

THE BECKLEY FOUNDATION  
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# DRUG POLICY IN INDIA: COMPOUNDING HARM?

*Molly Charles, Dave Bewley-Taylor and Amanda Neidpath*

The Beckley Foundation Drug Policy Programme (BFDPP) is a new initiative dedicated to providing a rigorous independent review of the effectiveness of national and international drug policies. The aim of this programme of research and analysis is to assemble and disseminate material that supports the rational consideration of complex drug policy issues, and leads to more effective management of the widespread use of psychoactive substances in the future.

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## INTRODUCTION

Contemporary international drug policy seeks to control both the demand and supply of drugs through the criminalisation of production, trafficking and use. Furthermore, adherence to the United Nations drug control conventions ensures that most nation states adopt a similar prohibition-oriented approach when formulating national drug control legislation. Recent research suggests that this can be problematic in some Asian countries where longstanding cultural sanctions already existed for drug use; particularly those involving psychoactive plant products such as cannabis and opium.

With its focus on India, this briefing paper examines the impact of the punitive approach towards drugs in those societies and communities that have traditionally exerted socio-cultural controls over the use of mind-altering substances. The discussion highlights the unintentional but often harmful consequences of such drug control policies.

In framing the discussion of this topic, it is important to note that the socio-cultural context of traditional drug use within many Asian countries means that experiencing an altered state of consciousness is only a part of the drug taking experience and not the ultimate goal of users.

Indeed, norms controlling excessive and regular drug use have customarily governed socially and culturally accepted consumption of native mind-altering substances.

While such traditional use management strategies vary across Asian countries, it is possible to identify similarities that exist between these approaches to drug use and contemporary interventions that collectively fall within the so-called harm reduction paradigm. The defining feature of harm reduction programmes is their focus on the prevention of *harm* rather than the prevention of drug *use* itself.

It can be argued, therefore, that as signatories to the 1961 UN Single Convention on Narcotic Drugs, many Asian countries have been required to move away from longstanding approaches to control customary drug use. In many respects, there has been a subsequent shift from traditional drug use management to an emphasis on eradicating all drug use and trade. The implementation of law-enforcement-dominated policies has generated a tense relationship between contemporary legislation and culturally ingrained drug use patterns and associated management strategies.

This situation is compounded by changing patterns of drug use within India. This is the result of a number of inter-related factors; the rising popularity of new non-traditional forms of drug use introduced via tourism; urbanization; and leakage from illicit drug production in the region. Indeed, evidence suggests that changes in policy may have contributed to increases in the use of harder forms of drugs and more harmful modes of consumption, notably drug injecting. Such a change in user behaviour is particularly significant given the role played by injecting drug use in the transmission of HIV/AIDS and other blood borne infections. The management of this issue has become a cause for concern within the field of drug demand reduction and has serious implications for the development realities of many Asian countries.

## History

The use of the cannabis plant for a variety of purposes has long existed in India (Charles et al, 1999; Charles, 2001), a fact also noted for many other countries of Asia (Li Hui Lin, 1975; Martin 1975, Fisher, 1975; Khan et al 1975 and Charles, 2004).

Its use for medicinal reasons, as well as its mind altering capacity, is significant. Cannabis has been used along with other ingredients to treat rheumatism, migraine, malaria and cholera; to relieve fluxes; facilitate surgical operations; to relax nerves; restore appetite; for general well-being; and it is also considered beneficial for the functioning of the heart and liver. Additionally, the cannabis plant provides food grain, oil seed and fibre for manufacture of fibrous products in select parts of India.

The practice of using cannabis to alter consciousness and as part of religious and shamanistic rituals has also existed in India for centuries. For example, the drug has a strong religious association as a gift from Lord Shiva to his followers.

Opium has also been used for socio-cultural reasons in different parts of the country (Chopra et al, 1990), with medicinal use being more prevalent than cultural use, like that seen among the Rajputs in Rajasthan and Gujarat (Masihi et al 1996).

Prior to the introduction of contemporary drug control legislation, a system for procuring opium and cannabis through legal outlets existed. However, drug control initiatives put in place procedures that made it difficult to obtain these substances. Legislation in 1985 and 2001 include provisions for medical use, but there has been a trend not only to reduce the quantity released by the government, but also to tighten up procedural regulations for obtaining the drugs by traditional

medicinal practitioners. The resulting inability to source sufficient licit opium and cannabis for traditional use has forced such practitioners to make purchases from the expanding illegal market.

