmen and industrialists is another regular source of income for organized criminal gangs. Since the entire business community can be terrorized into submission, few will oppose making the regular payment or 'hafta' to the gangs. In return for the hafta, the organized criminal gang provides 'protection' from other criminal gangs. The city of Mumbai is thus divided into territories among different organized criminal gangs. Gang warfare among these groups is common.
- e) **Drug trafficking:** India is one of the few countries of the world where drugs are manufactured, smuggled into and out of the country, sold in the large domestic market and precursors are manufactured and diverted both for use within the illicit drug industry within the country as well as for smuggling out of the country. These patterns provide considerable business opportunities for the underworld. According to information available to UNODC, most gangs have a specialised department dealing with drug manufacture and trafficking.
- f) **Human trafficking and prostitution:** Human trafficking including running brothels is another important business for organized criminal gangs. This subject is dealt with in detail below.
- g) **Hawala and money-laundering:** As explained above, Hawala is an informal method of transfer of money both within the country and to other countries. Hawala operators also convert the money into other forms of currency and move the money through different countries and banks to conceal traces of the money. Ill-gotten money earned through bribes, smuggling, drug trafficking and other crimes is transferred through hawala. Additionally, a significant percentage of legitimate business activities are unaccounted for mainly to evade tax. In some businesses, unaccounted for cash transactions have become the market norm. Money in such cases cannot obviously be transferred through banks and hence it is transferred through hawala operators. Hawala is thus a thriving profitable business.
- h) **Financing of Bollywood movies:** Until recently, Bollywood movie producers did not have access to credit from banks due to certain regulations. Organised criminal gangs find an excellent opportunity to invest their money in these projects and, although no statistics are available on the matter, it is reported that the Bollywood movie industry is financed to a significant extent by money from the underworld. The

government is currently considering regulatory changes which would give film producers access to bank credit thus reducing their dependence on the underworld.

- i) **Financing of real estate:** The cost of registering the real estate (commonly called “stamp duty”) is approximately 15% of the transaction value of the property in most states in India. Individuals thus tend to declare a much lower value on the property in the documents than the authentic transaction value. The result is that the average documented price of property in specific given areas is much lower than the market value. The remaining amount is transacted in cash. Thus, persons with illegal money can invest their money by buying real estate. Organised criminal gangs invest in real estate as it is not only an excellent place to deposit funds but also to earn money through businesses. Often properties are purchased in *benami* (pseudonymous) deeds to circumvent the regulations of land ceiling.

Most state governments in India do not have a law to deal with organized crime. In recent years, Maharashtra, whose state capital is Mumbai, enacted a law to deal with organized crime. The traditional judicial system has had difficulty addressing the problem of organized criminal groups. As per the Indian Evidence Act, confessions made to a police officer or to anyone else (except a magistrate) while in the custody of a police officer are inadmissible as evidence in the court of law. Most victims and witnesses of organized crime are too afraid to give evidence in the court of law against a criminal gang. Hence, the judicial process is stymied.

Corruption: According to the Transparency International Corruption Perception Index in 2003, India scored 2.8 and was ranked 83rd in terms of level of perceived corruption (TI 2003) (in 2004, score 2.8 and rank 90). In the first comparative study of corruption in South Asia examining what users of key public services actually experience, respondents in India considered the police to be the most corrupt public agency, followed by the health and power sectors (TI 2002).

According to a Price Waterhouse Coopers economic crime survey conducted in 2003, the admitted experience of economic crime in India is lower than in the Asia-Pacific region¹⁹ as well as globally, and was contrary to the general perception of the relative incidence of economic crime in India (PWC 2003). About 53 % of the respondents perceived corruption and bribery as the most prevalent economic crime in India. The perceived prevalence of corruption and bribery was significantly higher in India compared with the Asia-Pacific region or globally. Surprisingly, on being asked which type of economic crime their organization had suffered in the previous two years, only 11% of the respondents reported suffering corruption and bribery. This highlights that while people carry a perception about widespread existence of corruption and bribery, there is either a marked reluctance to admit that they have suffered from it, or it exists to a degree less than is perceived. Looking ahead over the next five years, 70% of the respondents from India believe that the risk from economic crime would be the same or higher. Thus, despite improved controls, there appeared to be a concern that the chances of being subject to economic crime in the future continue to be high.

¹⁹ For the purpose of the survey, this region included Australia, Hong Kong (SAR), India, Indonesia, Japan and Singapore.

