ISSN: 0975-833X

*Available online at http://www.journalcra.com*

*International Journal of Current Research*
*Vol. 4, Issue, 05, pp.114-123, June, 2012*

**INTERNATIONAL JOURNAL OF CURRENT RESEARCH**

**RESEARCH ARTICLE**

# HIV/AIDS, DRUGS AND SUBSTANCE ABUSE AMONG YOUTH

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**ARTICLE INFO**

*Article History:*
Received 14th March, 2012
Received in revised form
25th March, 2012
Accepted 19th April, 2012
Published online 30th June, 2012

*Key words:*
World Health Organization
HIV/AIDS,
Drugs and substance.

**ABSTRACT**

The present study categorically aimed at understanding the effects and impact of Hiv/Aids, drugs and substance abuse among the youth who are in aged bracket between 15 and 25 years. As the accurate data on youth involved in substance abuse in the city are not available, it may be difficult to determine the overall comprehensive perspective of the study due to relative responses from the sample respondents among youth in Visakhapatnam, A.P., India. It is worth discussing the magnitude of impact of HIV/AIDS, drugs and substance abuse among the youth in Visakhapatnam. According to the most recent study, it revealed that estimates of approximately 200,000 drug-injecting-related deaths may occur per annum based on the estimated size of the current world population of injecting drug abusers of at least 5.3 million. World Health Organization (WHO) reported that a multi-fold increase in drug-related deaths over the past decade occurred. The yearly mortality rates or "lethal impact" among intravenous drug users or drug addicts on treatment programmes ranged between one and two percent which primarily transpired in the younger generations. In addition to its adverse effects on health, injury and eventual death, drugs is among the most prevalent associated with HIV/AIDS). This social problem requires primary health and structural reforms to enhance the level of treatment, rehabilitation and prevention.



## INTRODUCTION

Drug Addiction and Drug Abuse is a chronic or habitual use of any chemical substance to alter states of body or mind for other than medically warranted purposes. Human being is a complex entity especially during the stage of youth. A person's relationship with drugs is difficult to understand. He may take drugs without any medical prescription for a disorder or for any obvious problem. He feels a compulsion to take a drug in order to avoid inner tensions and anxiety. He may be facing frustrating problems resulting from his adolescent period; identity crisis; vocational selection; peer pressure; marital problems, employment; family relationships and expected responsibilities. Soothing drugs and minor tranquilizers relieve him from above mentioned anxiety states. As a defined individual, man sometimes uses his own mode of behavior to resolve his problems. He may not take drugs in some frustrating situations and instead conforming to social norms. Addiction among youth is more often now defined by the continuing, compulsive nature of the drug use despite physical and/or psychological harm to the user and society and includes both legal and illicit drugs, and the term "substance abuse" is now frequently used because of the broad range of substances include, cigarettes, alcohol and inhalants that can fit the addictive profile. Drug use is related to the illness of man. Upon falling ill, man looks for treatment and tries to use appropriate drugs in order to get relief from the suffering. Man has been using drugs for ages primarily due for medicinal purposes in the past; however, the trend has changed in recent times because the nature and type of drugs also changed to meet the changing demands of society. Generally drug use is normal and socially acceptable behavior. Drug abuse is a worldwide menace. It has given rise to different types of addicts. An addict today is not an immoral or criminal but a sick person who needs cure and prevention. The impact of drug abuse on law enforcement is extensive. At each step along the way of production, distribution, and consumption, drugs have an impact because they divert time, energy, and resources away from other responsibilities. The overall costs of drug abuse to society are a subject of growing interest in the process of making national and international policy. Having found the hard realities of life clashing with their aspirations, ideals, some youngsters find it difficult to cope with the present day situation, the power of youth can adversely harm the interests of any society. Drugs have medicinal, social, political, functional and religious uses in India. These are embedded within its multi-cultural, ultra-complex societal and religious fabric. Owing to these myriad issues, the youth are prone to become addiction to substances that could ease their minds and indulged them to spoil their lives. It is therefore relevant that the different sections of society focus on heightening the social consciousness of the community to prevent the youth from further damage of drug use and substance abuse. The youth will be more active in positive changes in nation-building if law enforcement agencies tackle the social malady with vigilance and humane significance to protect the younger generations.

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Drug Addiction and Drug Abuse is a chronic or habitual use of any chemical substance to alter states of body or mind for other than medically warranted purposes. Traditional definitions of addiction, with their criteria of physical dependence and withdrawal and often an underlying tenor of depravity and sin have been modified with increased understanding; with the introduction of new drugs, such as cocaine, that are psychologically or neuropsychological addicting; and with the realization that its stereotypical application to opiate-drug users. Definitions of drug abuse and addiction are subjective and infused with the political and moral values of the society or culture. For example, the stimulant caffeine in coffee and tea is a drug used by millions of people, but because of its relatively mild stimulatory effects and because caffeine does not generally trigger antisocial behavior in users, the drinking of coffee and tea, despite the fact that caffeine is physically addictive, is not generally considered drug abuse. Even narcotics addiction is seen only as drug abuse in certain social contexts. (The Columbia Encyclopedia, 2004)

### Theoretical Framework

This complex issue will be primarily addressed through the lens of feminist post-colonialism. While the prefix 'post' generally indicates that the focus is centered around what occurred after, or following, the formal period of colonialism that ended in 1867, many authors argue that this is not so in the case of Canadian post-colonialism. Porter (2006) defined colonialism as a far-reaching and all encompassing "racialized hierarchy of difference" which works to ensure that the power balance between colonizer and colonized becomes "embedded within structures of economy and power, as well as embedded in frames of meaning" (p. 383). She also refuses to allow the 'post' in post-colonialism to stand alone, and places the word in parenthesis to illustrate the dynamic and evolving nature of colonialism. This theory rejects the idea that colonialism was a static process with a marked beginning and ending, and instead sees it as an ongoing phenomenon. Browne and Smye (2002) take this argument one step further by referring specifically to a distinct form of neo-colonialism, to which Canada's Aboriginal population are subject, which refers to those policies and practices embedded within

Canada's political, economic, and social systems which work to perpetuate original colonialist ideologies (p.31). It can be argued that ongoing colonialism is demonstrated in the continued existence of the Indian Act, which displaced Aboriginal peoples by exposing them to what can only be described as cultural genocide. For instance, Fullerton-Owl (2007) regards the Act as "imposed, foreign [and] titanic" in nature and asserts that "it speaks directly to, it speaks directly for, and speaks directly against First Nations cultural integrity, political autonomy and human dignity" (n.p.). The residential school system and its corresponding imposition of Western language and culture upon Canada's Aboriginal population is another example of external attempts at cultural domination. Finally, the lack of cross-cultural training and culturally relevant methods of addressing HIV and AIDS among Aboriginal Canadians, paired with the dominance of a Western, biomedical model of healthcare, is representative of the colonial-like mentality that continues to dictate policy (Browne, 2007; Bourassa, et al., 2004; Browne, et al., 2001). Women are often reduced to the image of the 'Other' which further marginalizes them as a population and has a direct impact on their health. For instance, the idea of the 'Other' is borrowed from Edward Said's seminal work, *Orientalism*, throughout which he describes the ways in which European conquerors, in an attempt to place unfamiliar attributes into neat and definable categories, unceremoniously generalized that which is foreign. It can be argued that Aboriginal Canadians, primarily women, have undergone a similar process of 'Othering' as a result of their minority status in Canada. Bourassa et al. (2004) assert that Aboriginal women bear their 'otherness' in more than one way due to the fact that they experience multiple oppressions such as racism, colonialism, and gender inequalities (p. 24). Embedded within the idea of the 'Other' is a hierarchy of power relations which inevitably places the reference group at the top, and the 'Other,' who is perceived as "somehow lacking or not quite up to an unmarked standard," at the very bottom (Heron, 2007, p. 7).

**THE GLOBAL CONTEXT OF DRUG USE**

The proliferating increase in global problems of illicit drugs reflects and contributes to international tensions. The origins of some of these tensions are clear: rapid changes in political alignment, reduced family and community cohesiveness, increased unemployment and underemployment, economic and social marginalization and increased crime. Today there is more awareness of the problems of illicit drugs and drug trafficking than ever before. How to translate that awareness into constructive action is a major challenge. The term "illicit drugs" is used in this paper to include the narcotic drugs and psychotropic substances listed in the schedules of the Single Convention on Narcotic Drugs of 1961, and that Convention as amended by the 1972 Protocol and the Convention on Psychotropic Substances of 1971. Of the more than 200 controlled substances listed, United Nations International Drugs Control Programme, UNDCP emphasizes opium-heroin, coca-cocaine, cannabis, and amphetamine-type stimulants due to their importance for both developing and industrialized countries.