## Socio-Cultural Controls

Until the 1980s cannabis consumption does not appear to have been regarded as an issue of major social concern in India, with little or no official mention of excessive use. Prevalent socio-cultural regulations with regard to the form of use, mode of consumption, context of use and profile of users, ensured a system of use management that limited drug use within the country.

For instance, norms restricted the use of cannabis and opium to the adult male population. In the case of cannabis, this is a pattern documented in a number of countries including Cambodia, Vietnam, Thailand, Laos, China, Nepal and Pakistan. Even among the male adult population, there were restrictions on the context for consumption, with sanctioned use often linked or limited to specific religious and social occasions.

In India and Nepal, the use of cannabis appears to be linked to religious festivals like *Shivaratri*, *Krishna Ashtami* (birth of Lord Krishna) and participation in *bhajan* sessions. Indeed, occasions like *Holi*, 'the festival of colours,' are not complete without the sharing of *bhang* - a drink made with cannabis. At such select occasions, women and youngsters were permitted to use *bhang* and other items made from cannabis, including snacks, sweets and curry. Opium is also offered at the harvest festival in a ceremony called *akha teej*, intended to strengthen family marital clan bonds and put aside old feuds.

It is this specification regarding the profile of users and a desire for cultural confirmation that ensured the existence of mechanisms to control drug use. The provision made for women and children to consume cannabis products in select cultural contexts and in specified forms indicates a strong cultural acceptance for cannabis within India. Norms reaffirmed the cultural dimension of cannabis use and probably prevented excessive non-cultural use of cannabis.

As noted earlier, the adherence to cultural norms on sanctioned use emerged from a strong association of cannabis with Lord Shiva. For example, *Sadhus* (hermits) of various sects who primarily worship Lord Shiva make use of the drug for strengthening their concentration and spiritual search.

Prior to smoking cannabis, the *sadhus* praise their Lord and take it in his name, a pattern of consumption seen also among lay followers. During *Shivaratri*, the distribution of

cannabis drink and other products is perceived as a way to strengthen the association with the Lord. It is likely that such a relationship played a major role in restricting its use within India and Nepal, despite easy availability and local cultivation. The drug's connection to *Shivaratri* almost certainly limited its use beyond the ceremonial context.

Unlike cannabis, opium does not appear to have any significant religious associations, but even here the link between cultural identity and the consumption of opium acted as a strong mechanism to restrict consumption of the drug in excess. Studies conducted into opium use in Rajasthan and Gujarat indicate strong links between cultural and caste membership, and use of the drug.

An opium drink can be used to greet guests to social functions that include marriage celebrations, sealing a business deal or mourning the demise of a relative. In this case, culture permits opium consumption in the male adult population but, unlike with cannabis, there is no specific cultural sanction for women and youngsters to use the substance except for medicinal purposes.

Such sanctioned cultural use, and its occasion or context, produces a situation within which a drug's mind-altering properties are not the sole focus of the practice. For example, in consumption during a celebration or get together, songs and social interaction form the binding force for consuming the substance. Consumption of *bhang* during *Holi* calls for community participation from the decision to prepare the drink, through to making it, and finally its consumption in a group setting.

The pattern of consumption for smoking cannabis and opium also restricts drug use, because as a group activity the users only inhale a few times from the pipe. Moreover, smoking the pipe is but a part of social interaction and not the sole activity of the group. Sharing the drug is also not the result of any economic consideration as is sometimes seen in the case of heroin (Charles et al, 1999).

## Narcotics Drugs and Psychotropic Substances Act (NDPS) 1985.

Prior to the present drug control legislation, the focus of Indian drug policies was control of the drug trade and the collection of revenues through licensed sales (Hasan, 1975).

The change in policy direction had much to do with India's international commitments. As a signatory to the UN 1961 Single Convention, India, like many other nations, was obliged to eradicate culturally ingrained patterns of drug use, including those involving cannabis and opium.

