Chapter III

Earlier Era

R. Ray

CHAPTER III

EARLIER ERA

R. Ray

The contemporary drug scene from the 1980s onwards has been described earlier (chapter I). Though the present manifestation of the drug abuse problem may seem dramatic, one must realize that drug use and abuse are long standing problems. The nature, extent and magnitude of the problem from the earlier period till the late 1970s are discussed in this chapter. Many of today's drugs were available in the past, often through licit outlets. Opium, cannabis and alcohol have been the traditional drugs of abuse in many countries of the region in the early twentieth century notably in India, Bangladesh, Nepal and Sri Lanka.

There was considerable socio-cultural sanction of the use of opium and cannabis. Opium was often eaten or drunk, while cannabis leaves *(bhang)* were chewed and *ganja* (marijuana) was smoked. Sometimes, these were mixed with sugar, milk and other ingredients and made into sweetmeats. A few subjects consumed a cocktail of alcohol, *bhang,* opium and *datura (Datura Stramonium).* While some subjects used these substances in excess, most were occasional, recreational or moderate users. Members from both the upper and the lower classes could be expected to be users.

Poppy Field - Flowers and Capsules

Additionally, the use of cocaine and *Khat* was also reported in India till the 1940s. The most affected areas were Bengal, Bihar, Orissa and Maharashtra. Cocaine, however, never grew in India, although an attempt was made to grow it in Sri Lanka (Ceylon). With strict enforcement, the use of cocaine disappeared (for details on traditional use please see **Box Item-8**).

The traditional use of opium and cannabis still continues. Opium users in Rajasthan, Gujarat and Punjab were reported in 1994 and 1995 (Charles et al., 1994; Ganguly et al., 1995). The ritualistic use of cannabis continues in Uttar Pradesh and Karnataka. Clinical profiles of subjects with opium and cannabis dependence are provided in **Box Items-6** and **7**.

BANGLADESH

Like other South Asian Nations, Bangladesh has a long history of drug abuse. Bangladesh was part of undivided India before 1948, and so much of the historical data available on eastern India (particularly Bengal) applies to Bangladesh. Subsequent information on the drug abuse situation is available in the National Master Plan, though no studies have been quoted in the document.

BANGLADESH

Drugs of abuse - earlier period:

- Opium; licit sale till 1984
- Cannabis; licit sale till 1988

From the British period to 1984, opium could be purchased from government controlled vendors. Cannabis too was available, though it was made illegal in 1989 in accordance with the provisions of the Single Convention on Narcotic Drugs, 1961. Although there are legal restrictions on the manufacture and consumption of alcohol, they are applicable only to Muslims. Psychotropics are controlled items and in the past illicit diversion or abuse was not a major problem. Of late, however, there has been concern about lax controls, and there have been reports of abuse. In a book on psychiatry for undergraduate medical students (1985) Dr. Dewan O. Nabi, devoted a chapter to drug abuse. Though no statistics were provided, Dr. Nabi wanted

Incising the Poppy Capsule for Exudate

to make the students aware of various drugs of abuse including psychotropic substances and mentioned the abuse and potential for abuse of opium, amphetamine, LSD and barbiturates. He clearly felt that there was a need for medical students to know about these substances.

INDIA

By about mid-1960, concern had risen about the increase in drug abuse in India. Several individual researchers carried out epidemiological studies to assess the magnitude. Period prevalence rates for various drugs of abuse are available from four kinds of studies:

1. Epidemiology of mental illness where drug use was inquired
2. Specific studies on drug abuse among
   - general population
   - student population
   - clinical subjects

STUDIES ON THE EPIDEMIOLOGY OF MENTAL ILLNESS

Various authors between 1969 and 1978 reported that 0.04-17.5 per cent patients had reported the use of various drugs of abuse including alcohol. The prevalence rate for cannabis varied between 0.4-17.5 per cent, and 0.04 per cent had reported opium use. However, these figures reflect lifetime (ever use) and no effort was made to specify current (last one month) use or dependent use.

GENERAL POPULATION

In an article, Channabasavanna (1989) reviewed seven epidemiological studies (1971-77) that covered both rural and urban subjects and reported that the lifetime prevalence rates varied between 24.8-28.7 per cent. Alcohol was invariably included as a drug of abuse. The prevalence rates for cannabis varied between 1.9-16.1 per cent, and for opium between 0.7-18.9 per cent. Abuse of barbiturates, methaquolone, tranquilizers and even LSD was reported. The sample size in each of these studies varied between 1,900 and 28,767. There were regional variations too, and the rates for various drugs were different. From these studies, it could be concluded that the proportion of non-users were large; that alcohol, opium and cannabis were the main drugs of abuse; that the percentage of regular users (addicts) was very small; and that drug abuse was mostly seen among men.

STUDENT POPULATION

From the mid-1960s it was felt that drug abuse by students in schools, colleges and universities had assumed serious proportions. **The first study was reported in 1963 from Calcutta.** Among 1132 university students, the prevalence rate was 37.4 per cent (tobacco - 26 per cent, Amphetamine - 11.4 per cent). From 1963 to 1979, at least 17 studies were carried out among students in various parts of India. These studies were reviewed by Channabasavanna (1989) in his article and also by an Expert Committee, henceforth called the Committee, appointed by the Ministry of Health and Family Welfare, Government of India, in 1977.

The Committee reviewed the current prevalence of drug abuse in India and proposed various measures to prevent and control drug abuse — legal and penal measures, preventive education, treatment and social action. The multi-disciplinary Committee had representatives from Universities, Central Board of Excise and Customs, Central Bureau of Investigation (CBI), Ministry of Social Welfare (now called Welfare), Institute of Social Sciences, Indian Council of Social Science Research (ICSSR), Narcotics Commissioner of India (NC), Drug Controller of India (DCI), and two eminent psychiatrists. The then Director-General, Indian Council of Medical Research (ICMR), was the Chairman. **The Committee submitted its report in October, 1977**. This was one of the first major national efforts to assess the drug abuse situation and initiate comprehensive measures to control drug abuse.

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BOX ITEM - 6

A TYPICAL CASE OF OPIUM DEPENDENCE

Anil Malhotra

M.S. is a 40 year old married, illiterate, farm labourer from a Sikh nuclear family in a village in Punjab (north India). He was married in 1972 when he was 17 years old, and was given a share of one-and-a-half acres of land by his father. The income from this piece of land was not adequate — he had to work as a farm labourer as well in order to make ends meet.

While he was working as a labourer during the harvest season two years later, the landlord suggested that he use opium *(afeem*, in the local language), suggesting that it would make him strong. Consuming a small quantity, he felt cheerful, excited and that he had gained a lot of strength. The landlord gave him "*afeem*" daily after this and deducted the cost from his wages. Over the next year, his consumption increased to about half a gm a day.

