

On the Frontline of Northeast India

Evaluating a Decade of Harm Reduction in Manipur and Nagaland

Northeast India is a region with serious drug use problems. This briefing examines the drug-related problems and evaluates the policy responses in Nagaland and Manipur,¹ two sparsely populated states in that region, bordering Burma.² These states have the highest prevalence of injecting drug users (IDUs) in India. Unsafe practices, especially needle sharing among IDUs, have been the main drivers of the HIV/AIDS epidemic in the region. By the end of the 1990s, Manipur had become the “AIDS capital of India”,³ and also Nagaland is suffering a high incidence of HIV among injecting drug users.

More recently, there has been a shift from injecting heroin to injecting pharmaceuticals causing other severe health problems, including abscesses leading to life threatening infections, and eventual amputations. Although antiretroviral therapy (ART) is now accessible in Northeast India, many drug users also suffer from hepatitis C infection, now their main cause of mortality, as affordable treatment is not available.

Northeast India is an isolated and mountainous area, home to a wide range of different ethnic groups, each with its own distinct culture, traditions and language. Many of these ethnic groups are in conflict with the Indian government, demanding more autonomy or independence. Several ethnic movements are in armed struggle, pressing for their political demands (see text box). There has also been communal violence between villages of different ethnic groups.

Conclusions & Recommendations

- The Northeast of India has seen dramatic shifts in drugs use patterns, from smoking opium and heroin to injecting heroin and pharmaceuticals.
- Unsafe behaviour among injecting drug users is the driving factor behind HIV and hepatitis C epidemics. Injecting of pharmaceuticals is causing serious health problems.
- The funding of the National AIDS Control Organization (NACO) has to be improved to ensure that these are used effectively and reach the most at risk populations.
- Although ART is now accessible for people living with HIV/AIDS, many drug users suffer from hepatitis C infection, which is now the main cause of mortality.
- Services for drug users need to be improved and increased, guided by harm reduction principles. Hepatitis C prevention and access to hepatitis C treatment is urgent.
- Access to oral substitution therapy (OST) needs to be increased. Following the approval of methadone as an opioid substitute, programmes should be established.
- Local authorities, including the police and non-state actors, should stop discrimination and mistreatment of drug users, and should allow them free access to services.
- More adequate responses are needed to address the specific problems of female drug users. A drop-in centre with a night shelter, reintegration programmes and sensitisation should be high on the agenda.

Human Rights Violations and the Armed Forces Special Powers Act

Manipur and Nagaland have a troublesome relationship with the government in New Delhi. In 1947 when the nation achieved independence, the Northeastern states also declared themselves independent. In response to the national government's rejection of the demand, local groups started an armed struggle. Since then, a violent civil war has raged in the region.

The Assam Rifles were sent to Manipur and Nagaland to control the uprising. Since 1958 the Armed Forces Special Powers Act (AFSPA) has been in force, giving the army unrestricted powers to arrest, search, and shoot to kill, with immunity from prosecution. The Act has led to grave human rights violations. Several human rights reports draw attention to the escalation of violence, torture and extrajudicial killings by the Armed Forces and the state police, advising repeal of the Act. After appointing a committee to review the Act, the government subsequently kept the report and recommendation to repeal the act a secret.⁴

In 1997 the National Socialist Council of Nagaland-Khaplang and the central govern-

ment agreed upon a ceasefire, resulting in a significant decrease of violence in Nagaland. In April 2010 the truce was extended another year.

The people of Manipur have on many occasions demonstrated against the impunity of the armed forces and the police. In 2004, a group of naked mothers demonstrated in front of the Assam Rifles camp to protest against alleged rape and murder committed by soldiers.

Irom Sharmila, a Manipuri woman, has achieved national prominence due to a hunger strike she has maintained since November 2000 to demand the repeal of the AFSPA, after she witnessed the murder of ten civilians by the Assam Rifles at a bus stop. As the maximum sentence in India for attempted suicide is 12 months imprisonment, Sharmila has been force fed in a guarded hospital room, and upon her release been re-arrested for continuing her strike, re-installed in hospital and force fed again. This cycle has continued for more than a decade.⁵

Conflict and underdevelopment in the region have contributed to drug consumption and production, and are hampering access to treatment, care and support for drug users. Obstacles include curfews imposed by the national government, as well as punitive actions by armed opposition groups against drug users, and discrimination and stigmatization from the local population.