**IMPACT OF HIV/AIDS AND DRUG ABUSE ON FAMILY AND COMMUNITY**

Family is often viewed as the basic source of strength, providing nurturance and support for its individual members as well as ensuring stability and generational continuity for the community and culture. In reality, the family is far more complex. At least four conceptual views of the family have been identified. First, it may be seen as protecting and sustaining both strong and weak members, helping them to deal with stress and pathology while nurturing younger and more vulnerable members. Secondly, the family may be a source of tension, problems, and pathology, influencing weaker members in harmful ways, including destructive drug or alcohol use. Thirdly, it may be viewed as a mechanism for family members to interact with broader social and community groups, such as peer groups, schools, work colleagues and supervisors and persons associated with religious institutions. Fourthly, the family may be seen as an important point of intervention - a natural organizational unit for transferring and building social and community values. Families can have a powerful influence on shaping the attitudes, values and behavior of children, but the influence of peer groups, which is usually strong during formative years of youth, may be stronger than that of parents in some cases. According to (Denise Kandel, 1973), he found out that friends are more similar in their use of marijuana than in any other activity or attitude. In this situation, drug use by peers may exert a greater influence than the attitudes of parents. Peer and parental influences are synergistic, with the highest rates of marijuana use being observed among adolescents whose parents and friends were drug users. (Richard Blum et al, 1972), however, had found that peers have a high degree of influence only when the parents have abdicated their traditional supervisory roles. Hence, parents exercising traditional family roles may be able to limit the influence of peer groups on children's attitudes towards drug use and therefore have a crucial influence on children's behavior. Family factors that may lead to or intensify drug use are thought to include prolonged or traumatic parental absence, harsh discipline, failure to communicate on an emotional level, chaotic or disturbed members and parental use of drugs, which provides a negative role model for children (Anthony Jurich et al, 1983). Lack of household stability, income or employment for a parent may increase stress on the family and its vulnerability, pushing marginal individuals to find "solutions" or solace in alcohol or drugs. Single-parent families may have increased difficulties, with the single parent being forced to function beyond his or her ability. Alcohol and other substance abuse and psychopathology have been studied among family members. It is well known that having biological relatives with alcoholism increases the risk in unaffected individuals. Also, families with histories of psychological and social pathology may be at increased risk for alcohol problems. Persons who are heavy users of alcohol or other drugs may show psychiatric symptoms such as depression. Dysfunctional drug or alcohol use may mask an underlying emotional illness. Reports of disturbed family life related to drugs are frequent in the literature. In Ireland, it was found that disrupted family life appears to be a major risk factor for drug abuse among some young persons and that as many as 10 per cent of the young people between 15 and 20 years of age in the northern part of Dublin were addicted to heroin (Corrigan,1986). In India, an increased number of heroin addicts seeking assistance at treatment centres have been reported. It has been estimated that between a half million and a million persons became addicts in the 1980s, challenging cultural traditions and services (Mohan et al, 1987). Many families are supported and cared for by women. They frequently have the key role in teaching the young, ensuring that health care is provided and maintaining links with and mobilizing community support when necessary. Women who are not drug abusers may be affected by problems related to drug abusing men. The problems of male partners may affect women in the form of difficulties in interpersonal relationships, instability, violence, child abuse, economic insecurity, deprivation of schooling and risk of sexually transmitted disease, including HIV infection.

The Human Immunodeficiency Virus (HIV) causes the clinical disease Acquired Immune Deficiency Syndrome (AIDS). Unknown before the 1980s, it now is an epidemic for which there is no known cure and no vaccine. The virus is spread by sexual intercourse, contaminated blood like during transfusions, mother-to-child transmission during the prenatal period and use of contaminated syringes and injection equipment. The importance of each of these means of spread varies from one region of the world to another. The devastating effects of AIDS are seen most clearly in the developing world. Two-thirds of the AIDS cases, adults and children, are in Africa, where the primary means of spread is heterosexual contact. Males may acquire the virus through use of dirty injection equipment and then transmit it to female or male sex partners. Ever since drug injecting has been identified in 80 countries, and HIV infection is prevalent among 52 out of them. It is a relatively recent phenomenon in many countries and the new diffusion of injecting is "occurring in countries which are mostly poor, and are either in drug producing areas or along drug transshipment routes (www.bioinfobank library.com, 2006). In many countries the recent rapid diffusion of injecting has been followed by major outbreaks of HIV infection, for example throughout urban, rural and hill tribe areas in Thailand and Manipur in North-east India, Ruili in southern China, and Myanmar. Manipur, which shares a long border with Myanmar, and Chennai, India, are examples of places where rapid increases of heroin injection have taken place (Stimson, 1992). Among persons who administer drugs by injection, the proportion estimated to be infected with the virus varies widely from a low range of 1-5 per cent in the United Kingdom to 20 per cent in Germany, 30 per cent in the Netherlands, 30-80 per cent in Italy, 40-60 per cent in Spain and 58 per cent in France, International Narcotics Control Board (INCB, 1992). As the proportion of injecting drug users who are HIV positive increases and increased numbers of them travel, the rate of spread of the virus may also increase. The most conservative predictions by public health institutions foresee increased use of illegal drugs via injection in many countries and increased transmission of HIV among people who have taken drugs in this way (Du Del Girls, Friedman, 1994). The relationship between the injection of drugs and HIV transmission has become a major concern in many parts of the world. But, according to a WHO report, less well "recognized, but statistically and medically more significant in terms of its overall societal impact, is the relationship between substance abuse and hepatitis, tuberculosis, cardiovascular diseases, cirrhosis and neuropsychiatric disorders; When it is estimated AIDS cases are considered along with available data on the distribution and spread of HIV infections worldwide, it is estimated that as of late 1993, over 14 million adults and over 1 million children have been infected with HIV since the start of the pandemic (WHO,1994). Aggregate multi-country information on the costs of drug abuse is not available. In the United States, however, where this issue has been examined, drug abuse was found to impose a $44.1 billion dollar burden on the economy in 1985, with the projection of $58.3 billion for 1988. Calculations were based on the

human capital approach, which is based on the value of productivity in terms of market earnings and attributed value for household services. Drug abuse, compared to alcohol abuse and mental illness, was comparatively low in direct and indirect costs and high in other related costs, such as crime, motor vehicle crashes, administrative costs of related social welfare programmes, and costs associated with the destruction of property by fire. This study's calculation of cost also included the value of productivity losses for victims of crime. Costs for men were twice of for women. The significantly higher costs for men reflect their higher prevalence as drug users, their greater labor force participation rates, and their higher earnings relative to women. Estimates do not include costs of crack cocaine addiction and its devastating consequences because that problem emerged after this research was carried out in 1985 (Rice et al, 1990). Although the magnitude of these figures is not typical of other countries, this same study found that relying solely on diagnoses that explicitly mention alcohol or drugs on the medical record in order to measure the prevalence and cost of drugs and/or alcohol problems in hospitals grossly underestimates the full impact of substance abuse. Cases where alcohol and drug treatment were the primary diagnoses represented less than 3 per cent of the substance-abuse total costs. The conclusion is that substance-abuse-related costs may be a serious but unrecognized drain on national income; it is often unrecognized because drugs or alcohol may not appear directly in diagnoses and classifications but may be major risk factors contributing to other diseases that caused serious social disorders.

**FATAL EFFECTS OF HIV/AIDS, DRUGS AND SUBSTANCE ABUSE**

The fatal effects of drugs and substance abuse can be felt on many levels: on the individual, on friends and family, and on society. Drugs and substance abuse is a death trap, enticing the youth as friendly "demon". It kills the personhood of the youth and deteriorates the humane condition. Researchers have found a close connection between HIV/AIDS, drug abuse, criminal behavior, and social attitudes. Review of the crime/drugs literature supports three notions: heroin addicts are usually deeply involved in crime; daily opiate use increases criminality several fold; and many heroin abusers are not interested in obtaining treatment although drug treatment programmes do reduce the criminality of addicts while they are in treatment (Tullis, 1991). There were few differences in models predicting violent as opposed to property crime, although minority status was a more important predictor of violent crime, and poverty was a more important predictor of property crime (Harrison and Gfroerer, 1992). When drug problems in a community are perceived as serious, people must face unpleasant alternatives. They can accept the reality of drugs in their neighborhood, adapting to a situation that they cannot hope to change immediately; they can change their lifestyle to reduce the threat of drug dealing and violence in their streets and buildings; they can change the environment by some form of community action either with or without the support of the police; or they can flee to safer housing if possible. Many of these alternatives are not available to persons living in poverty or with limited means. Thus, with fewer choices, the poor pay a greater personal price for drug problems than others.