At the end of the year, the landlord stopped calling him for work and his supply of *afeem* was abruptly cut off. He experienced severe body aches, particularly in the knees, back and calves, and also excessive weeping, running nose, loose motions, marked weakness, restlessness and difficulty in falling asleep. These symptoms were distressing and unbearable, so he approached the landlord again. They struck a bargain where he would give up half his daily wages in lieu of a daily supply of *afeem.* By 1983, his intake had gradually increased to 10 gms a day. He did not attempt to give up *afeem* for fear of experiencing painful symptoms.

In 1983, however, he began to experience withdrawal symptoms by the evening even if he consumed *afeem* in the morning. He then began consuming it in two divided doses rather than in a single daily dose. Between 1983 and 1995, his daily intake increased further to about 15 gm a day, which he consumed in three doses to offset withdrawal symptoms. His expenditure on *afeem* was now exceeding his income, and in these 12 years, he incurred a debt of Rs. 12,000 (US $ 310) to the landlord. Despite consuming about 15 gm of *afeem* daily, he no longer experienced a "kick", but felt weak throughout the day and his productivity reduced drastically.

Increasingly, the family depended only on the earnings from their land, which was barely sufficient for survival. They had to hawk various pieces of furniture or kitchenware to survive during 1994-95. Adding to the problem, his 17 year old son, who had begun contributing to the family income, left for Calcutta to become a truck driver. The financial difficulties often led to quarrels with his spouse and occasionally culminated in violence against her. His social circle was limited to those who consumed *afeem* along with him or those who provided the means for its supply. As a result, he received little emotional or financial support from his relatives.

He heard about the medical facilities available for detoxification through another person in the same village who had successfully undergone treatment in mid-1995. He travelled nearly 200 km to seek treatment and was admitted in mid-1995, for 36 days. He was detoxified, received individual and group counselling as well as a weekly session with a yoga therapist, and attended self-help group meetings.

After his discharge, he became involved in a land dispute with his brother who had tried to usurp his land while he was undergoing treatment. He remained tense and also experienced aches and pains in the body and severe weakness. He restarted *afeem* (5 gm/day) in an attempt to overcome these complaints. He continued to consume *afeem* and was unable to give up till he was admitted again in 1996. During the second admission, in addition to the usual treatment, family counselling was undertaken and the family was also put in touch with a self-help group. He did not maintain contact following his discharge and has not yet responded to repeated reminders. In addition to opium (*afeem*), he has also been chewing 25 gm of tobacco daily since 1974-75, and drinks country liquor once or twice a month. But his use of these substances did not fulfill the criteria for dependence.

M.S.'s case is a typical instance of opium dependence from rural Punjab. It illustrates the adverse effects that opium can have on the individual's occupational functioning, socio-economic status and interpersonal relationships—as well as the frustration involved in handling such a case.

BOX ITEM - 7

PROFILE OF A TYPICAL CANNABIS USER: A CASE HISTORY

H.K. Sharma

There has been a long history and tradition of consumption of cannabis in the Indian subcontinent. However, from the 1960s onwards, one also notices a secular use pattern in the absence of rituals and ceremonial significance in urban areas. The present case history represents a typical cannabis user with gradual shifts from a traditional to a secular use pattern.

N, a rickshaw puller (manual tricycle operator), 35 years old, married with four children and resident of an urban slum in West Delhi, is typical of the cannabis users in the locality. N was the eldest child of a farmer's family with a small house and an orchard field. The family lived in a village in Bihar (eastern India) and was from a caste low in the social hierarchy. He was enrolled in a village school at the age of seven but could not sustain an interest in studies. He spent about four years at school and was able to pass two elementary classes.

At the instance of a village boy, he chewed *khaini* (oral tobacco) once or twice. His teacher tried to persuade him not to take it, even resorting to the repulsion method by making him ingest good quality *khaini*. N vomited, but the permissive social environment led him to regular tobacco use in the next two years. At home, his parental uncle consumed *bhang thandai* (a beverage prepared from a paste of cannabis leaves, milk, sugar and dry fruits) regularly and N was occasionally allowed to drink it.

After dropping out of school, N started helping with agricultural work. As an errand boy, he had some leisure time and spent most of it in the company of a group of older people who were economically better off than him. The group consumed marijuana *ganja* in a clay pipe (*chillum*) outside a house and he was asked to assist them in the preparation of the smoking paraphernalia. On one occasion, he was allowed one or two puffs from the *chillum*. His first experience of *ganja* was not pleasant and he felt as if "the whole world was dancing" before him. Subsequent experiences were pleasant, however, and the use continued.

At the age of 15, he came to Delhi to work in a factory. He shared a single room in a slum with his friends. Alcohol and cannabis were freely available in the area, and he had little difficulty in consuming *ganja*. In the absence of family control, he was also free to consume two *chillums* (one each in the morning and evening). He also tried cigarettes containing *charas* (hashish) in between. This continued for almost three years before his father recalled him to the village to help with agricultural work and other family responsibilities.

At the age of 20, he got married but his *ganja* smoking continued. During this time his *ganja* intake became open and public *(rabat* in the local dialect). He was then invited to join other user groups, including people of other castes. He later said that he was fortunate not to have joined a group of ascetics and others who were heavy smokers of cannabis and had renounced the materialistic world.

He left the village again and got a job as a labourer in a sugar mill in a town of Uttar Pradesh (north India). He was not able to locate marijuana to his liking and switched over to smoking cannabis leaves (*bhang*). On a few occasions, he took *bhang* in a confectionery form (*bhang burfi*). This continued for almost six years. He cited many laughable incidents as well as his silly behaviour with his family including the de-personalization phenomenon (he was floating in space) on account of cannabis use.

After spending about six years in this town, he went to Punjab on a contractual agriculture job for six months. In Punjab, he could not obtain any cannabis products and was initiated into alcohol for the first time in his life. He consumed country liquor once or twice a week, but did not enjoy the taste. "The effects were not smooth as that of cannabis products", he reported. When the contract expired, the first thing he did was to visit his village in Bihar and smoke as much *ganja* as possible. Within a month of his stay, he was smoking four to six *chillums* a day.

He moved to Delhi once again and started working as a rickshaw puller, sharing a room with four or five friends from his state. *Ganja* use continued and gradually became part of his day to day life. Some of the features of his continuous use of *ganja* over the last eight years are as follows:

- His consumption went up to 25 *chillums* a day from his earlier 5-6 *chillums.*
- Earlier, a few rituals were observed with *ganja* smoking (chanting a few words in the name of Lord Shiva), but with increased frequency smoking took on a secular pattern.
- He stopped cannabis use for three to six months on two occasions because of serious physical illness.
- After the illness, he has stabilized his *ganja* smoking at around 10 *chillums* a day at a cost of around Rs. 25 to 50 per day (a little over US $ 1). On a few occasions, he has consumed alcohol during festivals. The oral use of *khaini* (pouch tobacco) has continued over this period. Despite the easy availability of heroin in the area, he never felt the temptation to experiment with it.
- His own perception is that cannabis is not as harmful as other substances (alcohol, opium, heroin etc.) and 2-4 *chillums* is what he considers a safe limit. With cannabis use, diet plays an important role in maintaining health. Two of his former companions from the village died around the age of 50 when they stopped eating properly.
- Except for his physical problem (chest pain and severe episode of dysentery) N did not seek treatment for cannabis use and does not plan to leave his cannabis habit.