The seriousness of the situation brought unconventional responses. In 1996 Manipur was the first state in India to adopt an AIDS policy that included a harm reduction approach addressing vulnerable groups such as injecting drug users. Nevertheless, the new policies and services have proved inadequate to deal with the scale of

the problems. However, there exists a strong community sense among ethnic groups in Northeast India, and society is well organized locally. Hence community-based organizations and self-help groups have taken it upon themselves to respond to problems posed by drug use and the related health crises.

DRUG USE IN NORTHEAST INDIA

Northeast India has a long tradition of opium smoking. Until outlawed in the 1960s, opium dens were commonplace in Manipur. In the 1970s many of the opium users switched to morphine, produced in central India for medicinal use and legally sold over the counter in pharmacies. At the time the use of drugs was considered a status symbol.



With stricter control of morphine in the Northeast limiting its sale, a new trend developed. Production of heroin in the Golden Triangle – roughly the area that spans northern Burma, Thailand and Laos – started in the 1970s, and cheap high quality Burmese “no. 4 heroin”⁶ was abundantly available in Manipur and Nagaland. As a result, many users switched to smoking heroin, usually in cigarettes.

When poppy cultivation in the Golden Triangle diminished in the early 1990s heroin became scarce and more expensive. Law enforcement by the Indian authorities further contributed to the price rise. As a result, many heroin users switched from smoking to injecting, to obtain a maximum effect from a relatively smaller dose. The high cost of needles and syringes, fear of being exposed as a user and ignorance of the danger of unsterile needles led many injecting drug users to share needles and to fashion makeshift needles and syringes made from ink droppers.

The scarcity of heroin and its soaring prices led to another shift in drug use in North-east India. In 2000 the analgesic Spasmo-Proxyvon (Dextropropoxyphene), locally referred to as ‘spasmo’ or ‘SP’, first entered the market and became a cheap alternative to heroin. However, for many users heroin remains their preferred drug. “SP causes a sparkle in your head, like a bomb,” says a drug user at the Care Foundation drop-in centre in Imphal. “But heroin is nicer and gentler, and peace prevails.”

Other popular drugs are prescription medicines such as Nitazepam, Nitrosun 10 and Valium, which are sleeping pills and/or tranquilizers, used to treat withdrawal symptoms. Non-opiate poly-drug users, who sniff glue and use diazepam, are relatively few. Cannabis use is widespread, especially among the male population, who do not consider it problematic. Cannabis cultivated in Manipur is well known for its high quality and is exported to other parts of India and internationally.

According to the National AIDS Control Organization (NACO) of India there are 50,000 IDUs in Northeast India, the majority of them in Manipur, Nagaland, and Mizoram. However, local NGO workers say these figures are inaccurate, underestimating the scope of the problem. They say many drug users remain hidden, mainly because of stigmatization.⁷

The Social Awareness and Service Organisation (SASO), a local NGO, estimates there are 34,500 IDUs in Manipur alone, almost half of them living in Imphal.⁸ In Nagaland and Manipur prevalence of injecting drug use is estimated between 1.9 percent and 2.7 percent of the general population,⁹ and 85-90 percent of all users are men.¹⁰

Many drug users provide a long list of economic and social reasons causing their drug problems. Unemployment, poverty, and school dropout or lack of education show little sign of diminishing, due to continuing conflict and instability in the region. An additional driving factor often cited by users in the Manipur and Nagaland is peer pressure.

Amphetamine-type stimulants (ATS) have recently appeared on the market. Users say ATS first arrived in Moreh, a small town on the Burmese border, in 1998, brought by Burmese and Chinese traders claiming it was good medicine for workers. TNI research in 2008 found ATS use only in Manipur, still concentrated in Moreh. Use of ATS, locally known as WY (the brand name), is not as popular as heroin.

HIV/AIDS AND OTHER HEALTH PROBLEMS

The first case of HIV infection among IDUs in India was reported in the Northeast in 1989. Since then HIV infection rates have soared, the HIV prevalence among injecting drug users in Manipur was estimated at 28.65 percent in 2008.¹¹ The epidemic has now spread to the general popu-

lation. Manipur has shown the highest adult HIV prevalence of any state, estimated at 1.40 percent. Nagaland has an estimated prevalence of 0.78 percent, the fourth highest.¹²

Under the “3 by 5” initiative of the World Health Organisation and UNAIDS anti-retroviral treatment has been freely available at major state hospitals in Manipur and Nagaland since 2004. The Manipur State AIDS Control Society claims intervention projects aimed at IDUs has reduced the HIV prevalence among them from about 70 percent in 1998 to 20 percent in 2006.¹³ Dimapur (population 135,860),¹⁴ one of the major towns of Nagaland, is identified as a drug use and HIV/AIDS hotspot with an estimated 4,000 IDUs. The HIV prevalence among IDUs in Nagaland has also been reported as declining, from 8.43 percent in 2003 to 1.19 percent in 2007.¹⁵