Trafficking in Human Beings:

India is a country of origin, transit and destination for trafficked persons. Most of the trafficking, however, takes place within India itself. The problem of bonded labour²⁰ and indentured servitude is also significant. Indian women and children are trafficked to the Middle East and the West for purposes of forced labour and sexual exploitation. However, India remains – above all – a destination for trafficked women and girls (both internally and externally) because of the demands of the local sex industry, estimated to be worth 400,000 million Rupees annually. Many women and girls arriving in India are intended for forced labour and sexual exploitation. Concentrated evidence of this is available in Mumbai (which contains one of the largest red light districts in the world) and Kolkata. Some local culturally-sanctioned practices (e.g., the *Devadasi* system) also expose women and girls to sexual exploitation and trafficking (DWCD 2004). One worrisome recent trend is that India is now also a destination country for sex tourists from the Middle East and the West.

Nature: In India, most trafficking takes place for the following purposes: sex work, drug peddling, organ trading, child labour, camel jockeys and domestic work. Traffickers pay Rs. 2,000 – 5,000 for each child in the village. This price may rise to as high as 60,000 by the time the child reaches the city (STOP 2002). The demand for younger children is increasing because of paedophilia, and myths of sex with a virgin increasing potency and getting rid of HIV/AIDS and STIs (STOP 2002). According to one study, 15 per cent of commercial sex workers are under 15 years of age, while another 25 per cent are between 15-18 years old (Mukherjee and Das 1996). Another study estimates that there are between 300,000-500,000 children in prostitution in India (UNICEF 2001a).

Magnitude: In India, current calculations about the number of people trafficked are obscured by the fact that no clear dividing line is made between trafficking and commercial sexual exploitation. The clandestine nature of operations and the stigma associated with trafficking make it difficult to obtain accurate figures. The number of women and children involved in sex work is variously estimated to be in the vicinity of one million (NHRC 2004). Another study suggests that approximately 2 million women are involved in sex work in India, 25-30 per cent of whom are minors (CATW 2002). The same study estimates that there are more than 1,000 ‘red light’ areas all over the country. At any given time in India, 20,000 girls are being transported from one part of the country to another (NHRC 2004).

The main states providing the trafficked people are Andhra Pradesh, Maharashtra, Karnataka, Tamil Nadu, Bihar, West Bengal and Uttar Pradesh. The main countries of origin for foreign trafficked sex workers in India are Bangladesh and Nepal where, according to one source, it is estimated that 300,000 and 200,000 women respectively have been trafficked into India (ADB 2002). A decade ago, it was reported that slightly over 50 per cent of female child prostitutes in India came from Nepal or Bangladesh (ADB 2004). Nepalese women and girls are currently working in situations of prostitution in several Indian cities. It is estimated that 5,000-12,000 of them are trafficked to India every year (ADB 2002). The traffickers deceive their victims with fraudulent promises of jobs or marriage and take advantage of the lack of sufficient cross-border cooperation between Nepalese and Indian authorities in respect of

²⁰ If a labourer is in dire need of money and has no means of raising a loan, he or she pledges their future labour as well as the labour of spouses and children and borrows the money. Thereafter, the labourer is expected to repay the debt by working for the person who lent the money. The labourers are usually illiterate and the person lending the money often manipulates the calculations to ensure that the debt is never completely repaid. Thus, the labourer and their offspring keep perpetually working free for the creditor/owner.

human trafficking. No passports are required at the Nepalese-Indian border, across which free movement is permitted for both Indian and Nepalese citizens.

Consequences: Indignity, social stigma and debt bondage are among the commonest consequences for the individual trafficked. Another result of the illegal trade in trafficked women and girls is the spread of HIV/AIDS. Most of the trafficked girls die very young (the average life span is estimated to be only 30 years) mainly from HIV/AIDS, but also from malnutrition, abuse, neglect and sexually transmitted diseases. It is already clear that the HIV/AIDS situation in Nepal is strongly linked to the question of trafficking in Nepalese women and girls into India.

Rescue and rehabilitation: The Indian NGO establishment that is involved in trafficking issues is widely regarded as being extremely energetic. They have taken the lead in requesting (and often providing) anti-trafficking training for state and federal police officials. They are also visible in awareness campaigns and protection for the victims of trafficking. The Department of Women and Child Development has established a network of over 350 short stay homes for the protection and rehabilitation of victims (TIP 2004). The central government has in the past two years opened 80 protective homes.

Enforcement: At present, human trafficking is not treated as an “organized crime” at the federal level, even though many states have already enacted special laws on organized crimes. Trafficking has not been declared a federal offence and the Central Bureau of Investigation (CBI) has no *suo moto* authority to intervene unless specifically asked by a state government. By the same token, the CBI is unable to take on even international trafficking crimes without federal clearance. A study undertaken by the National Human Rights Commission (NHRC 2004) has recommended that trafficking in women and children should be made a federal crime with the CBI given powers to investigate cases on its own. The report of the study, which covered 13 states and union territories, expressed concern over current restrictions on the Central Bureau of Investigation which prevent it from probing such cases unless specifically asked to do so by a state government or Delhi. The report has also suggested the establishment of a special cell in the CBI to deal with trafficking. The CBI director should be left to pick cases for investigation, keeping in view their “multi-state or international ramifications”. The CBI should be given “contiguous powers” of investigation of cases involving states, it recommended.