Indian delegations at the UN had long objected to a proposed policy of international cannabis prohibition, but had "made little headway against the massive," predominantly Western and US-led, "anticannabis bloc." (Bruun, Pan and Rexed, 1975). Yet, in order to gain widespread acceptance, the final draft of the Single Convention included transitional reservations allowing so-called grace periods for phasing out traditional drug use. This meant that the "quasi-medical use" of opium had to be abolished within 15 years of the Convention coming into force. Similarly, the non-medical or non-scientific use of cannabis was to be discontinued as soon as possible, "but in any case within 25 years" from the date the convention came into force (United Nations 1972). Referring to cannabis, one expert has commented that it was a rather optimistic timetable when "matched against three thousand years of use by untold millions" (see Bewley-Taylor, 2001).

In political terms, any moves to phase out cultural drug use within India were problematic, since it was difficult for any party in power to tamper with popular religious and cultural feelings concerning the use of opium and cannabis. Consequently, mindful of international obligations regarding the UN grace period and the political sensitivity of the issue within the country, the NDPS Act was quietly put on to the statute books with little national debate (Charles et al, 1999). The only provision for non-medical cultural use within the 1985 Act was that drinks made from cannabis leaves were to be sanctioned (Britto, 1989).

As such, the legislation made many traditional forms of drug use a criminal act that could be punishable by imprisonment. Some of the significant measures taken under the NDPS Act (1985) include:

- For the consumption of substances such as narcotic drugs or psychotropic substances or any other substance specified by the Central Government, the punishment is imprisonment for a term, which may be extended to one year, or a fine, which may extend to twenty thousand rupees, or both.
- In the case of consumption of cannabis products other than *bhang*, imprisonment may be for a term of six months, or a fine which may extend to ten thousand rupees, or both.
- The quantity specified for various substances that could lead to arrest for trading in drugs was not very large. For example, 250 milligrams of heroin, five grams of opium, five grams of charas or hashish, 500 grams of *ganja* (marijuana) and 25 milligrams of cocaine (NDPS Act, 1985).

Evidence suggests that, in largely ignoring the socio-cultural context of traditional drug use, the NDPS Act led to a significant increase in the arrests of low-level drug users. Arrests under the Act in 2001 totalled 16,315, of which around 76 per cent (12,400) were prosecuted and 28 per cent (4,568) convicted. A study undertaken in the same year in Tihar jail provides an insight into the make-up of such figures. Interviews with 1,910 individuals arrested under the NDPS Act (1985) indicated that around 325 (17 per cent) were arrested under Section 27 (Seethi, 2001). This refers to the possession of small quantities of drugs meant for personal consumption. While the law has provision for such arrestees to seek treatment instead of serving a sentence, the provision is rarely utilised (Annuradha, 1999).

Research also shows that many of those arrested on drug charges spent years in jail before their cases came up for hearing (Annuradha, 2001; Charles et al, 1999). This was a result of the notoriously slow pace of the Indian judicial system. In some instances, it has meant that those caught with small quantities of drugs were eventually acquitted after spending years behind bars. Beyond concerns about the obvious injustice of such cases, prolonged prison time for low level drug offenders also raises the issue of recruitment by criminal groups. A recent study on organised crime in Mumbai suggests that prisons in India, as in many other parts of the world, are ideal places for orienting vulnerable individuals into the world of crime (Charles et al, 2002).

## Changes in patterns of drug use

The convergence of a number of important structural changes, at both national and international levels, around the time of the NDPS Act (1985), impacted on long-standing patterns of drug use within India.

Research suggests that tourism has contributed to a diversification of drug use patterns. In the mid and late 1970s, exposure to other cultures in both Nepal (Fisher, 1975) and India produced new forms of drug taking behaviour. Since the early 1980s, most major Indian cities have been introduced to new “foreign” drugs such as heroin. The interaction of young Indians with tourists has also facilitated an alteration in the relationships they later form with those drugs traditionally consumed (Charles et al, 1999, Charles, 2001). This is seen in all parts of the country, although the process is more gradual in rural areas.