The reported decrease of HIV prevalence was of such magnitude that self-help groups have questioned its validity: “Claims by India's Health Ministry that the number of new HIV infections in the country have dropped by more than 90 percent have dismayed voluntary agencies and those who insist the government is in ‘denial mode’ concerning sexually transmittable diseases.”¹⁶

The hepatitis C virus (HCV) prevalence among IDUs has now overtaken HIV as the most serious health threat. Infection rates in Imphal are up to 90 percent.¹⁷ Estimates are that 80-85 percent of users will develop chronic HCV, a progressive liver disease.¹⁸ The treatment, Peginterferon and Ribavirin, is costly and not available through current services for drug users. It also causes side effects such as nausea, flu, weight loss and depression. Depending on the type of HCV, patients are required to take these medicines from several months up to a year. HCV is difficult to treat, especially if there is co-infection with HIV.¹⁹

There are also serious health risks related to the use of ‘spasmo’, a synthetic pain reliever capsule meant only for oral use. It is poorly soluble in water, and when injected by IDUs can result in terrible abscesses. If left untreated these abscesses can cause infection necessitating limb amputation or they can cause other life threatening situations. Because the ‘spasmo high’ does not last long, its use is frequent, some IDUs report 14-16 injections a day.

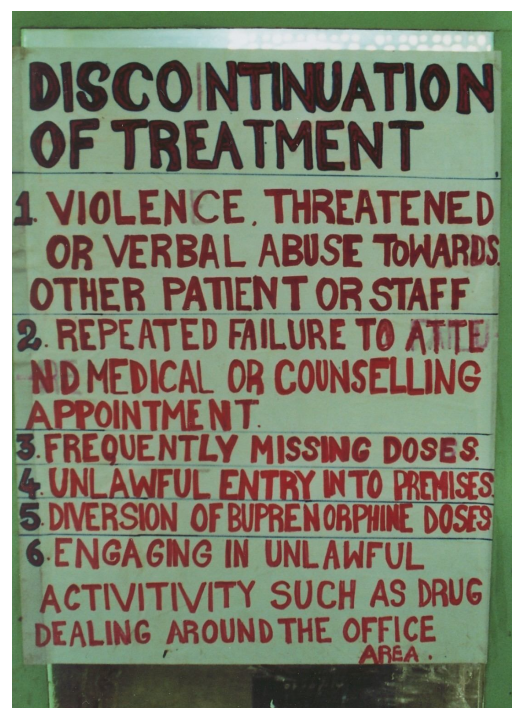
STIGMA AND DISCRIMINATION

The strong sense of community among the people in the Northeastern states has its negative aspects: drug users, sex workers, people living with HIV/AIDS, and their immediate families are often the target of fierce discrimination. Stigma and discrimination are a major impediment in availing care and treatment services to drug users. They tend to hide their situation as long as possible, making it difficult to reach them before it is too late.

Partners, widows and children of drug users are also highly stigmatized by the general population, especially if the drug user is believed to have died due to AIDS-related illnesses. Their families are discriminated against, and face difficulty finding jobs. Their children are ostracized by classmates and teachers. In some cases children have been denied admission to school.²⁰

In 1987, a drug user in Imphal killed a six-year-old in order to steal the child’s golden earrings weighing only a few grams. The incident brought out vehement reactions from the society. Local clubs and social organizations went on a rampage against all known and suspected drug users. “De-addiction camps” sprung up, and by way of treatment drug users were imprisoned. Armed groups shaved the heads of users and sometimes even shot them in the leg.²¹

Eventually the very high prevalence of HIV/AIDS infections among IDUs and the fear that it would spread to the general



Rules at the SASO drop-in centre in Imphal

population brought unconventional health-oriented responses. In 1996 India’s first harm reduction approach was developed in Manipur. Over the years the attitude towards drug users has slightly improved. According to our correspondents the advocacy of various groups has educated the general population as well as the armed groups and police, helping to increase support for the harm reduction approach. In 2009 the national government began implementing a comprehensive strategy to sensitize the police and ensure their proactive support to government and NGO initiatives on HIV prevention, especially with most-at-risk populations: sex workers, men having sex with men and IDUs.²²

FEMALE DRUG USERS

About ten percent of drug users in Manipur and Nagaland are women.²³ Female drug users are highly stigmatized. Contrary to the support most male users will get from their families, female users are in many cases banned from their home and the village community. In some instances they flee “voluntarily” because of the shame they are made to feel. A high percentage of female drug users are from ethnic minorities, many of them hill people. There is also

Female Drug Users Speak

I am pregnant and I am using drugs. I would like to stop but I can't. I started using after coming to Imphal. First I worked at a roadside hotel. There I started to do some sex work; this was followed by drug use. I don't have any family support, my mother died of cancer and my father died in a road accident.