Number of cases booked under the Immoral Trafficking (Prevention) Act

Act	1998	1999	2000	2001	2002
Immoral Traffic (P) Act	8,695	9,363	9,515	8,796	11,242

Source: National Crime Records Bureau, *Crime in India* 2002, (July 2004)

The all-India reporting of crimes under the ITPA shows a continuous increase year after year, except in 2001. This reflects a combination of increased trafficking and increased awareness among law enforcement of the issue. However, the vast majority (87 per cent) of the arrests made spanning the period 1997-2001 were against the actual victims of trafficking under Section 8 of the ITPA (soliciting) and not against the brothel owners or traffickers (NHRC 2004).

Under orders from the Supreme Court, the Department of Women and Child Development established a committee in 1998 which found that “in spite of many interventions for prevention, law enforcement, rescue and rehabilitation, there does not appear to have been

much impact on the prevalence of commercial sexual exploitation of women and child” (DWCD 1998). The following reasons were adduced:

- Lack of seriousness among law enforcement machinery and administration²¹;
- Risks faced by social workers, NGOs, and government officials working in red-light areas and among victims;
- Insufficient awareness about the prevalence of child trafficking;
- The lure of a comfortable lifestyle, which made it more difficult to “rehabilitate” some victims;
- Social stigma and family problems facing victims;
- Difficulties in estimating the age of child victims;
- Inadequate institutions for care and rehabilitation of rescued victims;
- Lack of coordination between border police of neighboring countries to stop cross-border trafficking; and
- Lack of support lines and drop-in centers for women in need

The Committee also found that quite often it is the prostitutes rather than those who traffic them who are arrested and prosecuted, thus re-victimising the victims²². In order to reduce such a possibility, the committee recommended:

- Modification of criminal procedures to make them more gender-sensitive and child-friendly;
- More provision for NGO participation in criminal proceedings on behalf of victims;
- Provision for confiscation of assets and income of exploiters;
- Better enforcement of the Bonded Labour System (Abolition) Act;
- Setting up of exclusive anti-trafficking and prevention cells, including women police officers, in major cities and high-impact areas;
- Provision of counseling and free legal advice to women in custody;
- Establishment of task forces in major cities to coordinate activities of government agencies, NGOs, and others;
- Review of laws relating to elimination of child pornography; and
- Continuation of police raids on brothels as permitted under the ITPA.

²¹ For example, one study (NHRC 2004) interviewed 852 police official, and found that 80 percent admitted that trafficking received “no priority or low priority”.

²² It has been found, for example, that instead of prosecuting the traffickers under sections, 3, 4, 5 and 6 of the Immoral Trafficking (Prevention) Act, most prosecutions take place under section 8. Section 8 prosecutions are undertaken against the trafficked persons and result in further victimization of the victims and trafficked person (Prayas 2004).

5. POLICY – DRUGS

5(a) National drug control framework

Convention adherence

India is a signatory to all three UN drug control conventions, namely, the Single Convention on Narcotic Drugs 1961 (as amended by the 1972 Protocol), the Convention on Psychotropic Substances 1971 and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

Legislation

The broad legislative policy on narcotic drugs and psychotropic substances is contained in the three Central Acts. These are:

- Drugs and Cosmetics Act, 1940,
- The Narcotics Drugs and Psychotropic Substances Act, 1985 (NDPS Act, 1985), and
- The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988.

Amendment to the NDPS Act:

The NDPS Act 1985 was amended with effect from 2nd October 2001. The amendments now incorporated in the Act have brought about significant changes in the penal structure under the NDPS Act 1985 as they have made financial investigations and the forfeiture of illegally acquired property more purposeful. In addition, provisions have been included for new investigative techniques and for removing certain practical difficulties faced by the investigating officers. The amendments are:

- Graded punishments:** The amended Act grades punishment into three categories depending on the quantity of drugs seized and also provides for judicial discretion as far as the severity of punishment is concerned. Violations relating to small quantities now attract imprisonment of up to six months or fine or both. Violations in respect of commercial quantities continue to attract a minimum prison sentence of 10 years, which may extend to 20 years and shall also involve a fine of not less than Rs. 100,000 (approx. US\$2,100) that may extend to Rs. 200,000 (approximately US\$4,200). Any violations involving quantities of drugs more than prescribed the small quantities but less than commercial quantities shall be punishable with rigorous imprisonment for a term, which may extend to 10 years and with fine.
- Financial investigations made easier:** The property of a drug offender can, after the amendments be frozen as soon as he is arrested, without waiting for conviction or completion of full period of preventive detention.
- Money laundering becomes an offence:** The laundering of illegally acquired property has been made an offence under the Narcotics Act.
- Removal of difficulties in compliance with Section 50:** The provisions of Section 50 of the NDPS Act, non compliance of which has resulted in a large number of acquittals, have been made more flexible to cater to the real life situations where it is not practicable to take the person to be searched to the nearest Gazetted Officer or Magistrate without the possibilities of the suspect parting with the drugs.