**RECOMMENDATION: LAW ENFORCEMENT AGENCIES**

Drug laws have tried to keep up with the changing perceptions and real dangers of substance abuse. By 1970 over 55 federal drug laws and countless state laws specified a variety of punitive measures, including life imprisonment and even the death penalty. To clarify the situation, the Comprehensive Drug Abuse Prevention and Control Act of 1970 repealed, replaced, or updated all previous federal laws concerned with narcotics and all other dangerous drugs. While possession was made illegal, the severest penalties were reserved for illicit distribution and manufacture of drugs. The act dealt with prevention and treatment of drug abuse as well as control of drug traffic. The Anti-Drug Abuse Acts of 1986 and 1988 increased funding for treatment and rehabilitation; the 1988 act created the Office of National Drug Control Policy. Its director, often referred to as the drug "czar," is responsible for coordinating national drug control policy. The impact of drug abuse on law enforcement is extensive. At each step along the way of production, distribution, and consumption, drugs have an impact because they divert time, energy, and resources away from other responsibilities. Intelligence, surveillance, interdiction and seizure, prosecution and adjudication, sentencing, prisons, probation and parole - all of these measures may need to become specialized to deal with the complexity and volume of drug cases. Special drug courts are needed in some countries to process the load of drug cases. The overall costs of drug abuse to society are a subject of growing interest in the process of making national and international policy.

**GENERAL PERSPECTIVE SNOWBALL SAMPLE**

The investigator identified some pockets of areas in the Greater Visakhapatnam Municipal Corporation limits where people are engaged in substance abuse. It may be noted that this kind of clandestine activity is carried out at lonely places, playgrounds, parks, beach areas and grave-yards where the people are found infrequently. The investigator, with the help of identified substance abusers tried to identify such abusers who fall in the age groups specified earlier. As such, the investigator followed Snowball sampling method in identifying the subject for the study. Snowball sampling is a technique for developing a research sample where existing study subjects recruit future subjects from among their acquaintances. Thus the sample group appears to grow like a rolling snowball. As the sample builds up, enough data are gathered to be useful for research. This sampling technique is often used in hidden populations which are difficult for researchers to access e.g. drug abusers, HIV infected, pick-pockets et al (D.K. Lal Das, 2000). Further, a quota sampling of one hundred (100) each from the student and non-student youth categories was identified in the areas specified above.

**RESEARCH TOOLS OF ANALYSIS**

In order to gather valuable data from the respondents, a structured interview schedule is devised. The Schedule is broadly divided into five major sections. The first section deals with the demographic data of the respondents. The second section contains queries aimed at collecting the details of various types of substance abuse such as smoking, alcohol and drugs. The opinions of the respondents about the use of substance and their self-consciousness were elicited in section three. The fourth and the fifth sections cover the feelings of the respondents on their substance abuse and the effects of substance abuse on the individual and the family, respectively.

**DATA COLLECTION**

Survey technique along with personal interview method is employed for data collection. A pre-designed Schedule is used for collecting data related to substance abuse among the respondents comprising the student and the non-student youth. In addition to this, secondary data are obtained from Narcotics Control Bureau of India, World Drug Reports of various years and publications of International Narcotic Control Board, Vienna, and National Sample Survey on Drug Abuse in India.

**ANALYSIS OF DATA**

Different statistical tools are employed for analyzing the data. Simple techniques like averages and percentages are extensively used. For easy understanding and assimilation of data, bar diagrams, pie diagrams and simple graphs are also made use of. The data were processed through SPSS (Statistical Package for Social Sciences) and analyses were drawn based on simple percentages, mean, standard deviation, chi-square tests, additive chi-square and Z-tests. Chi-square test (written as $\chi^2$ ): This test provides us with a method to evaluate whether or not frequencies which have been empirically observed differ significantly from those which would be expected under a certain set of theoretical assumption (D.K. Lal Das, 2000). With the help of the chi-square test it is possible for all researchers to (a) test the goodness of fit (b) test the significance of association between two attributes and (c) test the homogeneity or the significance of population variance (C.R. Kothari, 2010 reprint). Additive chi-square: An important property of Chi-square is its additive nature. Several values of $\chi^2$ can be added together and if the degrees of freedom are also added, this number gives the degrees of freedom of the total value of $\chi^2$. Thus, a number of chi-square values that have been obtained from a number of samples of similar data, because of the additive nature of $\chi^2$, can be combined by just adding them. Such addition of various values of $\chi^2$ gives one value of $\chi^2$ that helps in forming a better idea about the significance of the problem under consideration (C. R. Kothari, 2010 reprint).

## INDIAN YOUTH, HIV/AIDS & SUBSTANCE ABUSE

**DRUG ADDICTS IN INDIA, A FEARFUL STATISTICS!**

**4 lakh AIDS deaths in India**

The word "youth" means as the period of transition from childhood to full adult status of full membership in society and during this period the individual is no longer a child but is ready to undertake many attributes of an adult and to perform adult roles. The term "illicit drugs" is used in this paper to include the narcotic drugs and psychotropic substances listed in the schedules of the Single Convention on Narcotic Drugs of 1961, and that Convention as amended by the 1972 Protocol and the Convention on Psychotropic Substances of 1971. Of the more than 200 controlled substances listed, United Nations International Drugs Control Programme, (UNDCP) emphasizes opium-heroin, coca-cocaine, cannabis, and amphetamine-type stimulants due to their importance for both developing and industrialized countries. According to Rashme Sehgal, Denis Broun, country representative of UNAIDS, a recently-published report by the organisation states that over 4

lakh AIDS-related deaths occurred in India in 2005 -- the highest in the world. Death certificates in India rarely specify death from AIDS-related causes. Less than 2,000 death certificates in India carry this label. It is very widely underreported. Denis Broun, country representative of UNAIDS, finds himself in the eye of a storm. The recently-released UNAIDS Report on the Global AIDS Epidemic highlights the fact that over 4 lakh AIDS-related deaths occurred in India in 2005. This is the highest in the world. South Africa, where almost 20% of the population lives with HIV, reported 3.2 lakh deaths for the same period. Broun stoutly defends his position, insisting that India is facing a major AIDS epidemic and must take strong steps in order to avert a catastrophe. Broun has served as director at the World Health Organisation (WHO) and has worked with the Geneva-based Management Sciences for Health.

UNAIDS has put the number of AIDS-related deaths in India at over 4 lakh a year. How did it arrive at this figure?

The whole life of HIV/AIDS, from infection to death, takes nine to 10 years. On average, people who were infected nine years ago will die now. You take the course, the evolution of the number of people living with HIV, those who have just become patients to those who have been living with it for some time, and you arrive at this figure. It is pure 'modification'; one deduces how many are likely to have died. The figure UNAIDS arrived at was between 2.8 and 6.3 lakh, and so we took the average of 4 lakh. There has been no body count, no death certificates given out for so many AIDS patients. The diagnosis for AIDS is not easy. There is a huge amount of stigma attached to it; there is no insurance being given out to the families of patients who have died from it. Death certificates in India rarely specify death from AIDS-related causes. Less than 2,000 death certificates in India carry this label. It is very widely underreported.

What methodology did your organisation use to arrive at this 4 lakh figure, and what are the methodologies being used by other India-based organisations?

The Institute of Medical Statistics and the National Institute of Health and Family Welfare are using a method called Kink Regression, whereby they try and determine, through excess mortality figures, the number of deaths that can be attributed to AIDS. UNAIDS is following the Global Reference of Estimation and Models approach. More than 110 top scientists around the world, including India's top statisticians, are involved in this method. We use Indian government figures which state that 5.2 million people in the 15-49 age-group are positive. When we take the whole population, we find 1 lakh people living below the age of 15 are likely to have AIDS. We try and arrive at a similar figure for those above the age of 50. What we know about AIDS is then distributed among these two groups. We have done this by looking at the statistics put together by the huge baseline behaviour survey conducted by the National AIDS Control Organisation (NACO) in 2001. NACO is presently conducting a second baseline behaviour survey whose results will be out this year. The questions asked in this survey include whether an individual has had sex with multiple partners, condom usage, and so on. Sujata Rao (director general of NACO) has agreed to change the figures and go by (UNAIDS') 5.7 million figure. Three major changes have taken place recently. In Tamil Nadu, the number of AIDS cases has declined by one-third. This has happened because the number of (sexual) contacts (of the HIV-positive) has gone down. There is a need to specify that 99% of Indians are free of the virus. Looking for an AIDS case is like looking for a needle in a haystack. To find one case, one has to test 100 cases. NACO has set up 400 sentinel sites at antenatal clinics where blood samples are taken from patients visiting here between the months of August to October. NACO is, in fact, planning to set up around 400 additional sentinel sites all over the country.