I have no idea what can help us reintegrate. If we get clean there is nothing for us to do. We cannot go back to our families and no one wants to give us a job. We do not have a place to stay. The problem is also that we only have one chance. We need more.

I would like to go home, but I can't. At home there are too many problems. People think women drug users are witches, and I can't tell about being HIV positive.²⁴

a marked presence of women from migrant communities from other parts of India as well as from Bangladesh and Burma.²⁵

Many of the women drug users grew up in single parent households, experiencing an unstable and unhappy childhood. Some women were displaced because of the conflict. Many female drug users have no permanent residence. They are adrift and a difficult group to provide adequate care and support. A large number earn their living as sex workers, which pays for their drug use but increases the stigma they face.²⁶

Women users are reluctant to go to oral substitution clinics attending men; hence many female users stay out of reach of treatment facilities. Since 2007 some organizations have started addressing the specific problems these women encounter. One solution is a women-only drop-in centre offering daytime treatment and a bed for the night to sleep without harassment. In recent years more services to help female drug users and sex workers have been set up, but funding remains difficult.

According to a service provider in Dimapur the night shelter for women has been forced to close because of lack of funding. The female drug users are now compelled to sleep on the railway platform.

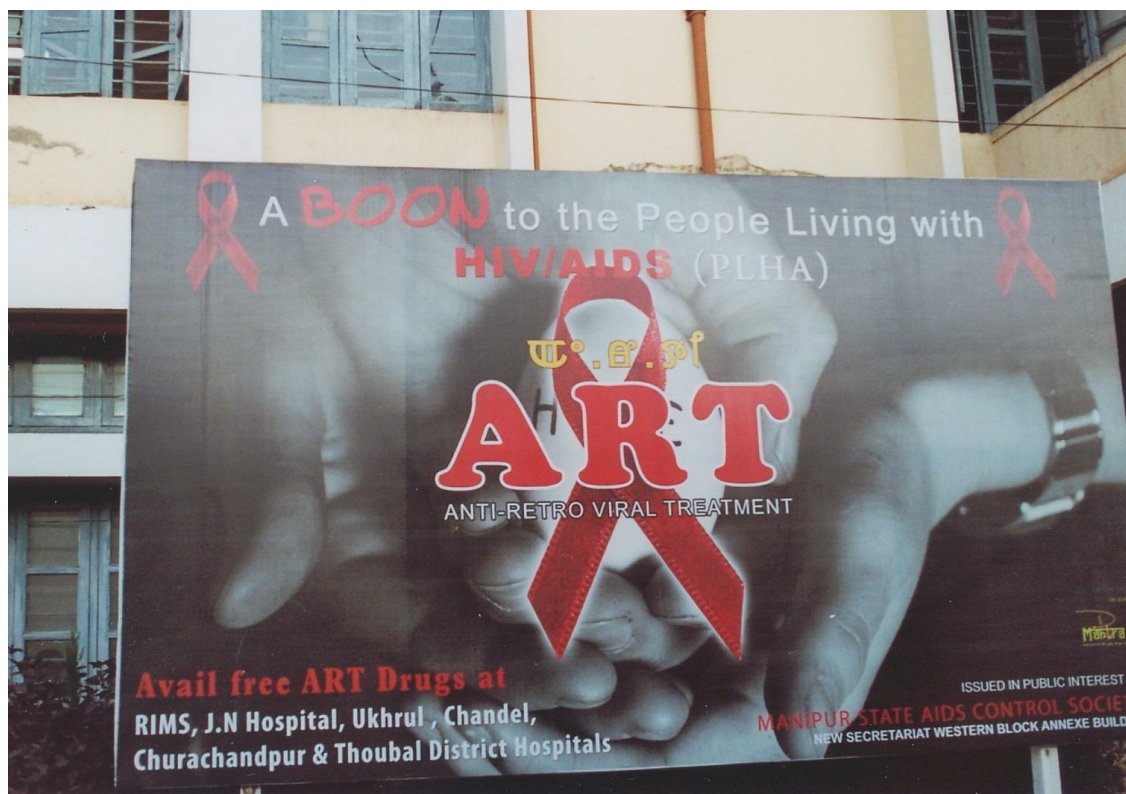
Many female drug users are caught in a vicious circle: even if they manage to stop using they remain stigmatized, facing great difficulty earning a living and finding a place to live. As a result many return to sex work and then start using again. Hotel owners, looking for women to provide sexual services to their guests, exploit this situation. The women are offered drugs if they come to work in the hotel. That the women are especially vulnerable to harassment, often sexual, by the police, only exacerbates their problems.