- e) **Controlled deliveries:** Further to facilitate complete investigations and to neutralize the entire syndicate involved in drug trafficking, a provision has been made for the movement of seized drugs from one place to another within and outside the country under controlled conditions.
- f) **Ambit of Sections 41 & 42 enlarged to include Controlled Substances and Financial Investigations:** The provisions of search, seizure etc. under sections 41 & 42 shall now be applicable for cases relating to financial investigations and controlled substance as well.

The NDPS (Regulation of Controlled Substances) Order, 1993

While the NDPS Act 1985 contains provisions for the control of precursor chemicals, in 1993, the government of India promulgated the NDPS (Regulation of Controlled Substances) Order, which sets out the detailed rules and procedures governing the manufacture, distribution, trade, import, export, etc. of specified 'controlled substances'. Presently five substances namely, acetic anhydride, anthranilic acid, N-acetylanthranilic acid, ephedrine and pseudo-ephedrine have been notified for controls under this order. In addition controls are also exercised on imports / exports of a few other chemicals.

Together, the 2001 amendments and the 1993 order constitute substantive compliance with the asset forfeiture and precursor control provisions of the 1988 Convention.

The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act is a preventive detention law. Persons who indulge in drug trafficking can be detained through an executive order passed by designated authorities. The Joint Secretary (Revenue) in the central government is empowered to issue such detention orders. Similarly, relevant authorities are also designated to act in this capacity by the state governments.

Institutions

The Department of Revenue in the Ministry of Finance has the nodal co-ordination role as administrators of the NDPS Act, 1985 and the Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988. The Ministry of Social Justice and Empowerment is responsible for implementing the drug demand reduction programme in the country, mainly through support to NGOs.

The nodal agency dealing with drug trafficking is the Narcotics Control Bureau (NCB) located in the Ministry of Home Affairs. However, officers of the Central Bureau of Narcotics, the Directorate of Revenue Intelligence, Customs, Central Excise, Border Security Force, the Coast Guard and the Police authorities of State governments are also empowered to take action against drug trafficking under the provisions of the NDPS Act, 1985.

The nodal agency for drug demand reduction is the Ministry for Social Justice and Empowerment (MSJE) that implements its programmes mainly by supporting NGOs all over the country. The health, treatment and hospitalisation facilities are the responsibility of the Ministry of Health and the Health Departments of the States and Union Territories.

National Policy

National policy on Narcotic Drugs and Psychotropic Substances is based on Article 47 of the Directive Principles of State Policy, Constitution of India, where the 'Duty of the State [is] to

raise the level of nutrition and the standard of living and to improve public health'. It directs, *inter alia*, that the "...the State shall endeavour to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and of drugs which are injurious to health". The government's policy on the subject which flows from the above said constitutional provision is also guided by the international conventions on the subject, mentioned under 'Conventions adherence' (Para. 7.1.1) above. However, India does not have a national drug control policy or an apex organization in respect of drug control.

The NDPS Act, 1985 lays down the focus and direction of drug control strategy in the country. This Act made an express provision for constituting a Central Authority for the purpose of exercising the powers and functions of the central government under the Act. In exercise of the powers, the "Narcotics Control Bureau (NCB)" was constituted with Headquarters in Delhi on 17th March 1986.

Though the master plan has not been formally adopted, many of its provisions have been absorbed into subsequent National Five-Year Plans.

5(b) Licit control (drugs and precursors)

Licit control: Licit opium cultivation in India is supervised by the CBN headed by the Narcotics Commissioner. An elaborate control system has been designed to ensure that all opium produced in India is duly accounted for and to prevent its diversion to illicit channels. The main elements of the system are licensing control, with the prescription of Minimum Qualifying Yields (MQY), and government monopoly of purchasing. Strict monitoring measures, including stepping-up test measurements and checking of Preliminary Weighment Registers, have been introduced. The entire licensed harvested crop is procured by CBN, and is processed in its two opium and alkaloid factories at Neemuch and Ghazipur.

Precursors: India has an advanced and large chemical industry which manufactures and uses a wide range of chemicals for legitimate purposes. Some of these chemicals are also precursors or essential chemicals frequently used by the illicit drug industry and are, therefore, susceptible to diversion. India produces 15 precursor chemicals, including acetic anhydride, ephedrine, pseudo-ephedrine, anthranilic acid and N-acetylanthranilic acid. The chemical and pharmaceutical industry manufactures, uses and exports many of the precursors listed in Tables I and II of the 1988 UN Convention. India is a signatory to all the three UN Conventions. It exercises control over precursors under three different laws as follows:

Controls under the NDPS (Regulation of Controlled Substances) Order, 1993: This order issued under Section 9A of the NDPS Act, 1985 requires the manufacturers, distributors, sellers, importers, exporters and consumers of controlled substances to maintain records and file quarterly returns with the Narcotics Control Bureau. It also requires any loss or disappearance of the controlled substance to be reported to the Director General, NCB.