Such a rural-urban split can be explained by the impact of urbanization upon traditional patterns of drug use and management. Put simply, urban communities do not tend to adhere to traditions to the same degree as those in rural areas. Furthermore, the relatively easy availability of a

“foreign” drug like heroin, in comparison to opium, within the urban setting contributed to a shift in the drug of choice. As such, data from 16,942 drug users as part of the Drug Abuse Monitoring System reveal that, other than alcohol, there is significant variation in drug use patterns between urban and rural areas. With regard to heroin, for example, 14.9 per cent of users were from urban areas with nearly half that figure (7.9 per cent) being from rural areas (Siddiqui, 2002). The shift to heroin is also more likely to take place in urban settings that fall along the illicit heroin trafficking routes from South West and South East Asia.

Indeed, the illicit drug trade has a significant, although complex, impact on drug use patterns within many parts of India. Shifts from opium to heroin use can be seen to depend on a number of inter-related factors. These include proximity to areas of illegal cultivation and processing, traditional regional drug use patterns and geographic accessibility. For example, there is illicit poppy cultivation in the North Eastern state of Arunachal Pradesh. Nonetheless, in a state with a history of cultural opium use and, due to the densely forested nature of the terrain, limited connectivity with the surrounding areas, drug use is limited to opium (Narcotics Control Bureau Report, 2001). In other parts of North East India (especially Manipur, Nagaland and Mizoram), circumstances are different, however. The combination of the easy availability of heroin from Myanmar and absence of cultural use of opium in these regions resulted in the emergence of heroin use. In the states of Madhya Pradesh, Rajasthan and Uttar Pradesh there is a history of cultural opium use with the demand long supplied by diversion from licit cultivation. A study in Rajasthan in 1989 indicated that drug use was largely limited to opium and cannabis. Nonetheless, recent research shows that in the mid-1990s there was a shift from traditional drugs to heroin. It is significant that this change took place at a time when there was an increase in the illicit heroin traffic to India from Afghanistan via Pakistan (Charles, 2004).

Evidence suggests that the new legislation exacerbated the problems arising from such structural changes. For example, far from reaching its goal of eradicating drug use, enforcement of the NDPS Act (1985) appears to have inadvertently facilitated a shift to harder forms of drugs and riskier modes of consumption.

The impact of the legislative changes was initially felt in urban areas in the 1990s, especially the major cities (Charles M, Nair K.S., et. al, 1999). As a result of the factors discussed above, hard drugs seem to have found a niche in many cities. An official study showed that of those drug users seeking treatment, significant numbers were using heroin, opium and the narcotic analgesic, propoxyphene (Siddiqui, 2002).

Another study among opiate users in fourteen sites across India indicated the primary substance of abuse was heroin followed by buprenorphine, a synthetic opiate. From the total sample of 4,648 drug users, around 43 per cent had injected drugs at some time. In many cases, the drug of choice was buprenorphine followed by heroin and propoxyphene. Among the injectors around 51 per cent in Amritsar (in the State of Punjab) were found to have shared needles at some time, with 15 per cent from Hyderabad, New Delhi, Dimapur, Trivandrum and Chennai reporting the same practice. The conditions for widespread transmission of HIV and other infections through drug use are therefore increasingly present in India.

It is possible to see that the shift in patterns of use is not only from traditional drugs to derivative drugs but also to synthetic products as well (Kumar, 2002). A 2004 study on the illicit Indian drug trade indicated that increasing controls over poppy straw used in the preparation of opium drinks is creating a shift towards synthetic opiates (Charles, 2004). This is a dangerous trend considering that the morphine content in poppy straw is very low.

Given the cultural acceptance of cannabis and opium, monitoring of the drug of initiation among users can be a useful process in identifying changing patterns of drug use across the country. For example, the 2002 Ministry of Social Justice and Empowerment Rapid Assessment Study revealed that within the majority of fourteen study sites respondents cited cannabis (40 per cent) followed by alcohol (33 per cent) to be dominant drugs of initiation. However, in Dimapur, a city from North Eastern region, for around 34 per cent of the sample the first drug of abuse was propoxyphene, followed by heroin for 30 per cent (Kumar, 2002).

The profile of drugs users is another area that has undergone significant changes. As mentioned above, traditional users were predominantly from the male adult population (Masihi et al, 1996; Charles et al, 1999). Data collected from fourteen study sites in the Rapid Assessment Study indicate that after legislative measures were put in place to criminalise drug use, the age of initiation to drug use fell. The Study showed the mean age to be nineteen and below, with around 52 per cent of the users in the sample starting to use drugs between the ages of 16 and 20 years (Kumar, 2002).