Is the Indian government minimizing the figures? Is it doing enough to eradicate this disease?

The Indian government receives the figures. There is no game being played out there. The sentinel sites conduct their tests very regularly so I do not want to get into a statistical grinder. The NACO model is very solid; we don't have anything more solid. We have accepted the government's 5.2 million figure but have added the figures of the young and the old who are also suffering from this disease. The Indian government is committed to eradicating AIDS. The prime minister himself is chairing the National AIDS Commission. AIDS-prevention is becoming increasingly important for Indian legislators across the country. In a nation with a big population of more than 1 billion individuals, what lies ahead if one-third of the youth population would become drug addicts? It might not be frightened to learn that an estimated 7.5 crores Indians are drug addicts and the amount is working over significantly, drugs are now opening to semi-urban and backward areas, according to formal numbers. Reported to the major officials of Ministry of Friendly Justice and Empowerment, drug and alcohol abuse is becoming an area of interest in the Indian community. Reported to the National Survey on Extent, Pattern and Trends of Drug misuse in India conducted by the Focus in collaboration with UN Office on Drugs and Criminal Offence, the actual preponderance values inside the age group of 12-18 age was Alcoholic Drink (preceding 21), Cannabis (3), Opiates (0.7) and other illicit drugs (3.6 per cent). This is an alarming statistics in India.

According to the survey a high concentration of drug addiction goes in certain friendly sections and high-risk groups, much as, commercialized sex workers, transportation workers and street kids. Among full the provinces, usage is higher in North Eastern states/border areas & opium development areas of the nation. The drug insult prevalence is uneven in the state. A last point of alcohol abuse was according from the North Eastern states, high cannabis function from North East and Eastern regions and high opiate use in North East, North and Western geographical areas around the world. The National Survey also indicates the prevalence of drug misuse among 371 women out of the try out size of 4,648 persons which is 8 per cent. It is figured that on that point are most 6.25 crores alcoholics, .90 million Cannabis and 0.25 gazillion opiates and nearly 1 million illicit drug exploiters in India. What does the administration state regarding kids and students? Ministry references said on that point is no authentic information to indicate that on that point is a development menace of drug addiction in the country particularly among kids and students as zero timeline information for are available. Nevertheless, they said that students at the secondary and higher associate levels are insecure to slipping into drugs and substance abusing behaviors due to family circumstances, peer pressures in society, distress elements & social stigma that match the mold of the younger generations in India. The question is how the government of India responds to this alarming scenario of the youth. Reported to functionaries, the administration has place into performance a multi-pronged strategy taking motivational counseling, social-reintegration and building consciousness about the ill results of drug abuse. The administration is besides considering in terms of training the people on the ill effects of drug insult over appropriate comments in the educate curricula and services concentrate the factor of risk of succumbing to this vice, the references. To harness the menace, the Ministry has also taken a two-pronged scheme-supply and need step down approach. The spell of supply reduction is below the view of the Enforcement Authorities the demand simplification strategy as revealed in the purview of the Ministry. The Scheme for Prevention of Drunkenness and Means (Drugs) Abuse is being implemented through 350 Non Government Organizations for going 387 De-addiction Centers and 52 Counseling Centers full over the nation for leaving facilities like intervention, renewal Helps and carrying knowingness programs for victims of meaning dependency. Now the challenge is to make people aware of the menace and encourage them to join in the battle once more this malady that endangers the country, and provide recent lease of living to make a concrete effort to eradicate the numerous addicts!

HISTORICAL PERSPECTIVE OF HIV/AIDS, DRUGS AND SUBSTANCE ABUSE

Traditionally, Indian cultural diversity successfully handled the varied associations with mind-altering drugs and substances among its people without excessive use becoming a cause of major concern. With the entry of tourists from western countries since 1960s, the association with drugs and substance abuse became glamorous and the demand from wealthy tourists increased the profit margins of petty peddlers. In the eighties, derivative drugs began to replace natural drugs in the cities. During this period, a set of new legislative measures against drugs, based on the Single Convention of 1961 came to be enforced. Human behaviour cannot be isolated from the social, cultural and environmental reality surrounding it. While objective reality is related to the processes of production, subjectivity is the experience of individuals that shapes their worldview and lifestyle. Both these realities form the basis for social action.

Earlier, society was self-regulating and did not need precise rules for effective drug control. Drug consumption was carried out openly, legitimized by cultural norms and restricted by traditional demand. It was also free of underground dealings. With the intervention of the U.S., however, indigenous controls have been displaced by a single model, developed for the West. In the Indian context, instead of reducing drug supply, the imposition of this model has resulted in the replacement of culturally sanctioned use by secular use and of traditional suppliers by criminal networks. The natural psycho-active plants commonly found in India include cannabis, poppy, khat and datura. Cannabis and opium are part of the cultural and religious elements in India, used and kept under control for thousands of years. The international community, however, views these two drugs as particularly troublesome. Cannabis is processed into three main products before it is consumed: bhang, ganja (marijuana) and charas (Chopra, 1990). Opium use flourished despite

invasions from Alexander to the Mughals; it was finally monopolized by the British. It takes many forms from being blown through a hubble bubble pipe *(*hukka) as madak to being brewed with tea as bonda chai. Drugs in India have medicinal, social, political, functional and religious uses. These are embedded within its complex societal and cultural fabric. Despite several races, religions and sub-sects, 18 languages and 1,652 mother tongues, Indian culture has formed an identity over the years, which remains dynamic, symbolizing cultural continuity and a unified principle of consciousness. This inner structure of tradition contributed towards the growth of a unified worldview, projecting an image of unity in value structures, ritual styles and systems of beliefs. The early stage of influence of the cultural structure was characterised by Sanskritisation of the little traditions, creating a cultural renaissance of the great tradition. The period under the British brought in legislation and systemic change, but only at a superficial level.

The present phase of modernization is the most challenging period for Indian tradition, with multiple structural inconsistencies such as democratization without spread of civic culture (education), bureaucratization without commitment to universal norms, rise in media participation (communication) and rising expectations without a proportionate increase in resources and distributive justice, verbalization of welfare ideology without its diffusion in the social structure and its implementation as social policy, over-urbanization without industrialization, and finally, modernization without meaningful changes in the stratification system of castes. It is within this context of emerging changes and tensions that drug abuse and trafficking must be considered. British policy with regard to poppy cultivation in India was linked to its trade relations with China, whose staple export commodity was tea. Since the British had developed a taste for tea, by 1785 the East India Company was buying and selling 15 million pounds of China tea per year. The problem in trade arose because Britain had no commodity to sell in return to China. This situation led to aggressive sales of opium to China. The new business strategy changed the earlier association with poppy and cannabis. Unlike poppy, cannabis can be grown anywhere in India; in some regions it grows wild, which has made it difficult to effectively control cultivation. The British went about opium trading, systematically controlling cultivation, consumption, production and sale within the country and its export. Production, however, did not exceed demand, ensuring that profit margins were kept high. When the locals saw the huge revenue generated by the British from poppy cultivation, their perception changed. A profitable cash crop now, opium became a viable commodity for sale. This facilitated illicit cultivation as well as smuggling of opium across native states and from provinces to the native states. A widely felt change since Independence has been secular drug use (devoid of cultural or religious significance). Traditional forms of control have dwindled. The reasons can be traced to the onslaught of western tourists in the 1960s and '70s, the implementation of new drug laws in the 1980s, and liberalization in the 1990s – major structural adjustment – which has led to the marginalization of large sectors of the population and pushed some of them to adopt drug use and sale as a coping mechanism. Meanwhile, the new legislation criminalized drug use, pushing users and suppliers underground. The simultaneous influence of secular drug use and commercial drug suppliers in a context of widespread poverty and desperation, and in some areas of political conflict, has paved the way for the spread of heroin, mostly in mega cities.