Precursors covered: Acetic anhydride, Anthranilic acid, N-acetyl anthranilic acid, Ephedrine and Pseudoephedrine. **Enforcement agency:** Narcotics Control Bureau for scrutinizing returns. For violations, any officer empowered under NDPS Act can take action.

Controls imposed under the EXIM policy: The EXIM policy (export-import policy) framed under the Foreign Trade (Development and Regulation) Act, 1992 imposes restrictions on the import and export of goods. Export of seven precursors is subject to a No Objection Certificate and import of three precursors is restricted. **Precursors covered:**

Export of Acetic anhydride, Ephedrine, Pseudoephedrine, Methyl-ethyl-Ketone, Phenyl-2-Propanone, 3,4 methylenedioxyphenyl-2-propanone and Potassium permanganate requires a No Objection Certificate from the Narcotics Commissioner. The import of acetic anhydride, ephedrine and pseudoephedrine is restricted in India. **Enforcement agency:** Narcotics Commissioner issues NOC for exports and licences for import of precursors whose import is restricted by the Director General of Foreign Trade.

Controls under Section 11 of the Customs Act 1962: The goods specified under this section are subject to intensive checks in the specified areas by the customs officers. The Government of India has notified acetic anhydride as a specified substance under this section within an area of 100 km. along the Indo –Myanmar border and 50 km. along the Indo Pak border. Broadly, the special measures under this section require all persons who own, possess or control the specified substance to maintain records and notify the Customs officers of the details of quantities held and transported. **Enforcement agency:** Customs.

5(c) Supply reduction

An effective statutory and administrative framework has been set up in India to combat drug trafficking. India complies with the regulations under the various United Nations Conventions and co-operates with countries in the region in supply reduction and law enforcement efforts. India is also signatory to the SAARC Convention on Narcotic Drugs and Psychotropic Substances. The detection and eradication of illicit drug crops is a law enforcement priority.

At the operational level, India's drug law enforcement strategy is coordinated by the NCB and is focused upon: (a) combating trafficking through appropriate intelligence, interdiction and investigative initiatives; (b) eradicating illicit drug crops; (c) preventing leakage from licit opium crop; (d) implementing a regime of domestic and international trade controls over select precursor chemicals; and (e) increasingly targeting assets derived from drug trafficking for confiscation and forfeiture.

5(d) Demand reduction

The Ministry of Social Justice and Empowerment has developed a strategy for Drug Demand Reduction in India. The strategy is based on the conviction that a co-ordinated response of government and non-government organisations is more effective for drug abuse prevention. This is being achieved through the Scheme for Prohibition and Drug Abuse Prevention wherein funds are released to voluntary organisations for setting up/maintenance of counselling and awareness centres. The Ministry is supporting 369 NGOs running 459 (counselling, awareness and de-addiction cum rehabilitation centres). Every year on average in excess of 300,000 addicts register at these centres.

The health, treatment and hospitalisation facilities are the responsibility of the Ministry of Health of the States/Union Territories.

MSJE has drawn up a three-pronged demand-reduction strategy (MSJE 2003) based on the approach that drug abuse is a psycho-socio-medical problem that can be handled through community-based interventions. The three components are:

- a) Building awareness and educating people about ill effects of drug abuse.

- b) Dealing with addicts through a programme of motivation, counselling, treatment, follow-up and social reintegration.
- c) Imparting drug abuse prevention rehabilitation training to volunteers having in view to build up and educate a cadre of drug abuse control operators.

The strategy involves the training of volunteers in drug abuse prevention and rehabilitation and is based on the conviction that a coordinated response of government and non-government organisations is more effective for drug abuse prevention.

This is achieved through the Scheme for Prohibition and Drug Abuse Prevention wherein funds are released to voluntary organisations for setting up/maintenance of counselling and awareness centres, deaddiction-cum-rehabilitation centres, de-addiction camps and for preventive awareness programmes, workplace prevention programme and training of service providers.

The national demand reduction strategy formulated by MSJE is complementary to the national master plan drawn up in 1994. In order to counteract the demand for dependence-producing drugs, the **Scheme for Prohibition and Drug Abuse Prevention**, being launched since the Seventh Five Year Plan as a Central plan Scheme, has been reviewed, restructured and titled “Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse”. The revised Scheme was implemented from 1st April 1999 in the light of the approach and objectives envisaged for Ninth Five Year Plan. The Scheme is implemented through registered Societies / Trusts / Companies or the Organisations/Institutions by providing financial assistance to the extent of 90% of the total approved expenditure and in case of the north eastern states, Sikkim, Jammu and Kashmir it is 95%. These organizations are financially assisted for setting up and maintaining counselling and awareness centres and treatment-cum-rehabilitation centres and for organizing de-addiction camps, Awareness programmes and manpower development.