The increasing number of female drug users requires more focused services to address their problems. Research has shown the majority of these women are reusing needles and injecting equipment. They fear arrest when walking around with injecting equipment, and they find it safer to hide their needles where they can use their drugs quietly.²⁷

REGIONAL DRUGS MARKET

Northeast India is also an opium producing area. Poppy is cultivated by different ethnic groups in Manipur, Nagaland and Arunachal Pradesh. Communities living in isolated and undeveloped areas grow opium in the upland areas. Besides being a cash crop opium is used as a medicine, and has a cultural and traditional role in the Northeast.

There are strong indications opium cultivation in the region has increased significantly over the last five years. This is most likely a response to the decline in opium production in the Golden Triangle from the mid-1990s until 2006. It also coincides with a shift in opium cultivation from Burma's Wa and Kokang regions in northern Shan state (where it was banned in 2003 and 2005) to southern Shan state. Demand



for opium and heroin in the Southeast Asian and Chinese drug markets, poverty in upland communities in Northeast India, and the continuing conflict in these areas create further incentive.

There are several links between drug consumption and production and the conflict in Northeast India. “There is no evidence that armed groups are involved in the drugs trade,” says a local NGO worker in Manipur. “But everyone knows that money and guns go together. The armed groups need money for guns. But there are others who are the drug dealers.” Corruption among local authorities also plays a role, says another source in Imphal who used to work in the border region: “Government officials from both sides of the border are involved in drug trafficking and precursor smuggling.”

The conflict, having contributed to the high prevalence of problematic drug use in the region, hinders adequate responses. It has also further isolated the region from the rest of India, preventing much-needed socio-economic development.

POLICY RESPONSES

Several ministries in India are involved in drug policies. “All is scattered, with Ministries of Health, Social Welfare, Justice and Home Affairs all involved,” says a local NGO worker involved in drug treatment in Delhi. According to a representative of an international agency: “India has a huge bureaucracy with many layers. There are different Ministries who implement drug treatment with different approaches. There is no national strategy and there is no central drug control agency.”

At the national level, the Narcotics Control Bureau (NCB) is the agency overseeing drug control policy in India. In addition, many states in India have different policies and practices in law enforcement and harm reduction. As mentioned above, Manipur was the first to introduce a harm reduction policy, only fifteen years ago. Lack of coordination between the Ministries and the states has hindered important policy shifts towards harm reduction. But NGOs point out that this situation has also provided some flexibility in preventing more repressive policies from being implemented.



In 1985 the Ministry of Social Justice and Empowerment drafted a scheme for prevention of substance abuse, subsequently revised in 1994, 1999 and 2008. The demand-reduction strategy consists of education, treatment, rehabilitation and social integration of drug users to prevent drug abuse. It is meant to give financial support to NGOs to help implement these aims.²⁸

Developing a policy to address drug use problems has not been a priority for the Indian government. “If it is getting more prominence today, it is because of the links with HIV”, says an Indian professor working on drug treatment.²⁹ In 1992 the government set up the National AIDS Control Organization (NACO), which coordinates the National Aids Control Programme (NACP).

Several UN agencies have started joint projects in the Northeast through NACO. The Global Fund and AusAID are funding a large HIV prevention and treatment programme through NACO. The organization plays a pivotal role in allocating funds to harm reduction projects, but it has not been functioning well. In 2004 India’s Comptroller and Auditor General signalled

“significant shortcomings”. In 2002 and 2003 NACO wasted large sums on malfunctioning equipment and awareness campaigns that totally missed their target. Besides poorly distributing those sums, NACO failed to spend more than half of the funding received from its main financier, the World Bank. Perhaps the most flagrant example was the neglect and underfunding of the NACP’s targeted intervention component, even in states suffering high prevalence such as Manipur.³⁰ In 2007 the World Bank published an internal report revealing corruption and fraud at NACO and on state level in the second phase of the NACP.³¹

The Government of India still seems to view some harm reduction policies and substitution therapies as too controversial under the NACP. Methadone maintenance treatment for example has only recently been allowed but is not available yet. “The government does not fully understand what harm reduction means”, says an international observer. “India also produces methadone, but exports it to other countries.”