In new move towards drug control, the Government of India (GoI) shut down outlets supplying opium for oral consumption in 1959. At the same time, with the ever-increasing need for revenue, the state governments promoted the onslaught sale of alcohol to raise tax revenue while threatening the users just in case being caught red handed of consuming the substance. To cite the trend, in 1979, in order to increase the demand for alcohol, the Government of Maharashtra (GoM) took measures to make alcohol more easily accessible. A large number of licences, allowing tea stalls and eating-houses to sell liquor from 6 pm to 11 pm were issued. Since the '80s, industrial night shift workers especially among BPOs call centers and college students became the new target group and several bars and hubs remain open till 4 am. In the year 2000, the GoM raked in Rs.1,900 crores as taxes from alcohol. The case of alcohol after Independence provides an interesting illustration of the links between changes in the drug scene and government legislation. While cannabis and opium products were made illegal throughout India, alcohol has remained legal in many states. Further, the government has taken measures to make it more easily available and to promote its sale, even though under the influence of Gandhian philosophy, some states outlawed alcohol. The present drug control strategy of India can be traced back to the Single Convention on Narcotics Drugs of 1961. This was enforced in December 1964 and amended in 1972. The developing countries became puppets in the hands of U.S., via the UN. Increasingly we witnessed the incursion of international drug legislation into the national scene as aid became conditional on countries accepting the U.S. inspired drug laws. This threat was posed (among others) to Nepal when it refused to implement national drug laws modeled on international requirements. Western tourists tipped up the scales for cannabis especially those countries like Canada, USA and UK where cannabis is deemed legal use. Their demand modified the traditional association with drugs that existed in India, roping in several Indian youngsters. It became a sought after substance in certain elite echelon of society. With higher profit margins, and the demand coming from comparatively richer consumers, cannabis laid the dragnet for many commercial traders locally. Finally, in 1981, the member states formulated the International Drug Control Strategy that was supposed to cover all aspects of the drug issues: use, abuse, trafficking, treatment, rehabilitation and crop substitution. In 1984, though the member states pledged to include economic, social and culturally relevant alternative programmes, they had no strategy on how to deal with problems arising from the criminalization of centuries-old cultural habits in India. Western tourists tipped up the scales for cannabis. Their demand modified the traditional association with drugs that existed in India, roping in several Indian youngsters. It became a sought after substance in certain strata of society. With higher profit margins, and the demand coming from comparatively richer consumers, cannabis laid the dragnet for many traders.

Nevertheless, the Indian government enacted the Narcotic Drugs and Psychotropic Substances Act, (NDPS Act), which did not take into account the Indian situation and its plural cultures. The NDPS Act was designed to conform to the Single Convention of 1961, which the Indian government had signed in 1964. India subscribed to the international goal of eradicating all cultural uses of cannabis within a 25-year period. Since the decision was taken without any planning, little or no attention was given to the methods used to achieve the stated goals and implications. There was no real public debate on the new legislation, and it was adopted without much research. The government's mismanagement has led to the leakage of opium produced from licit to illicit channels. After the enactment of the NDPS Act in 1985, there has been an attempt to reduce the area of cultivation. However, high yielding varieties of poppy had been introduced, producing over 42 kg. of opium per hectare, whereas the official computation of productivity remained for long at 28 kg per hectare.

Further, there was a decrease in the floor purchase price of opium from Rs. 280 to Rs. 270 per kilo, inducing the farmers to divert sales to drug traffickers instead. Finally, the commission payable to the lambardar*s* (agents who buy opium from the farmers and sell to the government) was reduced from 3.5 per cent to 0.75 per cent. This also gave the agents an incentive to sell opium to the traffickers. Fresh legislation changed the face of drug trade. With criminalization, the sale of cannabis/opium became as risky as that of modern drugs such as heroin, if not more. While some traders left for safer pastures, others took to selling hard drugs. A few traders continued to sell cannabis and opium on a small scale and refused to deal with heroin. However, with an increase in profit margins, new traders appeared among the marginalized sections of society who started dealing in brown sugar heroin (a crude form of the opiate). Addiction to brown sugar set off a chain reaction and helped increase its price. Marketing strategies were established to popularize the drug. This paved the way for a shift from traditional drugs to heroin and other non-traditional substances such as pharmaceutical opiates.

In no country can the modern drug scene be studied in isolation from national developmental dynamics especially in India. Drug production, trafficking and use are often linked to the process of marginalization. Prior to the '80s, India's economy was highly regulated. After the initial phase of liberalization in the '80s, the country recorded a GNP growth of over 5% a year. However, while the economy was growing, the government gave low priority to improving income distribution. Out of the present labor force, only 8.5% belong to the organized sector, which means that they have job security and are protected by unions. By and large, unorganized sector workers are self-employed or work as casual laborers in agriculture, construction work and other industrial occupations. When the Indian authorities constructed an electrified fence along the India-Pakistan border in Punjab in 1999 and other parts of Rajasthan, traffickers in heroin, hashish and acetic anhydride had turned to unprotected Jammu and Kashmir. Now, with a view to preventing arms-cum-drugs trafficking, the Indian government is building another fence along the Jammu and Kashmir border. Little do we realize that as long as the conflicts persist, this area will continue to be affected by drug trafficking. Political disturbances do not occur in a vacuum. When a region craves for independence, vested interests or negligence from the centre sometimes leads to deprivation. This was clearly the case in the North East – a region whose underdevelopment is exacerbated by violent conflict, closing down of educational institutions and so on. In this situation of heightened insecurity, even school children have turned to drugs. The rate of Human Immunodeficiency Virus (HIV) infection has only added to the problems since, like other facilities, health care is insufficient to meet the needs of the people.

Based on the data provided, the study can only hypothesize that drug trafficking is linked to sub-nationalist movements in India (cf. publications of the Institute for Defense Studies and Analysis, New Delhi). It may also be applicable to some of the mass movements from the second half of the 1980s. It is conceded that in order to finance their political movement against the state, insurgent groups need a commodity that can be bartered, and drugs are especially suited to that purpose. All in all, these conflicts have facilitated the smuggling of heroin from multiple sources, thereby multi-plying potential sources of supply within India. Although a hard-to-quantify proportion of the heroin smuggled into India is re-exported abroad, it seems reasonable to assume that some of it becomes available for Indian consumers. As more heroin becomes available, more incentives are generated to become involved in selling it in the domestic consumer market. Therefore, a 'pressure of supply' is generated on the domestic consumer market, first in the areas of conflict and then in the country at large. The pressure of supply is coupled with a strong pressure of demand resulting from the poor and stressful living conditions of the population of the areas of conflict, especially the young.

Drug users in India make up a substantial proportion of the petty thieves 'working' in the city, but they are seldom arrested nowadays. As a result of past 'bad experiences' in the lockup with users undergoing withdrawal symptoms (some users broke light bulbs and swallowed the pieces, others ate lizards etc.) the police tend to avoid arresting them for fear of having to rush them to hospital. The sale of stolen goods, though on a small scale, is on a continuous basis, and can be a financially viable proposition for the buyer. While poor users do face problems when they become marginalized, the process of marginalization can be extremely painful to persons from the richer strata of society, who find it extremely difficult to adjust to the realities of street life in India. In addition, some users have died in custody. Others have developed a strategy to avoid arrest altogether: they slash themselves with a razor blade, usually on the chest or hands. They use a new blade each time for this purpose since they say 'it is safer'. Police officers are put off by such seemingly 'crazy' behaviour and would rather avoid having to deal with it. Another strategy that users have developed in order to avoid the police is to apply human excreta or filth from the gutters onto their bodies. While many policy-makers advocate tougher law enforcement, few have bothered to understand the extent to which lives are wrecked through the criminalization of drug use. Previously, the users avoided creating trouble to society. When new legal sanctions came up, antisocial activities became rampant, depending on the extent of their craving. The move towards a drug free existence is a long term process depending upon the user and cannot be attained merely through enforcement.

The current drug scene is characterised by the continuing presence of traditional substances which can be used for either cultural or secular purposes, and the spread of new products, all of which are used in a secular way. The use of opiates is evident in parts of the country such as the highly urbanized cities, tourists' spots, some border areas and areas located near poppy crops or manufactures of opiates. In India, the commonly used derivatives of opium for non-medical purposes are morphine, brown sugar, pure heroin and codeine. Besides heroin, abuse of pharmaceutical drugs has become common in certain parts of the country. The lack of proper procedures in the treatment of drug abuse has created a situation where addicts buy prescription drugs over the counter for self-medication and self-detoxification without proper guidance. This leads to a different kind of addiction. The abuse of pharmaceutical drugs among women is more common than the use of substances such as heroin and cannabis products chiefly because pharmaceutical drugs are purchased from legitimate sources and can be consumed under the guise of treatment for an illness. Pharmaceutical companies can market a product for a short span of time (two to three years), and subsequently withdraw it when the adverse effects generate criticism. However, in the process they retain the ability to market a 'drug' and yet be clean in the eye of the law. At present in the rural parts of India, cultural norms are still the order of the day; the question is how long this constructive form can last out against the attack of commercial trafficking networks. It is feared that the criminalization in the cities and the North East will be replicated in these parts. And with many drug users become more vulnerable to HIV, the chances are that this reality will remain hidden in a multi-dimensional aspect of society. The drug addicts and drug users buy heroin and pharmaceutical mixes after pooling money, sharing not only the same common solution but the same needle. Drug users range on an average from between two to five people while sharing the substance mixture. While heroin pushers may use the addictive two to four times a day, buprenorphine users and the pharmaceutical mixes tend to inject less often as a result of lasting kick. Drugs would be commonly administered intravenously but occasionally intra muscular injection is also seen. Injectable drug users were noted to pull and push the blood several times in the syringe before the final administration (Reid, G. 2001). Addictives are often used in India in open public places without any hesitation. While, those who are hesitant or apprehensive of enforcement authorities prefers abandoned or under construction buildings, public toilets, at home, offices, railway yards, and burial grounds (Indian Council of Medical Research Bulletin, January-March, 2008). Though India does not appear to have a widespread culture of professional injectors, or 'street doctors', as in some other Asian countries, there do appear to be 'shooting galleries' where IDUs come to a site and inject. As a general rule injecting equipment is discarded inappropriately. Often they are thrown onto garbage heaps in the neighborhood, and even though they are a risk to the local communities, they are frequently collected by people, washed and sold to others at a cheaper price.