The Ministry of Social Justice and Empowerment is also in the process of drafting its National policy and study for Drug Demand Reduction in India.

The National Youth Policy 2003 (MOYAS 2003) recognizes the vulnerability of young people to substance abuse, STDs and HIV / AIDS and considers these issues as a priority. The Policy, therefore, advocates a two-pronged approach of education and awareness for prevention and proper treatment and counselling for cure and rehabilitation. It further enjoins that information in respect of the reproductive health system should form part of the educational curriculum. The Policy also stresses the need for establishment of adolescent clinics in large hospitals and similar projects in rural areas to address the health needs of young adults. The department of Youth Affairs and Sports, through the National Service Scheme, (NSS) and the NYKs through their volunteers, carry out awareness generation on drug abuse and AIDS. NSS volunteers, (Urban Student Youth), concentrate on the integrated development of adopted villages and slums, and NYK carry out their activities in rural India. No specific policy on drug abuse control has been drawn up as yet in the Health Ministry.

The National Health Policy 2002 (MOHFW 2002) does not specifically mention drug use as a component or concern.

The programme of the National AIDS Control Organisation (NACO), Ministry of Health and Family Welfare recognises that injecting drug use is also one of the major causes for the spread of HIV/AIDS in the country. The NACO’s policy document (NACO 2003)

recognises harm minimization measures such as exchange of syringes and needles, peer education, community outreach, access to health services and oral drug substitution, as the appropriate strategy to prevent HIV among injecting drug users, although the policy further recognises that in India the harm-reduction approach is yet to find wider acceptability because of ethical and moral considerations.

An analysis of national policies pertaining to drug use and HIV/AIDS (UNAIDS and UNODC 2000) found that there was no signal from government that HIV/AIDS prevention will be established as a central element of all drug treatment programmes. Although it had become a part of the draft National AIDS Prevention and Control Policy by then, harm minimisation was (and still is) not a part of national drug control policy and strategy. Many drug treatment agencies did not consider HIV intervention as an urgent issue. Several key informants expressed the view that the injecting epidemic that arose in Manipur was substantially influenced by the adoption of harsh anti-drug policies at that time – the so-called “police model.” Instances were cited where severe law enforcement resulted in an acute shortage of heroin, prompting many heroin users to shift to injectable buprenorphine, (which, being licit, is relatively easily accessible).

The same analysis also noted that there was also no clear policy on opioid substitution treatment in India. Many government officers were reported to believe incorrectly that UNDCP (now UNODC) was non-supportive of substitution treatment and several NGO representatives expressed the view that this policy stance was hindering progressive policy reform in India.

5(e) Money laundering control measures

The Narcotic Drugs and Psychotropic Substances Act, 1985 contains provisions for tracing, freezing and forfeiting the properties of drug traffickers, their relatives and associates. It provides for tracing, identifying, freezing, seizing and forfeiting of illicitly acquired properties of drug traffickers, their relatives and associates. The definition of “relatives” is quite comprehensive and thus includes all the relatives in whose names traffickers might place drug money. The offence of acquiring properties illicitly under the provision of this act is punishable with imprisonment of 10 – 15 years or more. A quasi-judicial authority entitled the ‘Competent Authority’ who also decides on whether the frozen properties should be forfeited must confirm the freezing order. While freezing and seizing are techniques of temporary restraint, the process of forfeiture is a process that transfers the title of ownership to the government. The properties can be forfeited only after the person is either convicted or has been detained under PITNDPS Act. One interesting aspect of the law is that the burden of proving that the property is not illegally acquired rests on the charged person. Only properties earned during the previous six years can be frozen and forfeited under this law.

The President of India has signed the Prevention of Money Laundering Act 2002. The Act has ten Chapters. In Chapter II money laundering is defined as an offence punishable with imprisonment for a term which shall not be less than three years but which may be extended to seven years. Chapter III Attachment, Adjudication and Confiscation refers to the attachment of property involved in money laundering, Adjudicating Authorities and the Management of Properties confiscated. Chapter IV spells out the obligations of banking companies, financial institutions and intermediaries. Chapter V explains summonses, searches and seizures. Chapter VI through to Chapter X goes into administrative details regarding the appellate Tribunal, special courts, authorities, reciprocal arrangements for

assistance in certain matters and procedure for attachment and confiscation of property and Miscellaneous.