Under the Global Fund, antiretroviral drugs are generally provided through government hospitals.³² Local NGOs stress

Indian drug laws

The Narcotic Drugs and Psychotropic Substances Act was adopted in 1985. This Act prohibits the cultivation of opium poppy, cannabis and coca plants without a license. Offences can be punished with up to ten years imprisonment and a maximum fine of 100,000 rupees (2,200 USD). Production, trade and possession of drugs are punished according to quantity and substance. The Act discerns three levels of quantity: small, more than small and commercial.

In the case of cannabis, 1 kg is considered a small quantity and 20 kg is considered commercial. For morphine and heroin 5 grams is considered small and 250 grams is commercial. For amphetamine and methamphetamine 2 grams is considered small and 50 grams is commercial. Possession of small quantities can be punished with imprisonment up to 6 months or a fine up to 10,000 rupees (220 USD) or both. Conviction for more than small but less than commercial may be punished by up to 10 years and a fine of 100,000 rupees. Possession of com-

mercial quantities can be punished with 10-20 years imprisonment and a fine of 100,000 to 200,000 rupees.

Consumption of cocaine, morphine and heroin can result in up to one year's imprisonment and a maximum fine of 20,000 rupees (440 USD) or both. For other drugs, the maximum imprisonment is 6 months and/or a fine up to 10,000 rupees (220 USD). Users who volunteer to go into treatment are not be prosecuted.

Under section 31 of the Act, recidivists convicted of repeating the same crime can be sentenced to prison terms and fines 50 percent greater than the maximums stipulated above. Mandatory capital punishment for some cases upon second conviction under section 31 A was added in 1989. Since then, two people have been sentenced and are on death row. At the time of this writing the Bombay High Court is hearing a petition by the Indian Harm Reduction Network challenging constitutional validity of section 31 A.

the need to start primary prevention programmes at schools. They argue that much can be gained with such programmes, as peer pressure is one of the main causes linked to starting drug use, and many children are not aware of the dangers. The NGOs also stress the need to target partners of drug users.

The only prison running an oral substitution therapy (OST) program in the country is Tihar Jail in New Delhi, where drug users can receive buprenorphine. There is no OST available in any other detention facility and needle exchange programmes do not exist. Prisoners' chances of contracting disease are increased exponentially in that the prisons are not only rampant with HIV and hepatitis C, but are a schooling ground for criminal activities.

Furthermore, although HIV infection among women and children is fast increasing, the government has no projects on sexual and reproductive health care. And while condoms are freely distributed at drop-in-centres for drug users, female drug users often do not feel comfortable going there. In response, Guardian Angel, an NGO focusing on female drug users in Dimapur, has started involving local bars known as "booze joints" in the free distribution of condoms.

Across the border in Burma, these projects are practically inexistent. Hence desperate people cross into the region to get access to needle exchange programmes, condoms, OST, and ART.³³

The position of the armed groups in the region towards drugs is very ambivalent.

They are believed to use drug production to earn money and influence in the region, yet they are known for their violence towards drug users. According to a representative of a local NGO in Imphal drug users used to be chained to the benches in “treatment” centres to keep them from running away. No medical care was available at these centres and drug users were often physically abused.

“They used to kill drug users and traders. Instead of killing them, they started shooting their leg, and putting them in low small cages,” says a Naga NGO worker in Kohima. “After some advocacy and dialogue they brought it down to forced labour. They call it work therapy.”

Organizations such as the All Manipur Anti Drug Association (AMADA) and the Coalition Against Alcohol and Drugs (CADA) that are allegedly working closely with the government and rumoured to be secretly backed by the armed groups, are also aggressive toward drug users, dealers and producers although the practice seems to be less frequent of late.³⁴ In the first half of 2010 AMADA “hauled up and reprimanded” 412 persons dealing in drugs or alcohol.³⁵ Local newspapers regularly publish articles naming and shaming people either reprimanded by AMADA or arrested by the police on suspicion of drug offences.

LOCAL ORGANISATIONS

NGOs play a major role in implementing the prevention and care programmes, above all in remote areas. “Since the late 1980s NGOs are mushrooming in Manipur because there was a lack of government services,” says a local NGO worker. People from the drug using community decided to start self-help groups. “People from the community felt we needed to do this work better, and do it ourselves. That is why most leading NGOs in the field of drugs and HIV/AIDS here are community based,” say the founders of the Care Foundation and the Social Awareness

Service Organisation (SASO). “Our friends were dying; we had no choice and needed to do something. We started buying ART in bulk and the price went down by 30 percent.”