In most of the cases pharmacies sell syringes and needles without any need for prescriptions. Though these are inexpensive, many drug users tend to focus on buying the drug rather than purchasing new syringe and needle. Glass syringes are regarded as no good for the purpose while, plastic syringes are the preferred choice. Even though the injecting kit is very inexpensive, the use of improvised injecting equipment such as ink droppers fitted with syringes has been evinced. However, hypodermic needles and syringes are not common (Manning, G., 2001). This makes the drug users more vulnerable to HIV/AIDS due to desensitized and unhygienic use of injectable syringes. Among India's IDU community sharing of injecting equipment is widespread and in many circumstances it is considered normal. A recent Rapid Survey in India showed that most addicts had at some stage shared their needle and syringe (within a period of six months). It has been found that the rates of sharing in metropolis of Delhi, Chennai, Mumbai and Kolkata ranges from 50 per cent to 78 per cent, while Imphal tops with 86 per cent (Manning, G., 2001). Though many druggies clean their injecting equipments, the majority did so inappropriately for protection against blood borne viruses such as HIV/AIDS and hepatitis C. While a large number of injectable drug users rinsed their equipment with readily available water, very few used boiling water, and fewer used bleaching soda (Sathiamoorthy, K., 1996). The IDUs also indirectly shared common spoons, solutions, cotton swabs and at the same time dipping of a needle into an ampoule of a pharmaceutical drug was also noted.

**PREVALENCE AND POTENTIAL THREATS OF DRUGS**

Account of addicts in India has always been a difficult task and this still remains the case. It was estimated in late 1980 and early 1990s that India had five million opium users and one million heroin addicts respectively. These figures are still used by government officials and United Nations (UN) sources. By the beginning of 1990 it was estimated that there were 50,000 IDUs in India[Jain, M.K et al 1994). In the latter part of 1990s figures from an assessment of injecting drug users in various Indian sites showed a major change in the estimates of drug pushers (Manning, G., 1999). Most of the drug users in India are male but in many drug treatment centers female drug users may constitute up to 10 per cent depending on the city and geographic region (UNAIDS and UNDCP 2001). However, the drug treatment data may not be an indicator of gender representativeness. It is defined that stigma is attached to women seeking assistance and many cannot seek treatment for long periods of time. In a recent survey on drug users, 15 per cent respondents were female (Panda, S 2000). A New Delhi study of female drug users although of small sample size shows that 30 per cent were commercial sex workers (CSW). Only 15 per cent admitted to being IDUs, though, it was not clear if these people were also CSW (NEIDAC, 2000). Rapid survey data on drug use show that the onset of drug use in various major cities starts as early as 15 to 21 years of age. Experts agree that the ages of starting injecting are similar in most of the states. Sizeable number of drug users is from a lower socio economic status with substantial numbers having almost no education and they work in insecure positions or are unemployed. Forty two percent among IDUs of Kolkata could not read or write: it was nearly 50 per cent among the non-injectors. Delhi also showed near identical result, although in Mumbai it was little better. However, in Meghalaya among drug injectors and non-injectors, it was determined abysmally low i.e. three percent (Tellis, E. et al 2000). The drug addicts' health condition in India is often poor. Improper usage of needle causes ulcers, abscesses, cellulitis and thrombophlebitis among IDUs. Most of them are undernourished and have experienced excessive drug intake (Gokhale, N.A., 2000). Risk behaviors (having sex often with multiple partners) are common and a substantial number of IDUs and non-IDUs visit Commercial Sex Workers (CSW). Reluctance to use condom with either to non-CSW or CSW was common. The HIV infection in India was reported in mid 1980s and was first identified in a CSW in Madras in 1986; the first case of AIDS was also detected in 1986. By the end of 2000 up to 82.6 per cent HIV infection in India was from sexual transmission and 4.16 per cent from IDU. By the end of the century (1997) it was estimated that 2.5 million people were HIV infected and by the turn of 2000 it increased to a total of 3.9 million (living with HIV/AIDS) in the reproductive age group (15-50 years old). Incidentally India has the notoriety of the largest HIV/AIDS epidemic in the region. The city areas of Manipur observed surge of HIV from

61 per cent in 1994 to 85 per cent in 1997 and in 1998 it was nearly 88 per cent (MAP, 2001). In 2000 HIV infections among IDUs in different cities ranged from 2 per cent to 49 per cent; as in Kolkata (2 per cent), Bangalore (4.2 percent), Nagaland (7 per cent), Mizoram (9.6 per cent), Chennai (31 percent), Mumbai (23.7 per cent) and Delhi (48.9 per cent). There was a critical level of 10 per cent prevalence or more was observed in many places causing great public health concerns. Among IDUs the transmission of HIV infection to their non-injecting wives increased from 6 per cent in 1991 to 45 per cent in 1997. The rise of HIV infection among pregnant mothers from 1.3 per cent in 1994 to 2.7 per cent in 1999 in Manipur is a case of concern.

Accountability of State to Illicit Drug Menace Promulgation of legal measures to curve the illicit use of drug has been over due, however, the Narcotics Drugs and Psychotropic Substances Act 1985, and its amendment the Prevention of Illicit Traffic in Narcotics Drugs and Psychotropic Substance Act 1988, strengthened the state to confront the issue under the legal ambit. It is through these two Acts the punishments for various drug related offences can range from 10 to 20 years plus a fine of Rs.0.1 to 0.2 million. The latter Act has resulted in less draconian punishments in some cases where possession can be proved for personal use only. The death penalty can be imposed for certain offences for those with a previous conviction.

In some cases, if a person is convicted of involvement in production, manufacturing, possession, transporting, importing or exporting an amount equal or in excess of 10 kilograms (kg) of opium, one kg of heroin or 20 kg of hashish can be sentenced to death although the death penalty has yet to be carried through. Those convicted of possession or consumption of a small quantity of drugs for their own use are allowed to be released as long as they attend a de-addiction centre and within one year provide the court evidence of their medical follow up. Section 64 A of the Act allows for no prosecution to be imposed for a first time offender if the offence is related to possession of a small amount of drugs and the person agrees to seek drug treatment on a voluntary basis from a recognized institution.

As a general rule the criminalization of drug use has forced many drug users to choose drug treatment in order to evade imprisonment. As per the record of the Ministry of Social Justice and Empowerment in 1992 there were 145 counseling centres, 86 de-addiction centres and 14 after-care centres and over three million registered drug addicts in the country. The approach adopted by the Ministry is to recognize drug use as a psychosocial-medical problem and involve as much NGOs as possible in care and cure of the druggies. Community participation has been encouraged by the government as part of the process of care and cure, as it is not only cheaper but also maintains the link between the drug users, their families and the community. In north eastern states some unfortunate addicts with HIV are treated in hospices as well. At present there are 72 government de-addiction centres and 123 NGO de-addiction centres. Ministry of Health and Family Welfare has made provision of 300-450 beds in each major cities but still for a large drug using population getting treatment is often difficult.

The treatment being expensive in many such centres limits access of the addicts. Ninety thousand people were admitted in 1998 for detoxification. Admission is generally on a voluntary basis but coercion by others has also been reported. Sending an addict by an authority or a GP to a psychiatric hospital is involuntary, while courts could send drug users and dependent people to prison also where drug treatment is generally unavailable (IMC Bulletin, 2005). As there are number of opportunities for higher education on account of numerous academic institutes and job opportunities as a result of industries, the prospective youth population also will be in proportionate to this. A look at the population of Greater Visakhapatnam Municipal Corporation makes it clear.

It is observed from the table above that nearly 4 lakh people are in the age group 15-35 which is considered youth group. As there are lot of opportunities academically, industrially, socially and financially- many people have made this city as their '*City of Destiny*' to quote Dr. C.R.Reddy. Owing to the trends of modern life style, increasing exposure to the world around them, the young men and women of the city are susceptible to certain temptations and are lured by the ecstasy offered by experimentation with smoking, alcohol and drugs.