Other laws: In addition, certain other laws namely (1) the Benami Transactions (Prohibition) Act 1988, (2) the Income Tax Act 1961, (3) the Foreign Exchange Regulation Act (FERA) 1973 and (4) the Smugglers and Foreign Exchange Manipulators (Forfeiture of Property) Act, 1976, also contain provisions for countering money laundering to some extent. The current legislation provides for a holistic approach to matters that perpetuate or result in money laundering. The Foreign Exchange Regulations Act, 1973 (FERA) has been repealed and is replaced by Foreign Exchange Management Act (FEMA). The Directorate of Enforcement is the enforcement authority for the control of crimes relating to money laundering.

5(f) International cooperation

India has hosted an international, regional and bilateral exchange programme under the aegis of UNODC, SAARC, system, ICPO-INTERPOL and Colombo Plan Bureau. Particularly noteworthy are India's contributions in the fields of precursor control and demand reduction. India has entered into bilateral agreements with a number of countries on matters relating to combating trafficking in narcotic drugs, psychotropic substances and precursor chemicals. To date, India has entered into bilateral agreements with several countries including USA, Mauritius, Afghanistan, Russia, Myanmar, Zambia, the UAE, Bulgaria, Egypt, China, Italy, Turkey. These agreements relate to: a) exchange of information/experience of operational, technical and general nature; b) assistance in joint investigations, identification and destruction of illegal drug processing sites/laboratories; c) control over precursor chemicals; d) prevention of money laundering; e) training and measures to reduce demand through prevention; and f) treatment and public awareness activities.

The Government is a signatory to the 1990 SAARC Convention on Narcotic Drugs and Psychotropic Substances.

The UNODC Regional Office for South Asia is located in New Delhi.

6. POLICY – CRIME

Criminal Justice System: The criminal justice system is derived from the British model. Established procedures for the protection of defendants, except in the case of strife-torn areas, are routinely observed. The penal philosophy embraces the ideals of preventing crime and rehabilitating criminals. Courts of law try cases under procedures that resemble the Anglo-American pattern. The machinery for prevention and punishment through the criminal court system rests on the Code of Criminal Procedure of 1973, which came into force on April 1, 1974, replacing a code dating from 1898. The code includes provisions to expedite the judicial process, increase efficiency, prevent abuses, and provide legal relief to the poor. The basic framework of the criminal justice system, however, was left unchanged.

Constitutional guarantees protect the accused, as do various provisions embodied in the 1973 code. Treatment of those arrested under special security legislation can depart from these norms, however. In addition, for all practical purposes, the implementation of these norms varies widely based on the class and social background of the accused. In most cases, police officers have to secure a warrant from a magistrate before instituting searches and seizing

evidence. Individuals taken into custody have to be advised of the charges brought against them, have the right to seek counsel, and have to appear before a magistrate within 24 hours of arrest. The magistrate has the option to release the accused on bail. During trial a defendant is protected against self-incrimination, and only confessions given before a magistrate are legally valid. Criminal cases usually take place in open trial, although in limited circumstances closed trials occur. Procedures exist for appeal to higher courts.

India has an integrated and relatively independent court system. At the apex is the Supreme Court, which has original, appellate, and advisory jurisdiction. Below it are 18 high courts that preside over the states and union territories. The high courts have supervisory authority over all subordinate courts within their jurisdictions. In general, these include several district courts headed by district magistrates, who, in turn, have several subordinate magistrates under their supervision. The Code of Criminal Procedure established three sets of magistrates for the subordinate criminal courts. The first consists of executive magistrates, whose duties include issuing warrants, advising the police, and determining proper procedures to deal with public violence. The second consists of judicial magistrates, who are essentially trial judges. Petty criminal cases are sometimes settled in *panchayat* courts.

Legislation: Under the constitution, criminal jurisdiction belongs concurrently to the central government and the states. The prevailing law on crime prevention and punishment is embodied in two principal statutes: (a) the Indian Penal Code and (b) the Code of Criminal Procedure of 1973. These laws take precedence over any state legislation, and the states cannot alter or amend them. Separate legislation enacted by both the states and the central government also has established criminal liability for acts such as smuggling, illegal use of arms and ammunition, and corruption. As such several Special Laws (applicable to particular subjects²³) and Local Laws (applicable to particular parts of India) have been enacted from time to time to meet the growing crime prevention needs. All legislation, however, remains subordinate to the constitution.

Human trafficking: In addition to the Indian constitution, which establishes a right against exploitation by “traffic in human beings” (Article 23), the laws which bear relevance to human trafficking are as follows:

1. Indian Penal Code, 1860 – deals with kidnapping or abduction for various purposes including selling and buying and slavery.
2. Child Marriage Restraint Act, 1929 – prohibits marriages of females below 18 years and males below 21 years of age.
3. Child Labour (Prohibition and Regulation) Act, 1986 – sets hours and conditions of work for children under 14 years.
4. Bonded Labour System (Abolition) Act, 1976 – formally frees all bonded labourers, cancels their outstanding debts and prohibits the creation of new bonded labour arrangements.
5. Immoral Traffic (Prevention) Act, 1956 – deals with various aspects related to prostitution.