N should not be seen as a single isolated case of cannabis use. He reflects traditional use with a new meaning in a secular pluralistic society. Inspite of stringent enforcement laws, the popularity and consumption of cannabis products lingers among a section of the population and its controlled use does not pose a serious public health problem.

Opium Exudate

INDIA: DRUG ADDICTION COMMITTEE - 1977

Committee members - 11
DG, ICMR - Chairman
Other members:
- University V.C. (2)
- Central Board of Customs and Excise
- NC (CBN-Central Bureau of Narcotics)
- CBI
- Tata Institute of Social Sciences
- ICSSR
- Ministry of Social Welfare
- DCI
- Eminent psychiatrists (2)

Report submitted in October, 1977
Recommendations on comprehensive measures to control drug abuse

The Committee concluded that an overwhelming percentage of students had not taken any drugs, ever (60-80 per cent). If alcohol, tobacco and painkillers were excluded, the percentage of lifetime users for other drugs varied between 0.2-29.6 per cent. One of the studies reviewed was a multicentred study carried out among college students in seven cities in 1976 (Mohan et al., 1981). Current (last one year) prevalence rates for various drugs among 26,167 students varied among centres and is seen in **table 11**. Single drug abuse was uncommon and students often used multiple drugs. Drug abuse was far more common among male students. Certain inter-centre differences were seen. However, most students used infrequently (less than once a week to once a month). The percentage of regular users was between 0.02 - 0.1 per cent. In other words, **a large number of students were lifetime abstainers**. **Figure 7** depicts the prevalence of drug abuse (last one year) among college students at two points of time, with a gap of 10 years (1976 and 1986). These two studies were multicentered and carried out in the same cities using similar methodology. It can be seen that prevalence rates were essentially similar for cannabis, opioids, amphetamines and tranquilizers. Rates for alcohol use were higher (around 11 per cent) and, as a healthy sign, came down in 1986. Another study by Dube, a cross-sectional study for five consecutive years among medical students, found that except for alcohol, cannabis (*bhang*) and painkillers, there was a gradual decline of drug use by students over the years.

TABLE 11: Multicentred Study Among University Students, India (N = 26,167)

Seven cities
Current (past one year) prevalence rates in percentages

Cannabis	0.4 - 10.9
Opium	0.03 - 0.4
Pethidine	0.05 - 0.9
Amphetamines	0.1 - 1.3
Cocaine	0.03 - 0.1
Barbiturates	0.4 - 1.8
Tranquilizers	1.0 - 2.9
LSD	0.07 - 0.9
Regular users	0.02 - 0.1

Source: Mohan et al., 1981

The Committee noted that drug abuse surveys among students generally tended to converge on boys and girls from affluent upper middle class families where parents had a high level of education and prestigious occupations. Vulnerable groups identified were public school educated children, who were living in hostels away from their families. Most were introduced to drugs soon after entering college, at about 17 years of age. By and large, medical students displayed a higher rate of abuse.

School children

A few studies also looked into drug abuse among school children. Between 1975-78, 500 - 2032 students from senior classes in selected English medium schools were interviewed in three studies. About 34 per cent reported drug use, ranging across alcohol, amphetamines, cannabis, LSD, tranquilizers, opium, pethidine and barbiturates. The current use (past one year) pattern varied for various drugs. The prevalence rates, excluding alcohol, varied from 0.2 per cent (opiates, LSD, amphetamine, cocaine) to 3.5 per cent (tranquilizers).

All these studies were methodologically sound. After selecting a city, the sample was chosen by stratified random sampling. The information was obtained from self-administered questionnaires; the non-response rate was low (2-5 per cent). Some of these studies were sponsored

by national funding bodies such as the ICMR, ICSSR and Ministry of Welfare. Almost all parts of the country were covered — the east, west, north, south and central Indian States. Drug abuse among special groups — juvenile delinquents — were also carried out, and one study estimated that 17 per cent of them were drug abusers.

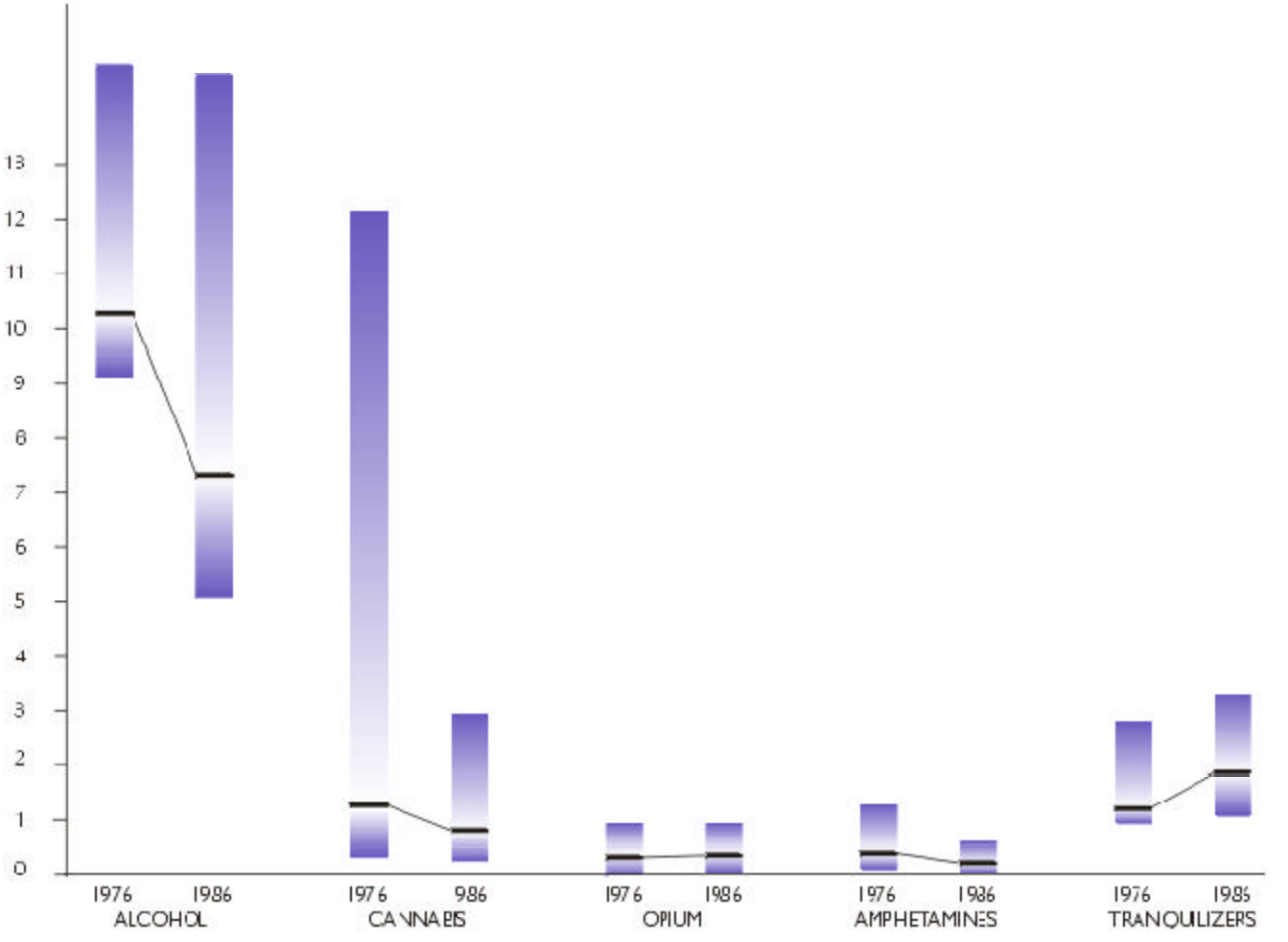
All these studies have been reviewed in three excellent monographs: *Current Research in Drug Abuse in India,* Series I (1981), Series II (1985) [editors - D. Mohan et al.] and *Drug Abuse - An Overview* (1978), ICAA (International Council of Alcoholism) and GAMHA (Group for the Advancement of Mental Health in Asia) [Mohan and Tongue].