Socio-cultural mechanisms also traditionally ensured that drug use by women within India was limited. There now appears to be a shift in this pattern. Drug use among women is often hidden with available data being based on random sampling of identified drug users. Nonetheless, data collected from 75 drug users in Mumbai, Delhi and Aizwal indicated the main substances of abuse to be heroin, propoxyphene, alcohol, minor tranquilisers and cough

syrup. Around 40 per cent were injecting drug users with 49.3 per cent of the sample aged between 21 and 30 years old. In Aizwal, a larger proportion of the drug users were between 15 and 20 years old (Murthy, 2002).

The consequences of an erosion of the traditional gender based restrictions on drug use also include negative secondary impacts. Of the seventy-five women within Pratima Murthy's 2002 study, 45.3 per cent derived their main source of income from sex work and drug dealing. In combination with the high incidence of injecting drug use, this reality clearly has serious implications for the management of HIV/AIDS and other blood borne infections.

### **The 2001 Amendments of NDPS Act (1985) and unaddressed concerns**

The criminalisation of drug use and the increasing rates of arrest for possessing small quantities of drugs led to officials, social scientists, members of the judiciary and others to question the suitability of such harsh legislation.

According to one observer, the Act failed because of delay in trials, a weak bail law that left the poor languishing in prisons, the failure of investigating agencies to follow the procedural requirements of NDPS Act and a poor understanding of the addiction problem (Anuradha, 2001).

As a consequence of such criticisms, including those from the National Addiction Research Centre, a reassessment of the Act in 2001 resulted in amendments relating to the length of imprisonment and the quantity and type of drug seized. This ensured that, where traditional drugs are concerned, only individuals with large quantities of cannabis can be arrested for drug trafficking and face imprisonment.

Further changes in the law in 2002 created two categories that are based on quantity seized. These are defined as small quantities and commercial quantities. For trafficking in commercial quantities, the sentence is imprisonment for more than twenty years and a fine varying between 100,000 and 200,000 Rupees. The categorisation of quantity varies according to the substance seized; for hashish, a small quantity is classified as below 100 grams and commercial quantity as 1 Kilogram and above; for heroin, a small quantity is below 5 grams and commercial quantity above 250 grams.

This is arguably a more realistic figure than the former law that classified those possessing more than a quarter gram as drug traffickers. Nonetheless, despite the efforts made to revise the Act, one contradiction persists. This is that any form of use remains a criminal offence, which can result in

imprisonment for a period of six months. Such an offence appears to be unrealistic in a country where the use of cannabis and opium retains widespread cultural acceptance in many states across the country.

The National Drug Policy follows the lines drawn by legislation and the focus has been on demand reduction through prevention and treatment, and supply reduction through enforcement activities. However, there has been a clear emphasis of political support and resource allocation to supply reduction. One example of this relates to one of the 2001 amendments to the act, which created a National Fund for Control of Drug Abuse. This was designed to support the expansion of demand reduction programmes, but has yet to become active (NDPS Act, 2003; Anuradha, 2001).

At present, efforts on the demand side focus on prevention, treatment, rehabilitation and after care services undertaken within institutional and community settings. There are currently 450 centres funded across the country for de-addiction and counselling services. National level Drug Abuse Monitoring Systems have also been established in an effort to understand trends in drug use and its implications for drug abuse management. Most efforts in the area of demand reduction are funded by Ministry of Social Justice and Empowerment and United Nations Office on Drugs and Crime.

## Ongoing issues of concern in the area of drug demand control in India.

As described here, the authorities have clearly made efforts to alter provisions of the NDPS to take more account of the indigenous drug use culture within the country. That said, evidence suggests that Indian drug policy could be made far more effective and appropriate to national realities. This is crucial at a time when overall, “the drug situation is still in a benign stage in India, though moving in dangerous directions” (Charles and Britto, 2002). While cultural norms in rural areas effectively restrict drug use to traditional forms and drug-related HIV is still relatively low within the national context of drug use, current trends suggest increasing levels of problematic non-traditional use and addiction. We suggest that in any assessment of contemporary Indian drug control policies, there are a number of key issues of concern:

- Most prevention efforts within India are, within the international framework laid down by the United Nations, currently based on experiences in predominantly Western countries. As such, they start from a position that considers all forms of drug use criminal and deviant. Thus, this leaves no scope for strengthening cultural mechanisms of use management or integrating them into contemporary legislation. For

example, where institutional care appears unsustainable, practitioners could consider traditional forms of control such as the use of *doda pani* (a drink made from poppy pod) to wean users away from excessive opium or heroin consumption. Research suggests that cultural norms in India are far more efficient means of drug control, and have fewer negative side-effects than legislation inspired by global norms (Charles & Britto 2002).