In the 1990s NGOs such as SASO and the Nagaland Users Network pioneered methods to best reduce the harm of drug use. The organizations learned while doing. “In the beginning we felt everybody had to be completely abstinent. It took us a long time to accept not everybody is able to completely stop taking drugs,” says one of the founders of SASO.

The NGOs are run by volunteers, most of them with an IDU background. Home-based care has proven to be very effective, and this is now a priority for SASO. Often IDUs are unable to visit a doctor. Service providers point out that the “conflict situation in Manipur, the everyday fighting, the frequent strikes and the curfews make the intervention programmes very challenging.”

In Manipur and Nagaland all oral substitution programmes are implemented by NGOs. At the drop-in centres where buprenorphine is handed out, the tablets are crushed and the clients are requested to swallow these tablets on the spot, to prevent the drug finding its way onto the illicit market.³⁶ Experience has also demonstrated that if both partners are using drugs they should both enrol in an OST program in order to increase the chance of a successful intervention.

An evaluation of the OST programmes in Manipur and Nagaland suggests that there has been a concomitant decrease in criminal activities.³⁷ A local NGO worker in Dimapur confirmed OST has helped to lower the crime rates. Many NGOs have had a vital role in providing much needed services. However, there has been criticism on the quality of services provided by some local NGOs and accusations of corruption.³⁸

NOTES

1. Unless a statement is footnoted, interviews with drug users, service providers and international organisations used to prepare of this report were conducted between 19 October and 1 November 2009 in Manipur, Nagaland and New Delhi. Many of the interviewees prefer to remain anonymous.
2. In 1989 the military government changed the official name of the country from Burma to Myanmar. Using either has since become a highly politicised issue. The UN uses the latter, but it is not commonly used elsewhere in material written in English about the country. Therefore Burma will be used in all publications of this project. This is not meant to be a political statement.
3. Chingsubam, B., and Khongbantabam, R., *Hepatitis C Virus and (HCV) and Hepatitis B Virus (HBV) prevention and treatment among IDUs PLHIV - Issues and Solutions*, 2008 Manipur (India), supported by: INP+ - Indian Network of Positive People, Manipur, 2008.
4. See "Report of the Committee to Review the Armed Forces (Special Powers) Act, 1958," The Hindu, <http://www.hinduonnet.com/nic/afa/> (accessed October 4, 2010) and These fellows must be eliminated, Relentless violence and impunity in Manipur, Human Rights Watch, September 2008 <http://www.hrw.org/en/node/75175/section/1> (accessed October 5, 2010)
5. Interview with Babloo Loitongbam of Human Rights Alert, Manipur, 22 October 2009
6. Heroin *no. 4* has 80-90 percent purity, making it suitable for injection once diluted.
7. Moses, G., *Drug Use, HIV/AIDS and Human Trafficking in the North East*, Dialogue, July-September 2007, Vol. 9 No.1.
8. Presentation at SASO, 21 October 2009. Most up to date figures are from SASO; last drug use survey by Indian government carried out in 2001, published in 2004. According to UNODC the government is now working on a new survey.
9. The total population Nagaland is nearly 2 million; the total population of Manipur is almost 2.2 million.
10. Tellis, E., *New approaches to contain HIV risk among injecting drug users*. <http://www.hivAIDSonline.in/index.php/Vulnerable-Groups/new-approaches-to-contain-hiv-risk-among-idus.html>, accessed 31 January 2011
11. Manipur State AIDS Control Society, 2010 Epidemiological Analysis-Sentinel Surveillance, <http://manipursacs.nic.in/assets/docs/epidemOct2010.pdf>
12. *HIV declining in India; New infections reduced by 50 percent from 2000-2009; Sustained focus on prevention required*, Government of India, Ministry of Health & Family Welfare, Department of AIDS Control, National AIDS Control Organisation, Press Release, December 2010
13. Website of the Manipur Aids Control Society, <http://manipursacs.nic.in/html/history.html>, accessed 22 December 2010
14. The figures we found on the population of Dimapur varies between 100,000 and 300,000 people.
15. *HIV Sentinel Surveillance and HIV Estimation 2007_A Technical Brief*, National Aids Control Organisation, Ministry of Health and Family Welfare, Government of India, 2008 see link: [http://nacoonline.org/upload/Publication/M&E Surveillance, Research/HIV Sentinel Surveillance and HIV Estimation 2007_A Technical Brief.pdf](http://nacoonline.org/upload/Publication/M&E%20Surveillance,%20Research/HIV%20Sentinel%20Surveillance%20and%20HIV%20Estimation%202007_A%20Technical%20Brief.pdf)
16. *Indian claims of decline in HIV cases dismays NGOs*, Civil Society Observer, Volume 2, Issue 3, May-June 2005
17. Devi KhS, Brajchand N, Singh H L, Singh Y M, *Co-infection by human immuno deficiency virus, hepatitis B and hepatitis C virus in injecting drug users*, The Journal of Communicable Diseases, 2005; 37(1): 73-7.
18. Chingsubam, B., and Khongbantabam, R., *Hepatitis C Virus and (HCV) and Hepatitis B Virus (HBV) prevention and treatment among IDU's PLHIV - Issues and Solutions*, Manipur (India) 2008
19. Poll, S and Soriano, V. Management of Chronic Hepatitis C Virus Infection in HIV-Infected Patients *Clin Infect Dis.* (2008) 47 (1): 94-101.
20. Interview with women and children affected by HIV/Aids in Ningthoukhong, Bishnupur, 22 October 2009
21. Mukta Sharma et al., *Five years of needle syringe exchange in Manipur, India: programme and contextual issues*, International Journal of Drug Policy, 14 (2003) 407-415
22. Letter from UNAIDS to Bangkim and colleagues <http://health.dir.groups.yahoo.com/group/AIDS-INDIA/message/10006?var=1>, accessed February 13, 2011
23. Murthy, Dr. P., *Women and Drug Abuse: The problem in India*, UNODC and Ministry of Social Justice and Empowerment Government of India, 2002
24. Female drug users in Imphal interviewed at the SASO drop-in centre for women, 21 October 2009.
25. Oinam, A., "Exploring the links between drug use and sexual vulnerability among young female inject-