It seems clear that among both the general population and students, abuse of alcohol, tobacco and pain-killers was quite common. Most studies included these three compounds, as was the practice in WHO sponsored studies at the time.

CLINICAL SUBJECTS

Several authors have reported drug abuse by psychiatric patients. Sethi and Trivedi (In *Current Research in Drug Abuse in India* - Series I, Mohan et al. [eds]) reported in their review (1981) that between 4 and 46 per cent of patients were also drug abusers. Commonly abused drugs were alcohol, cannabis and barbiturates. In one of India's largest psychiatric hospitals (National Institute of Mental Health and Neuro Sciences), 272 patients with histories of drug and alcohol abuse were treated between January 1976 and April 1978. Sampath et al. reported that thirty-two patients (11.7 per cent) had co-morbid psychiatric diseases (Mohan et al., 1981). **Special clinics or wards (for in-patient treatment) to treat subjects with drug dependence were established in early 1970.** These

FIGURE 7: Current (last one year) Drug Abuse Pattern (prevalence rates) Among University Students at two points (1976 and 1986) (Range and Median)



Source: Mohan et al., 1976, 1986

Cannabis Smoking through a Clay Pipe (Chillum)

were established in at least five large teaching hospitals (general and psychiatric) in various regions of the country.

In the period 1970-80, an overwhelming number of patients treated were alcohol dependent. A small number of subjects with dependence on other drugs were reported. Here too, dependence on opium, morphine, diazepam, amphetamine, methaquolone and cannabis was reported. Amphetamine psychoses were seen, though a good clinical case history is not included in the published reports. Dr. Venkoba Rao and his colleagues reported their findings on the outcome following the treatment of patients with various addictions in 1981 (*Current Research in Drug Abuse in India* - Series I). Out of a total sample of 178, it was possible to trace 94 per cent at the end of 5-10 years. Twenty-nine persons had died during this period. The follow-up among 138 subjects showed that 63 per cent were taking drugs regularly, 29 per cent had abstained for 3 years or more and 8 per cent were using drugs intermittently. **Surprisingly, two subjects with opiate addiction underwent cingulotomy (neuro-surgical procedure) in an attempt to treat their drug dependence!**

The Committee (1977) noted in its report that special facilities for the treatment of drug addicts in the country were very few at the time. By and large they were being seen in psychiatric hospitals. The shortage of beds was even more obvious in the perspective of overall shortage of hospital beds for patients with psychiatric illness.

The Committee estimated that between 1970 and 1973 there were about 99,000 (1970) to 94,200 (1973) opium addicts in the country, most (75 per cent) were male and about 25-30 per cent were women. The majority, 80 per cent, were 50 years and older. Most got their opium from licit sources — the authorized outlets for opium (see **Box Item-8**). Chopra and Chopra (1965) reported that there were 1511 opium smokers in India as on December 31, 1964. However, opium eating continued and was allowed on the issue of medical certificates.

A report from the office of the Narcotics Commissioner showed that in 1973, 82,873 opium addicts got their quota from licit sources — presumably they were registered addicts. However, it was estimated that between 1970-73 the actual number of addicts was slightly more and that about 11,000 subjects got their quota of opium from illicit sources. In the Union Territory of Delhi, these rules were known as the Delhi Opium Rules (1959). Fresh registration was stopped in Delhi in 1982-83 when it was felt that some heroin users might shift to opium eating. In 1989, there were 160 registered addicts in Delhi. The use of traditional drugs like opium and cannabis continues even today, and clinical profiles of subjects with opium (rural) and cannabis (urban) dependence has been described in **Box Items 6 and 7**, respectively.

To conclude, during the previous 15 years (1960-late 1970s), drug abuse among the general population and student population in India was noted by several researchers. Abuse of alcohol and cannabis was most often reported, but the abuse of cocaine, amphetamine, LSD and methaquolone was also reported among a small proportion of subjects. Some compounds have not been abused since 1980, notably amphetamines, cocaine and methaquolone since these are not available any longer. This was made possible through strict legal and preventive measures. Finally, the traditional use of opium and cannabis still continues in certain rural areas, mostly in Punjab, Gujarat and Rajasthan. **1981 is a landmark year. For the first time, heroin abuse was reported**

in 1981 from treatment centres in Delhi (Mohan et al., 1985b), Mumbai (Charles et al., 1994) and other cities.

NEPAL

Cannabis had been traditionally used in Nepal for centuries and was associated with religious festivals. Its use was not perceived as a problem. Drug abuse increased in the 1960s, mainly through tourists. By 1980, it was estimated that there were 25,000 addicts in Nepal as against 50 in 1978 (Bhandari and Sarmah, 1988). The distribution of subjects with regard to drug types was not mentioned. Hence, it is difficult to estimate the number of subjects excluding those dependent on alcohol. Several authors in the book commented on drug abuse in Nepal till the mid-1980s.

In the same book, Chaitanya Subba commented that **heroin abuse was reported for the first time in 1976 with a history of two years' addiction**. Between 1978 and 1985, the number of subjects with heroin dependence escalated from 50 to 12,000 in Kathmandu valley alone. The author commented that till 1988, no epidemiological study had been carried out in Nepal. However, between 1979 and 1980, various drugs (opium, morphine, heroin, cocaine, cannabis products and LSD) had been seized by the Narcotic Drug Control Administration, HMG, Nepal. These are indirect indicators of drug use and trafficking.