## ANALYSIS OF DATA AND INTERPRETATIONS

Visakhapatnam is a metropolitan city with a population of nearly 11 lakhs (Census 2001). It is a major port city with ample opportunities for growth – economically, individually, academically and socially. The youth of the affluent and the middle-classes are in abundance in the City. As they have access to material comforts, most of them try to lead lavish and stylish life that subsequently offers them a wide variety of things to experiment with. In this process they taste the thrill of cigarettes, alcohol and drugs- just for a change but unfortunately, they are caught in the vicious circle of addiction to these substances.

**Table 1. Population according to age-group gender-wise (In Five-Year Data)**

| AREA NAME | AGE-GROUP | PERSONS | MALES | FEMALES |
|---|---|---|---|---|
| Visakhapatnam (M Corp + OG) | All ages | 10,42,388 | 5,32,157 | 5,10,231 |
| Visakhapatnam (M Corp + OG) | 0-4 | 76,318 | 39,105 | 37,213 |
| Visakhapatnam (M Corp + OG) | 5 to 9 | 97,683 | 50,016 | 47,667 |
| Visakhapatnam (M Corp + OG) | 10 to 14 | 1,04,699 | 53,589 | 51,110 |
| Visakhapatnam (M Corp + OG) | 15 to 19 | 1,12,845 | 56,942 | 55,903 |
| Visakhapatnam (M Corp + OG) | 20 to 24 | 1,12,349 | 55,918 | 56,431 |
| Visakhapatnam (M Corp + OG) | 25 to 29 | 1,09,278 | 52,032 | 57,246 |
| Visakhapatnam (M Corp + OG) | 30 to 34 | 87,249 | 46,070 | 41,179 |
| Visakhapatnam (M Corp + OG) | 35 to 39 | 87,035 | 43,307 | 43,728 |
| Visakhapatnam (M Corp + OG) | 40 to 44 | 65,081 | 35,714 | 29,367 |
| Visakhapatnam (M Corp + OG) | 45 to 49 | 57,694 | 31,638 | 26,056 |
| Visakhapatnam (M Corp + OG) | 50 to 54 | 42,875 | 23,582 | 19,293 |
| Visakhapatnam (M Corp + OG) | 55 to 59 | 26,987 | 14,274 | 12,713 |
| Visakhapatnam (M Corp + OG) | 60 to 64 | 25,480 | 12,441 | 13,039 |
| Visakhapatnam (M Corp + OG) | 65 to 69 | 14,380 | 6,815 | 7,565 |
| Visakhapatnam (M Corp + OG) | 70 to 74 | 10,187 | 4,837 | 5,350 |
| Visakhapatnam (M Corp + OG) | 75 to 79 | 4,362 | 2,123 | 2,239 |
| Visakhapatnam (M Corp + OG) | 80 + | 4,971 | 2,165 | 2,806 |
| Visakhapatnam (M Corp + OG) | Age not stated | 2,915 | 1,589 | 1,326 |
| Gajuwaka (M+OG) | All ages | 2,76,552 | 1,42,172 | 1,34,380 |
| Gajuwaka (M+OG) | 0-4 | 23,461 | 12,029 | 11,432 |
| Gajuwaka (M+OG) | 5 to 9 | 31,154 | 16,038 | 15,116 |
| Gajuwaka (M+OG) | 10 to 14 | 29,103 | 14,915 | 14,188 |
| Gajuwaka (M+OG) | 15 to 19 | 27,484 | 14,247 | 13,237 |
| Gajuwaka (M+OG) | 20 to 24 | 27,544 | 13,401 | 14,143 |
| Gajuwaka (M+OG) | 25 to 29 | 29,663 | 13,173 | 16,490 |
| Gajuwaka (M+OG) | 30 to 34 | 26,027 | 13,851 | 12,176 |
| Gajuwaka (M+OG) | 35 to 39 | 24,166 | 13,372 | 10,794 |
| Gajuwaka (M+OG) | 40 to 44 | 16,141 | 9,206 | 6,935 |
| Gajuwaka (M+OG) | 45 to 49 | 13,380 | 7,564 | 5,816 |
| Gajuwaka (M+OG) | 50 to 54 | 9,659 | 5,375 | 4,284 |
| Gajuwaka (M+OG) | 55 to 59 | 5,737 | 2,883 | 2,854 |
| Gajuwaka (M+OG) | 60 to 64 | 5,615 | 2,667 | 2,949 |
| Gajuwaka (M+OG) | 65 to 69 | 2,846 | 1,310 | 1,536 |
| Gajuwaka (M+OG) | 70 to 74 | 2,146 | 984 | 1,162 |
| Gajuwaka (M+OG) | 75 to 79 | 873 | 410 | 463 |
| Gajuwaka (M+OG) | 80 + | 1,013 | 443 | 570 |
| Gajuwaka (M+OG) | Age not statec | 540 | 305 | 235 |

## RESULTS, RECOMMENDATIONS AND CONCLUSIONS

Drug abuse is a complex phenomenon in India. In most recent studies, it is known that Visakhapatnam as envisioned as a growing industrialized mega

city in the coming decade, various social, cultural, biological, geographical changes lead to the proliferation and prevalence of drugs. Historical and economic aspects prove that drugs and substance abuse is the one of the most heinous crime in society. The disintegration of the old joint family system, absence of parental love and care in modern families where both parents are working, decline of old religious and moral values etc lead to a rise in the number of drug addicts and drug abusers who take drugs to escape hard realities of life and sort ways to earn income. Drug use, misuse or abuse is also primarily due to the nature of the drug abused, the personality of the individual and the addict's immediate environment. The processes of industrialization, urbanization and migration have led to loosening of the traditional methods of social control rendering an individual vulnerable to the stresses and strains of modern life. The introduction of synthetic drugs and intravenous drug use leading to HIV/AIDS has added a new dimension to the problem, especially in the northeast states of the country. Drug abuse has led to a detrimental impact on the society. It has led to increase in the crime rate. Addicts resort to crime to pay for their drugs. According to this research, drugs remove inhibition and impair judgment egging one on to commit offences based on self-consciousness, feelings and repercussions that the drug users are inclined to take. Incidences of teasing, group clashes, assault and impulsive murders increase with drug use and abuse. Apart from affecting the financial stability, addiction increases conflicts and causes untold emotional pain for every member of the family. In this study, it is revealed that with most drug users being in the productive age group of 15-35 years, the loss in terms of human potential is incalculable and damaging. The damage to the physical, psychological, moral and intellectual growth of the youth is very high especially among non-youth category. Among the youth category, the rising trends becomes a fashion in society especially those who belong to the elite members of community.

Adolescent drug abuse is one of the major areas of concern in adolescent and young people's behavior. It is underscored that India has braced itself to face the menace of drug trafficking both at the national and international levels. The kind of menace has already beset urban cities like Visakhapatnam, although, limited information has been provided to give a clear and in depth understanding of the drug use and abuse situation in the City. Several measures involving innovative changes in enforcement, legal and judicial systems have been brought into effect such as arrest of culprits and conduct of raids in pubs and bars where drugs are commonly proliferating. The introduction of death penalty for drug-related offences has been a major deterrent. In India, the law is constraint only under the rules and provisions of offense and crime but not considered heinous crime. Perpetrators who violated the law are only arrested but not dealt sternly, so there is a great tendency that the crime will be repeated itself because more damages it will divulge to the growing younger populace in the city. The epidemic of substance abuse in young generation has assumed alarming dimensions in Visakhapatnam. Changing cultural values, increasing economic stress, constant migration of families and dwindling supportive bonds are leading to initiation into substance use. Substance abuse like the use of cannabis, heroin, and Indian-produced pharmaceutical drugs are the most frequently abused and used in India. Drug use, misuse or abuse is also primarily due to the nature of the drug abused, who can be considered as victim also, the personality of the individual and the addict's immediate environment and economic status in society. The processes of industrialization, urbanization and migration have led to loosening of the traditional methods of family values and social control rendering an individual vulnerable to the stresses and strains of modern life. Owing to various stress factors and increased influence of the internet exposure, media, the young people especially the student and non-student youth, generally get distracted as they have tendency to mimic the production of so-called and easy access to "designer drugs" is soaring out of control throughout the entire society. Major trends in drug abuse and trafficking in India and around the world as reported by the United Nations International Narcotics Control Board (INCB) has further show an increasing strategy to combat drugs related problems. Their potential can be proved in academics, social circles and other useful crafts of life. Unfortunately, lack of self-discipline, parental control, pampering, and peer pressure and their own vulnerability to get hooked to new and fascinating things – all these play havoc with the lives of the present generation of youth.