- Limited government funding means that the treatment of drug abuse is not widely available.
  - Centres tend to provide services on a fee paying basis and the marginalised street level drug user consequently has limited options. In the city of Mumbai, for example, there are no treatment centres that cater to street level users with complications. Furthermore, the government hospital catering to the general population dislikes dealing with drug users because they are considered to be ‘difficult’ patients. Treatment for drug addiction is consequently not widely available and this sometimes results in users dying without receiving any care (Charles, et al, 1999).
  - There is a systematic reduction of government grants to drug treatment centres and the remuneration for the services of professionals is so minimal there are few takers. Under such conditions, there appears to be limited scope for an appropriate approach to care.
- Attempts at cost management by users, in combination with the deteriorating quality of street drugs, have produced more risky forms of use; that is to say, injecting behaviour. This has serious consequences for public health in some parts of India. A recent study found that the purity of heroin sold on the street varies from 3 per cent to 12 per cent. The Narcotics Drugs Control Board of India places the purity of street level heroin at 5 per cent (Charles, 2004). In the north-eastern part of the country it seems that a shift to injecting drug use is also a result of time management issues. The behaviour of a drug user in these areas of political instability is more dangerous than in other parts of the country.
- The approach of the Indian government is law enforcement led, with limited resources provided for treatment. This is unfortunate, since studies in other cultural settings show that efforts dominated by the law enforcement are not particularly effective. A high rate of drug incarceration as a strategy to control drug use has at best a marginal impact and does not lead to a significant undermining of the drug market (Bewley-Taylor et al. 2005). Indeed, experience from around the world reveals the cost effectiveness of appropriate treatment and harm reduction programmes and interventions.

Mindful of these issues, and within the context of current research, we therefore urge Indian authorities to:

- Strengthen efforts to understand patterns and trends of drug use within the country, especially in rural areas falling along the drug trading routes and those close to cultivating areas.
- Develop methods for supporting socio-cultural controls on drug use.
- Urgently assess the demand for drug treatment, particularly amongst the urban poor engaging in the most dangerous forms of drug use, and increase the coverage of a range of treatment interventions.

By concentrating predominantly on the punitive aspects of UN legislation, the Indian authorities are currently failing to address adequately the issue of drug use within their own borders. Without an urgent change in approach, involving not only the refocusing of resources but also the recognition of traditional attitudes to the use and management of mind-altering substances, the nation may in the future face similar drug-related problems to those recently experienced in other countries in the region. Within the Islamic Republic of Iran, there is currently a high incidence of drug-related deaths and HIV/AIDS infection among injecting drug users (Nissaramanesh et al, 2005), while increasing problems surrounding the use of “amphetamine type stimulants” are to be found in Thailand (Roberts et al., 2004). Specific national circumstances mean that no two countries experience identical patterns of problematic drug use. Yet the timely implementation of pragmatic and culturally appropriate policies within India would surely do much to prevent a repeat of such crises.

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Under process patent, Indian pharmaceutical companies can produce a drug molecule by a different process and market it as a brand of their choice hence there are several brands of the same drug molecule available in the market. They are not brands in true sense, as they are not marketed by the innovator. Hence they are called "branded generics"™. These branded generics can be viewed as brands. Thus in India there are several brands and several generic products of the same drug molecule unlike one brand and several generic versions in USA. Impact of generics in public health The central and state In 1963 Indian government passed a drug price control order (DPCO) to keep a check on the prices of drug in market. While DPCO did not bring much difference, since, many drug manufacturers withdrew from the country. Production of certain drugs shifted to China from India. 1. Molly Charles, Dave Bewley-Taylor, Amanda Neidpath (2005) Drug Policy In India: Compounding Harm?