It was only in 1975 that drug addiction drew public attention as the economic and social consequences of drug abuse began making their impact on Nepalese society. Various service facilities started to help drug addicts and the role of the NGOs in the prevention and control of drug abuse came into the limelight. As a result, the Drug Abuse Prevention Association Nepal (DAPAN) was established in 1986. Between 1962 and 1980, several programmes and legislative actions were initiated. These include:

- 1962 - Enforcement of Intoxicating Substance Act and Rules
- 1976 - Enforcement of Narcotic Drugs Control Act
- 1977 - Seminar on Drug Abuse by Nepal Medical Association
- 1979 - Public Awareness Campaign
- 1979 - First International Conference of the International Federation of Non-Governmental Organizations (IFNGO) was held in Jakarta, where Nepal participated.
- 1980 - Seminar on Drug Abuse inaugurated by Her Majesty, The Queen (Bhandari and Sarmah [eds], 1988).

NEPAL

Drugs of abuse - earlier period:

- Opium
- Cannabis
- First report of heroin abuse - 1976
- Projected number of heroin addicts in Kathmandu valley - 50 (1978)
- Total number of addicts (various drugs) projected- 25,000 (1980)

SRI LANKA

Sri Lanka, too has a long history of drug use, primarily of cannabis and opium. Both compounds have also been used as pharmaceutical preparations in herbal medicines. The abuse of opium and cannabis was limited to a few individuals, was not perceived as a problem and did not attract public attention. Opium was available through licensed shops until public opinion against the sale of opium led to the closure of opium vends.

Most experts felt that the problem of drug abuse began increasing in 1970. Dr. Gunatillake (Mohan et al., 1985a), commented that no precise estimation was possible as no scientific survey had been carried out. He stated that in the period 1975-79, about 3000 persons had reported to various treatment centres. Ninety-nine per cent were male and 40 per cent were chronic opium users. About 38 per cent were between 15 and 25 years old; 51 per cent were between 26 and 40 years old. Interviews with cannabis users revealed that most were around 30 years old, and had been using cannabis for between 9 and 15 years. Some school children were also using drugs, though mainly out of curiosity, and were recreational users.

In another work (Lawton et al., 1983), Jans and Crooz narrated their experiences with drug abuse in Sri Lanka. They reported that the principal drugs abused in Sri Lanka until the late 1970s were cannabis and opium, and that the occasional use of morphine, cocaine and LSD was also seen. Among school children, about 42 per cent reported ever use of drugs, excluding alcohol and tobacco.

In 1980, about five per cent of convictions were a result of narcotic drug offences. Cannabis was the most common drug used among prisoners, and the Sri Lanka Police estimated that there were 500 acres under cannabis cultivation. All these factors suggested the continued use of opium and cannabis in the country. It was estimated that there were between 10,000 - 15,000 opium users in Sri Lanka.

Around 1981, the abuse of heroin was reported for the first time. At that time, heroin was very expensive and was used chiefly by foreigners, especially the 'Hippies'. Though cocaine was also seized from the street, no abuse was reported by the authors.

SRI LANKA

Drugs of abuse - earlier period:

- Opium - licit sale
- Cannabis
- Estimated opium users 10,000 - 15,000 (late 1970s)
- Drug use (occasional) among school children

It is apparent that prior to 1980, drug abuse was prevalent in all these countries. Cannabis and opium were the traditional drugs of abuse and were in use even in the 1970s and 1980s. However, traditional use has remained confined mostly to rural areas and reports from Nepal and India project a clear profile of these subjects. In India, the abuse of psychotropics — barbiturates, methaquolone, amphetamines — was reported both among the general population and students in a large number of epidemiological studies. Reports of LSD and cocaine use were made from 1963 onwards.

Drug abuse (other than alcohol and tobacco) in India was reviewed comprehensively and exhaustively by an Expert Committee in 1977. The Committee noted that most were non-users, but could not arrive at a definitive answer on the crucial issue: was drug abuse on the increase? It did feel, however, that drugs were more readily available. Other than this report, extensive information is available from various monographs, particularly from the series *Drug Abuse in India* (I & II). The Committee felt that society's safety measures against drug abuse were weakening and that it was likely that drug abuse would increase. No epidemiological studies had been carried out in Bangladesh, Nepal and Sri Lanka till the late 1970s.

For the first time, heroin use was reported from Nepal in 1976 and in all other countries of the region in 1981-82. In an unsurprising coincidence, people began using heroin, especially in urban areas. In other words, a shift from opium use to heroin use is seen in the early 1980s. The factors responsible and the implications of such a phenomenon are described in **Box Item-9**.

BANGLADESH

1. Nabi, DO (1985): *Psychiatric Illness and Problem* (Original Title in Bengali). United Printers, Rajshahi.

2. *National Master Plan* (1991).

INDIA

3. Channabasavanna, SM (1989): 'Epidemiology of Drug Abuse in India - An Overview'. In *Proceedings of the Indo-US Symposium on Alcohol Drug Abuse,* R Ray and RW Pickens (Eds), pp. 43-56.

4. Charles, M, EJ Masihi, HY Siddiqui, SV Jogarao, H D'Lima, U Mehta and G Britto (1994): 'Culture, Drug Abuse and some Reflections on the Family'. *Bulletin on Narcotics,* 46: 67-86.

5. Chopra, RN and IC Chopra (1965): *Drug Addiction with Special Reference to India.* Council of Scientific and Industrial Research, New Delhi.

6. Ganguly, KK, HK Sharma and KAVR Krishnamachari (1995): 'An Ethnographic Account of Opium Consumers of Rajasthan (India): Socio-Medical Perspective'. *Addiction*, 90: 9-12.

7. Ministry of Health and Family Welfare, Government of India (1977): 'Drug Abuse in India, Report of the Committee'.

8. Mohan, D and E Tongue (1978): *Drug Abuse - An Overview,* Proceedings ICAAA - GAMHA Seminar, New Delhi.

9. Mohan, D, HS Sethi and E Tongue (Eds)(1981): *Current Research in Drug Abuse in India,* Series I. Gemini Printers, New Delhi.

10. Mohan, D, HS Sethi and E Tongue (Eds)(1985a): *Current Research in Drug Abuse in India,* Series II. Jay Pee Brothers, New Delhi.

11. Mohan, D, Adityanjee, S Saxena and S Lal (1985b): 'Changing Trends in Heroin Abuse in India: An Assessment Based on Treatment Records'. *Bulletin on Narcotics,* 37: 19-24.

NEPAL

12. Bhandari, B and HP Sarmah (Eds)(1988): *Drug Abuse in Nepal: Prevalence, Prevention, Treatment and Rehabilitation.* DAPAN, Nepal.

13. *National Master Plan* (1992).