ing drug users in Manipur,” *Health and Population Innovation Fellowship Programme Working Paper*, No 6, New Delhi, 2008.

26. Ibid., finds 55.5 percent of her cohort is doing sex work to support the drug use.

27. Ibid.

28. Ministry of Social Justice and Empowerment, *Scheme for prevention of alcoholism and substance (drugs) abuse*, available at <http://socialjustice.nic.in/pdf/drugsabuse.pdf> (accessed January 28, 2011).

29. Dr Rajat Ray, Professor and Head of the Department of Psychiatry and Chief of India’s National Drug Dependence Treatment Centre, quoted in: “The Methadone Fix,” *Bulletin of the World Health Organisation*, 2008 March; 86(3): 164–165.

30. Report No. 3 of 2004 (CIVIL): Performance Appraisals – National Aids Control Programme, link: http://www.cag.gov.in/html/reports/reports/civil/2004_3/chapter1.htm accessed February 13, 2011

31. Padma TV, *India continues crackdown, dismissing hundreds of AIDS groups*. *Nat Med* 2008; 14 : 227

32. HIV/AIDS Policy Framework and Implementa-

tion in India, Transatlantic Partners against Aids and Global Business Coalition and HIV/AIDS, Tuberculosis and Malaria, 2007.

33. Namaram, K., *AIDS Response: Are we heading in the right direction?*, AHRN News, December 2010

34. Interview with representative of local NGO in Imphal, 21 October 2009.

35. AMADA report, by kanglaonline, September 19, 2010, available at <http://kanglaonline.com/2010/09/amada-report/>. Both Nagaland and Manipur are “dry states” as alcohol has been prohibited in 1989 and 1991 respectively. Still alcohol is illegally served in “booze joints”.

36. Direct observatory therapy (DOT): users stay at the clinic while using buprenorphine.

37. Armstrong, G., et al., *Opioid substitution therapy in Manipur and Nagaland, north-east India: operational research in action*, *Harm Reduction Journal* 2010; 7: 29.

38. Padma TV. Ibid.

TRANSNATIONAL INSTITUTE

Founded in 1974, TNI is an international network of activists and researchers committed to critically analysing current and future global problems. Its goal is to provide intellectual support to grassroots movements concerned about creating a more democratic, equitable and sustainable world.

Since 1996, TNI’s Drugs and Democracy Programme has been analyzing trends in the illegal drug markets and international drug control policy, causes and effects on the economy, peace and democracy.

The programme does field research, fosters political debate, provides information to officials and journalists, coordinates international campaigns and conferences, produces analytical articles and documents, and maintains an electronic information service on the topic.

The goal of the programme and the Drug Policy Briefing series is to encourage a reevaluation of current policies and advocate policies based on the principles of harm reduction, fair trade, development, democracy, human rights, protection of health and the environment, and conflict prevention.



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