²³ For example, the Arms Act, the Narcotics Drugs and Psychotropic Substances Act, the Immoral Traffic (Prevention) Act, the Foreign Exchange Maintenance Act and the Prevention of Money Laundering Act. At the same time, several committees have been formed, in order to help in fighting public sector corruption.

6. Juvenile Justice (Care and Protection of Children) Act, 2000 – is invoked to provide care, protection, treatment and rehabilitation to children in need of care and protection as well as those who come into conflict with the law.

Crime control institutions: The constitution assigns responsibility for maintaining law and order to the states and territories, and almost all-routine policing – including the apprehending of criminals – is carried out by state-level police forces. The constitution also permits the central government to participate in police operations and organization by authorizing the maintenance of the Indian Police Service. The Union Public Service Commission through a competitive nationwide examination recruits police officers.

The constitution also authorizes the central government to maintain whatever forces are necessary to safeguard national security. Under the terms of the constitution, paramilitary forces can be legally detailed to assist the states but only if so requested by the state governments. In practice, the central government has largely observed these limits. In isolated instances, the central government has deployed its paramilitary units to protect central government institutions over the protest of a state government.

The principal national-level organization concerned with law enforcement is the Ministry of Home Affairs, which supervises a large number of government functions and agencies operated and administered by the central government. The ministry is concerned with all matters pertaining to the maintenance of public peace and order, the staffing and administration of the public services, the delineation of internal boundaries, and the administration of union territories.

In addition to managing the Indian Police Service, the Ministry of Home Affairs maintains several agencies and organizations dealing with police and security. Police in the union territories are the responsibility of the Police Division, which also runs the National Police Academy and the Institute of Criminology and Forensic Science. The Central Bureau of Investigation investigates crimes that might involve public officials or have ramifications for several states. The ministry also is the parent organization of the Border Security Force.

In most states and territories, police forces are functionally divided into civil (unarmed) police and armed²⁴ contingents. The former staff police stations, conduct investigations, answer routine complaints, perform traffic duties, and patrol the streets. Since the late 1980s, women²⁵ have entered in larger numbers into the higher echelons of the Indian police, mostly through the Indian Police Service system.

There are a few Central Law Enforcing Agencies characterized as “Special Investigation Agencies” which also register cognisable crimes, investigate and place results to “normal” or

²⁴ Contingents of armed police are divided into two groups, the district armed police and the Provincial Armed Constabulary. The district-armed police are organized along the lines of an army infantry battalion. They are assigned to police stations and perform guard and escort duties. Those states that maintain distinct armed contingents employ them as a reserve strike force for emergencies. Such units are organized either as a mobile armed force under direct state control or in the case of district armed police (who are not as well equipped) as a force directed by district superintendents and generally used for riot-control duty.

²⁵ Women police officers were first used in 1972, and a number of women hold key positions in various state police organizations. However, their absolute numbers, regardless of rank, are small. Uniformed and undercover women police officers have been deployed in New Delhi as the Anti-Eve Teasing Squad, which combats sexual harassment against women (“Eves”). Several women-only police stations have also been established in Tamil Nadu to handle sex crimes against women.

“special” courts for trial. The agencies include the Central Bureau of Investigation, the Directorate of Enforcement, the Central Board of Direct Taxes, the Directorate of Revenue Intelligence, the Directorate of Preventive Operations, the Narcotics Control Bureau, and the Directorate of Income Tax.

Convention adherence

India is a signatory to the Transnational Organized Crime Convention of 2002 as well as the three related Protocols on human trafficking, migrants and firearms. It is also a signatory to the 2003 Corruption Convention.

7. TERRORISM

There are currently a number of sources of activity linked to terrorism in India. These include primarily conflicts between the government of India and groups which have either limited or expansive secessionist aims in some states which border other countries. India has emphasized that terrorist violence being inflicted in many parts of the world emanates from the same extremist sources such as the Al Qaeda network and its range of ideological affiliates which threaten parts of India. The country’s problems are compounded by insurgencies and ethnic violence in the Northeast, as well as left-wing extremist (Naxalite) movements in parts of Andhra Pradesh, Jharkhand, Bihar, Chhattisgarh, Madhya Pradesh, Maharashtra, Orissa West Bengal and Uttar Pradesh.

In March 2002, parliament passed the Prevention of Terrorism Act. The two other main pieces of legislation dealing with terrorism are: (a) The Unlawful Activities (Prevention) Amendment Ordinance, 2004; and (b) The Prevention of Terrorism (Repeal) Ordinance, 2004.

Convention adherence

India is a party to all 12 of the universal anti-terrorism instruments related to the prevention and suppression of international terrorism, including the 1999 International Convention for the Suppression of the Financing of Terrorism.