SRI LANKA

14. Lawton, JK, JN Gnanadson and KV Mathew (Eds)(1983): *The Christian Response to Alcohol and Drug Problems.* Ecumenical Christian Centre, Bangalore, and International Christian Federation for Prevention of Alcoholism and Drug Addiction, London (1993).

15. *National Master Plan* (1993).

BOX ITEM - 8

TRADITIONAL USE

Anju Dhawan

The term 'traditional use' refers to drug use related to local customs and beliefs that is passed down from one generation to another. In the South Asian region, cannabis, opium and alcohol were the conventional drugs of use for many centuries. The use of these drugs in India, Sri Lanka and Nepal reflected the cultural similarity among the three countries. In this part of the world, Maldives and Bhutan have remained largely spared from the problem of drug abuse.

Most of the literature on the customary use of drugs has been documented from India. This includes information about Bangladesh and Pakistan as part of pre-independence (before 1947) India. This article discusses the historical aspects of cannabis, opium and cocaine use in the South Asian region and also focusses attention on the persistence of traditional patterns of drug use despite legislation. A crucial source of reference was the comprehensive account of the historical and cultural background of drug use in India by Chopra and Chopra (1965).

CANNABIS

Cannabis grew wild in abundance in Sri Lanka, Nepal and India (Subba, 1988). It was available as *bhang*, made from leaves of the cannabis plant, *ganja* from the flowers and upper leaves and *charas* which contained a large amount of resin. *Bhang* was the least potent and was chewed or consumed in beverage or confection form while *charas* (the most potent) and *ganja* were smoked. A clay pipe called *"chillum"* was used for smoking *charas* and *ganja* in India. *Bhang* use was prevalent throughout the country particularly in north India. *Charas* use was confined to northern and western India and most of the *charas* was imported from central Asia. Uttar Pradesh and Rajasthan were the highest cannabis consuming States in India.

Cannabis was conventionally used for religious and medicinal purposes in Nepal (Subba, 1988), Sri Lanka and India. It was considered a special tribute to the God Shiva; *bhang* was often consumed from a common bowl on "Shivaratri" and other major Hindu festivals. High caste Hindus to whom alcohol was forbidden could take *bhang. Ganja* was also taken by both Hindu and Muslim ascetics to enhance concentration. Cannabis was an important drug in Ayurvedic, Hindu and Tibbi or Mohammedan medicine. It was used orally as an analgesic and sedative and as a household remedy for many conditions in rural areas. Newly married couples often took a cannabis preparation called *"majun"* for its aphrodisiac properties. Labourers commonly used cannabis to relieve fatigue, particularly during the harvest season. Its use as a euphoriant was primarily restricted to the lower class in Sri Lanka and India and was regarded as uncivilized. In India, *bhang* was used primarily for religious and medicinal purposes and *ganja* and *charas* for their euphoric effects.

In response to criticism of widespread cannabis use in India by the upper classes as well as British administrators, the Indian Hemp Commission was set up in 1893 to examine the situation. Kalant (1972) stated that the Commission was widely appreciated for its systematic evaluation of cannabis use from both medical and social perspectives. The report evaluated the wild growth and cultivation of cannabis, customary use, extent and effects of use and the system of taxation of cannabis. The Commission critically examined 1193 witnesses including doctors, made direct observations, and also studied records.

The Commission noted that although occasional use of *bhang* was almost universal among Hindus, only about 0.5-1 per cent of the population used cannabis regularly and only 5 per cent of these were heavy users. The dependence liability of cannabis was thought to be less than either alcohol and opium. *Bhang* drinking was considered less harmful than *ganja* and *charas* smoking. The Commission concluded that prohibition of cannabis was unjustifiable and politically dangerous as cannabis use was deeply entrenched in the local customs. It recommended adequate taxation, centralization of cannabis cultivation and limiting the number of retail outlets for controlling cannabis use. Based on the recommendations of the Commission, Act XII of 1896 was passed. Subsequently, cultivation and possession of cannabis was prohibited in Sri Lanka in 1905 after growing public demand. In 1934-35, the use of *charas* and its import were completely prohibited in India. Finally, the All India Narcotics Conferences of 1956 and 1959 recommended that the non-medical consumption of cannabis should be eliminated.

Meanwhile, the Second World War led to an increase in the cannabis trade in Sri Lanka to supply foreign soldiers. As a result, cannabis use increased amongst the lower class, especially manual labourers. A few decades later, with the development of the tourist industry and the arrival of 'Hippies', cannabis was introduced as a euphoriant to the youth in Nepal in the mid-1960s and in Sri Lanka in the late 1970s. This also marked the start of hashish smoking in the Maldives, which had been free of cannabis till the mid-1970s. Besides being smuggled in by tourists in these countries, wild growth of cannabis also continued in India and Sri Lanka despite legislation.

It has remained one of the predominant drugs abused in the region till today. The prevalence reported is highly variable in different settings, ranging from 1.2 per cent in rural Punjab to 40.8 per cent of students in Uttar Pradesh (Mohan, Sethi, and Tongue, 1981). The estimated number of cannabis users in Sri Lanka in the 1980s was 16,000 - 18,000 (Gunatillake, 1985). As many as 55.6 per cent of men in a poor urban area of Sri Lanka smoked cannabis according to another study (Mendis, 1997). It also remained one of the preferred drugs in Nepal even in the 1980s. Government efforts at eradication intensified in 1986 and the availability of cannabis decreased. However, in Tarai in Nepal 0.5 to 1 per cent of the population continued to take cannabis regularly (Subba, 1988). In Bangladesh, cannabis was sold legally through vends till laws to restrict its use were passed in 1989. These laws were unable to curb cannabis use.

There has however, been a change in the pattern of use in India with the involvement of younger adolescents. They smoke cannabis rather than consume it orally and use it for seeking pleasure instead of for ceremonial or medical purposes. On the other hand, there are still rural areas in India, as reflected by a study in Karnataka in south India, where cannabis use has social sanction for medicinal, religious and ceremonial uses. *Ganja* sessions are a community practice during which important family matters are discussed. Among the "Lambanis" — a tribe in southern India — distribution of *ganja* in marriages is a matter of prestige (Charles et al., 1994). Clearly, centuries of customary use cannot be completely wiped out by legislation.

Opium

Poppy was grown extensively in India from the 16th century onwards and was an important article of trade with China. It was used by all classes of people including the nobility who took a mixture of opium, hemp and wine called "Charbugha". Its use in Sri Lanka increased from the 16th century onwards under colonial rule. Poppy cultivation was encouraged by the British in Sri Lanka in the 19th century and licensed opium shops were also opened. As poppy did not grow in Nepal, it was used only by a limited number of people living in the western rural areas of Nepal who visited Burma and India (Subba, 1988). Opium was also used traditionally in the Maldives for pleasure and medicinal purposes (Shareef, 1997 - personal communication). Although its use was widely prevalent in people from all classes in India, regular users were less than 1 per cent of the population and its consumption was much less than in other opium-using countries. Punjab, Assam and West Bengal were high opium consuming states. Opium was most often eaten, but was also taken as a drink and smoked. The capsules of poppy plant called "*post*" were often soaked to prepare a beverage.