**DRUG TRENDS AMONG THE YOUTH IN VISAKHAPATNAM CITY**

The present study throws light on various parameters of substance abuse in Greater Visakhapatnam as is evident from the foregoing analysis of the primary data. The major findings of the study are presented in this concluding chapter. The aim of this report was to examine whether neighborhoods had an effect on adolescent delinquency and drug use among student and non-student youth in Visakhapatnam City, whose age bracket ranges from 15 to 35 years old. It was revealed from the recent data that the youth age 15 and above have experienced the blatant effect of individual characteristics and, if so, whether the effect was similar to dependency and abuse or victimization of the young users and offenders. There were two clear findings emerged. First, the characteristics of the youth in which the people live do play some part in influencing their delinquent and drug using behaviour, although fewer of these factors were significant as compared with individual characteristics and the explanatory power of the impulsivity measure was stronger than that of any of the significant youth characteristics. It is likely that the inclusion of further individual level explanatory variables would weaken the impact of drug abuse in the city even further, which is broadly in line with the findings of other cross-sectional analyses.

The finding is supported to an extent by the report of Drug Control Agency that confirmed the menace in Visakhapatnam these days. Based on the Hindu Newspaper, the article tiled: "The Devil in their veins" The city's hot spots for drug peddling include Thatchetlapalem, GVMC stadium in the Old Town and Allipuram. The drug peddlers conduct transaction trough cellular phones and most users are students and youth. (The Hindu, Metro Plus, December 03, 2011, Visakhapatnam, A.P. India). It is pertained evidence that weak law enforcing agencies affect in explaining trajectories of drug offenders, particularly for those who start offending later in adolescence. The second main finding from this analysis is that there are distinct differences in the characteristics of the city that impact on delinquency, cannabis and hard drug use, which suggests that quite different explanatory frameworks are required. The evidence presented here suggests that delinquency among the youth thrives within areas experiencing structural adversity and economic deprivation. This is consistent with other recent evidence from the research study that shows those living in highly urbanized city were less likely to desist from offending than those living in more affluent environment. Such evidence highlights the contextual importance of the places that youth who grow up and are broadly supportive of major social and economic changes.

The growing trends in society also have severe influence of impulsivity in explaining hard drug use. Impulsivity was still a stronger explanatory factor than the one emerging social and economic factors. Like the drug use and abuse, cannabis is becoming a common outlet and gender was not significant in explaining increased hard drug use. While most likely that delinquency among the youth has thrived significantly, drug use has increased by factor of familial socio-economic status. In contrast to both of the previous data, neither of the census measures proved to be significant in explaining more frequent involvement in drug use of the youth at an early age of 15 and expanded through the years. The only area level variable to emerge as significant within the drug use was living in the highly urbanized city with a high incidence of crime and drug proliferation such over the counter prescription drugs. There was an indication that concentrated deprivation, social dis-integration re-organisation, poor collective efficacy or social disorder had an impact on increased levels of drug use within the study area. In addition, when the measure of smoking, alcohol and cannabis acceptability was included in the research, it proved to have major impact on drug use which discounts general drug tolerance as an explanation. The association between drug use and economic prosperity has recently been noted. In this study, it is argued that those living in 'highly urbanized areas have the highest levels of drug use (of which the most common type was cannabis use). This strongly suggests that there are cultural factors at work in terms of explaining drug use, which may be in part environmentally determined (e.g. through the availability of drugs or the collective approval of such behaviour, although the study did not find this to be the case from previous data analysis) and that the developmental processes involved in drug use are quite distinct from those of youth delinquency.

On the other hand, it must be acknowledged that the very low prevalence of drug use at age 15 may have prevented a clear picture of the geographical distribution of this problem emerging in the city. The fact that different explanatory frameworks are required to suggest that different policy responses are also needed to address these drug related problems among the youth. The differences in the social, economic and cultural perspectives examined in this study only imply that community-based strategies which take a uniform approach to tackling offense, crime and drug use are unlikely to be entirely successful and that more specifically targeted approaches are necessary. The findings are supportive of crime control policies aimed at tackling underlying aspects of structural deprivation. However, such initiatives are unlikely to have much impact on reducing drug use, which is associated with greater social affluence and economic prosperity. There is great significance that emphasis must need to be placed on targeting health education, media campaigns particularly within the communities that have a high population of young people and transitional populations. Although, it appears that strategies for reducing drug use may be best targeted within the highly urbanized cities, it is likely considered that much more needs to be understood about drug use and abuse within a population as young as 15 to 35 years old before policy implications can be considered.

While the primary focus of this research has been on the impact of drug use and substance abuse, the individual level factors did prove to be strong explanatory factors for all three dimensions on the behavioural problems of the youth and revealed both similarities and differences. The differential impact of gender on delinquency and drug use indicates that different educational responses may be required. However, higher levels of delinquency in smoking, alcohol consumption, cannabis and hard drug use were all partially accounted for by behavioural self-control and by early social and economic factors. Analysis has shown that effective parenting and strong family values are also important in influencing both delinquency and drug use, so this may be being partly reflected in the study area. It may seem to appear to be risk factors that underlie problematic behaviour among the youth in general, there is evidence that they may impact differentially on delinquency and drug use, with impulsivity being more important in explaining delinquency and family disruption being more pertinent to the development of drug problems. These findings support the need for initiatives to provide parents with the skills to deal effectively with difficult children and to advise and support families, social institutions and law enforcement agencies particularly in the context of Visakhapatnam.

**IMPACT OF STUDY**

HIV/AIDS, drugs and substance abuse are the most prevalent issues that the current generation is forced to face. It has been around for centuries and has afflicted millions of people around the world. It is mainly a health concern but over the past decades, it has escalated into one of the worst social ills. Drug and alcohol addiction does not only affect the individual himself but everyone around him. Ultimately, the society is largely affected by his predisposition for substance use even when he's just one person. It is a social ill because practically every country in the world is compelled to come up with legislation, policies and other ideas geared at addressing the problem. Most experts agree that addiction has a ripple effect. It brings discord not only into the home but to the society as well. Impact of the study on a long-term basis of substance abuse in terms of legal and illegal sources causes millions of deaths and costs billions for medical care and substance abuse rehabilitation. The effects of drug abuse extend beyond users, spilling over into the larger society, imposing social and economic costs.

Reports by UNDCP have pointed out that the economic effects of drug abuse can be measured in two forms. One is the cost of government drug enforcement policies. Nations around the world spend billions yearly on law enforcement and other efforts aimed at drug interdiction. Because a central principle in economics is that resources are scarce and require decisions about how to allocate them, it follows that money spent on drug enforcement is money not spent on education, public infrastructure, or given to the public in the form of lower taxes. Another economic effect from drug abuse is the lost human productivity, such as lost wages and decreased production that results from illnesses and premature deaths related to drug abuse. Drugs and substance abuse can lead to the prevalence of more health issues. Crimes are just one thing but the spread of certain types of illnesses is another one of the many impacts of addiction. People who are addicted are apt to behave irresponsibly. This essentially translates to undertaking dangerous sexual activities and making wrong decisions that are otherwise prevented by sobriety. Irresponsible sexual activities can lead to the spread of sexually transmitted diseases, HIV and AIDS. Substance abuse, therefore, is a problem that has to be fully addressed. Its impact on the society is so massive that legislation is constantly being updated to ensure that this social ill finds sustainable resolution.

**RECOMMENDATIONS**

There must be greater awareness among the people about the dangers of using habit-forming prescription drugs. People with very bad habits die hard and relying on drugs for 'temporary relief' can prove to be a costly bet for youth.

**SUGGESTIONS ON THE IMPLICATION OF STUDY**

Work on drug treatment and rehabilitation is guided by the following:

a) Raise the awareness of policy makers with respect to the need and advantages of investing in drug abuse treatment.
b) Support national authorities in developing legislation, policies, and standards of care which enable the implementation of contemporary treatment approaches.
c) Strengthen the capacity of staff and care providers of treatment and rehabilitation centres.
d) Diversify and expand services for drug users and make them more accessible to different population groups, taking into account different gender needs,
e) Facilitate sharing of best practices and dissemination of knowledge Upscale drug treatment and rehabilitation services available
f) HIV transmission through injecting drug use is best prevented by providing a comprehensive package of services in outreach to injecting drug users and their partners.
g) UNAIDS, UNODC and WHO recommend a comprehensive set of measures for people who use drugs that includes the following:

- Needle and syringe programmes
- Voluntary HIV counseling and testing & anti-retroviral therapy
- Prevention and treatment of sexually transmitted infections condom programming
- Targeted information, education and communication
- Hepatitis diagnosis, treatment and vaccination
- Tuberculosis prevention, diagnosis and treatment

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