Like cannabis, opium was used for medicinal purposes in the indigenous systems of medicine in India as well as Sri Lanka. It was also popularized as an aphrodisiac. It was a common practice in India to sedate children with opium to enable the mother to work and for prevention of ailments. Middle aged men often ate opium to enhance their stamina. Opium distribution for smoking at marriages, funerals and other semi-religious ceremonies called "*Kenia Seba*" meaning the "serving of opium" was common among the lower class in north eastern parts of India. Opium drinking in Gujarat among the rich was common in gatherings of men of similar status called "dayaro". The host paid for the opium, which was prepared by his servant and served in vessels that reflected the economic and social status of the host. A refusal to join in was taken as an insult, though the drinkers could allow some liquid to overflow from their cupped hands to prevent excessive intake.

Opium smoking began in India only in the 19th century and remained less popular than oral consumption. It was restricted almost completely to the under-privileged and was considered more difficult to give up than oral intake. Some people who ate opium smoked it occasionally too. Excessive smokers often resorted to begging or thefts to finance the habit. People often gathered in opium dens and participated in preparing opium preparations called "*madak*" and "*chandu*" by heating opium and then smoking it at leisure. They would squat on the floor together; no social distinctions were apparent in the opium dens.

The addictive effect of opium was recognized quite early and the British Government in India appointed a Royal Opium Commission in 1893 to enquire into circumstances connected with its production and use. The Commission concluded that regular opium use was limited, mostly in moderation with no obvious ill effects and the medicinal and non-medicinal use of opium was often intertwined. Opium was socially accepted by Hindus and Muslims who

censured the use of alcohol, and prohibition was considered unnecessary.

However, the public soon started recognizing the harmful effects of opium and the policy faced criticism both nationally and internationally. In 1949, the All India Opium Conference launched a 10-year programme to eliminate non-medical use of opium by 1959. Habitual users were registered in governmental depots for dispensing opium, akin to the methadone maintenance clinics operating currently in many countries. The total number of registered opium addicts in 1959 was 4,32,609. It fell to 80,000 in 1975 (Ministry of Health and Family Welfare, 1977), suggesting a decline in opium use as new registrations were very few.

However opium use continues in different degrees in various parts of India and conventional patterns of use often persist. A recent study of opium users in villages in Rajasthan found that opium use usually took place in gatherings of middle aged men in the village. Most users were well accepted in the society and remained untouched by law enforcement (Ganguly, Sharma and Krishnamachari, 1995). In another study of opium addicts in Gujarat, "Bhandhani" was a term used as a mark of respect accorded to a person who could consume opium in large quantities. No negative social impact of opium use was detectable in most cases (Charles et al., 1994).

In Sri Lanka, following prohibition (1935), opium use dwindled and was confined to the older population who had acquired the habit earlier. The estimated number of addicts in the 1980s was about 3000 - 5000 only (Gunatillake, 1985). Bangladesh had legal opium vends which were closed only in 1984. In Nepal, following a ban on the cultivation, import and consumption of opium (1976), most of the opium users probably shifted to heroin. The pro-heroin effect of anti-opium laws in Asia have been a subject of debate and the transition from opium to heroin use has been discussed in **Box Item-9**.

COCAINE

The coca plant does not grow in India and cocaine was first smuggled into the country towards the end of the 19th century. Cocaine use spread in Bihar, Bengal, Uttar Pradesh and Punjab along the railway lines to the bigger towns. South India remained relatively untouched. It was eaten with betel leaf (*paan*) in India and distribution was through *paan*-sellers. About half-a-million people from different strata used cocaine, but the lower class was worst affected. Its use was usually initiated by association with addicts. It was also often linked to prostitution due to its reputation of being an aphrodisiac. Cocaine users were considered to be of low morality and capable of criminal activities for drug procurement. The extent and magnitude of the cocaine problem in India triggered enforcement by excise authorities which succeeded in curbing the problem by the 1950s. Although cocaine was extensively used for more than fifty years in India, its use was never really interwoven into the cultural fabric of the country unlike opium and cannabis use.

OTHER DRUGS

In Maldives, certain species of wild berries and weeds called "Oshmi", "Vinaahi" and "Binhima" were used for their hallucinogenic effects (Shareef, 1997 - personal communication).

In conclusion, traditional opium and cannabis use as it existed in the region illustrates a few important points. Firstly, use of safer routes of administration, lower potency preparations, ritualized drug-taking in social gatherings, social acceptance of moderate use and censuring of excessive use seem to have provided checks to prevent drug use from becoming a major social problem. It had the advantage of several generations of experience and informal, built-in societal controls. Secondly, though the extent of drug use in the region triggered legislation, conventional patterns of drug use still exist. Lastly, new patterns of use of traditional drugs are emerging and there is an increasing convergence with drug use patterns in the western world.

REFERENCES:

1. Charles, M., E.J. Masihi, H.Y. Siddiqui, S.V. Jogarao, H.D'Lima, V. Mehta and G. Britto 1994. 'Culture, Drug Abuse and Some Reflections on the Family'. *Bulletin on Narcotics,* 46 (1): 67-86.

2. Chopra, R.N. and I.C. Chopra (1965). *Drug Addiction with Special Reference to India.* New Delhi: Council of Scientific and Industrial Research.

3. Ganguly, K.K., H.K. Sharma and K.A.V.R. Krishnamachari (1995). 'An Ethnographic Account of Opium Consumers of Rajasthan (India): Socio-Medical Perspective'. *Addiction,* 90: 9-12.

4. Gunatillake, P.D.P. (1985). 'Drug Abuse and Control Status: Sri Lanka'. In D.Mohan, H.S. Sethi and E.Tongue (Eds), *Current Research in Drug Abuse in India,* New Delhi: Jaypee Brothers.

5. Kalant, O.J. (1972). 'Report of the Indian Hemp Drugs Commission, 1893-94: A Critical Review'. *International Journal of Addiction,* 7(1) 177-96.

6. Mendis, H.A.S. (1997). 'Sri Lanka - Country Report'. Presented at SAARC meeting on Relapse Prevention and Management, September 21-24, New Delhi.

7. Ministry of Health and Family Welfare (1977). *Drug Abuse in India - Report of the Committee appointed by Government of India.* New Delhi: Ministry of Health and Family Welfare, Government of India.

8. Mohan, D., H.S. Sethi and E. Tongue (Eds) (1981). *Current Research of Drug Abuse in India*. New Delhi: Gemini Press.

9. Shareef, A. (1997). 'Maldives - Country Report'. Presented at SAARC meeting on Relapse Prevention and Management, September 21-24, New Delhi.

10. Subba, C. (1988). 'Drugs and Drug Addiction in Nepal'. In B. Bhandari and H.P. Sarmah (Eds), *Drug Abuse in Nepal.* Kathmandu: Drug Abuse Prevention Association Nepal.

BOX ITEM - 9

TRANSITION FROM TRADITIONAL OPIUM USE TO HEROIN USE: INDIA AND ITS NEIGHBOURHOOD

Anirudh Deshpande

USE OF OPIUM AND THE COLONIAL PERIOD

Many ancient and medieval societies used opium for analgesic, therapeutic and recreational purposes. Well into the late 19th century and until the late 1970s, drinking and smoking opium had a well-defined place in the South Asian region. Opium use, like the use of *bhang* and *ganja* (cannabis) was simultaneously socially accepted and regulated. Opium also played an important role in newly urbanizing societies (Westermeyer, 1974). In India, the British promoted the cultivation of opium in the 19th century to meet the demand from their lucrative opium trade with China. The colonial authorities also used opium as a cash crop to further their commercial and financial interests, in countries like Sri Lanka and the Philippines (Jayasuriya, 1986).

However, due to causes that cannot be detailed here, opium addiction in India never assumed the proportions that were seen in China and South East Asia. In the post-1945 decades, Hongkong, Thailand and Laos passed strict anti-opium laws. Westermeyer (1976) studied these laws and came to the conclusion that by driving opium underground, these laws have assisted the transition from opium to heroin among erstwhile opium addicts. In Pakistan a similar process can be seen.

THE CONTEMPORARY OPIUM AND HEROIN SCENARIO

As of 1997, the Government of India allowed poppy cultivation on about 13,000 hectares in selected areas keeping in mind the medicinal requirement of opium. The peasants growing this poppy on licensed farms are supposed to sell their entire crop to the Government's agency, Central Bureau of Narcotics (CBN), but many do not comply and sell licit opium clandestinely to consumers, traffickers and producers of heroin (*National Master Plan*, India, 1994). Most of this diverted poppy is consumed illegally in India while some is converted to heroin in rudimentary factories. Illicit opium cultivation in certain other states has also been reported and its spread to other areas cannot be ruled out.

Some experts believe that due to liberalization of gold and silver imports in India in the 1990s, smugglers have shifted towards heroin as a source of large profit. As a consequence, heroin is being smuggled into India for both local consumption and illicit re-export *(The Weekend Observer,* 1997). In the 1980s India became a "user country", from being primarily a transit country. Thus the contemporary opium and heroin scenario in India, as elsewhere in the subcontinent, is replete with harmful socio-political potentialities. The transition from traditional opium use to heroin use should be reviewed in this context.

THE CHOICE OF HEROIN

Except for geographical availability, little distinguishes the causes of heroin addiction. The transition to heroin in societies accustomed to traditional and other uses of opium is based on the modern demand for and supply of heroin.

Studies suggest that in countries where opium is cultivated either legally or illegally the transition to heroin is probably easier. This has been the case with Laos, Thailand, Myanmar, Afghanistan and Pakistan. In chiefly transit countries like India, where poppy is grown but strictly regulated, and Sri Lanka, where opium use is tightly controlled by government agencies, heroin use has grown since the 1980s. Most governments try to strictly regulate the cultivation of licit opium, but the spillover of licit opium into illicit heroin production cannot be easily stopped.

There are obvious reasons why drug producers concentrate on the conversion of opium into heroin once the demand for it is established. *The first is the unusually high potency and profitability of heroin as a drug and commodity of smuggling*. Heroin has a higher value per unit weight as compared with opium. (UNDCP, 1997). It dissolves easily in water and can also be absorbed by consumers in many ways such as "chasing the dragon". When injected, it penetrates the brain barrier much more swiftly than morphine. Heroin is highly addictive and for most people tolerance develops in a matter of three or four days, after which progressively larger amounts must be used to get similar effects. This enhances the profitability of heroin trafficking. According to one study if half a million addicts each use 50 mg heroin daily only 25 kg a day will be required for them, that is, "an amount that can be carried easily in a few briefcases" (Goldstein, 1976). Further the

profits of the heroin market are astronomical enough to statistically undermine the importance of heroin seizures made and reported by enforcement agencies. In short, smugglers can easily afford to lose substantial quantities as long as they get sufficient doses through.

Opium is bulky, has a characteristic tell-tale odour and is therefore difficult to store for long periods. When smoked it emits a strong unmistakable odour, making it difficult to consume it illicitly. In comparison, heroin has several "advantages" — it is almost odourless and can be packed in precise doses. It has a long shelf life, is not bulky and can be used with a "minimum of paraphernalia" (Westermeyer, 1976). This easily makes it the preferred drug for hidden use among opiate addicts.

However, it should be realized that growing heroin addiction is above all, a social problem. Research clearly proves that drug abuse increases due to such factors as unemployment, poverty, family problems, stress and strains of modern life, peer pressure, curiosity and experimentation. Rise of drug dependence is a sign of the breakdown of social cohesion and moral values (*Five Year Strategic Plan*, Bangladesh, 1995). This seems to be happening on a significant scale in the Indian subcontinent where states have failed in their mission to provide prosperity to the vast majority of their people. In Nepal, the transition from socially accepted cannabis use to heroin use occurred mostly among unemployed and underemployed youth (*National Master Plan*, Nepal, 1992).

When countries experience systemic political and economic transition, the breakdown of social norms creates abnormal levels of social alienation and anomie (UNDCP, 1997). The traditional ways of containing personal and social estrangement are often replaced by unbridled individualism, unhealthy competition and loneliness especially in a slum dominated urban milieu. These gradually lead to the formidable combination of urban despair and heroin addiction. Market forces are swiftly tearing down the safety nets of an older system and a defensive state is spending less on education, health and social welfare. This expands the base of addiction and adversely affects the drive against drugs simultaneously.

Conclusion

Colonial rule, industrialization, urbanization and modernization in some Asian countries have laid down the socio-economic and psychological foundations of contemporary opiate addiction. Heroin (diamorphine) was developed in 1896 and originally launched as a non-addictive narcotic in this context. It turned out to be highly addictive. In the post-Second World War period, and specially since the late 1960s, it spread rapidly to several parts of the world due to its nexus with a wave of youthful anti-establishment rebellion, tourism, terrorism and socio-political instability.

Often this spread was accompanied by the anti-narcotic efforts of governments across Asia and there is reason to believe that in some societies the transition to heroin addiction occurred when opium became an illicit commodity. But this does not mean that societies facing heroin addiction should go back to legal opium use. That cannot and should not happen because societies cannot re-establish traditions erased by historical advance. In countries like India for instance, where licit opium leaks into illicit opiate production, the heroin problem for society and enforcement agencies can become immense in the near future if solutions are not found soon. It is true that heroin abuse is fairly widespread in societies that have a tradition of opium use in the same way that cocaine is popular in parts of the American continent. However in the Indian subcontinent drug addiction *per se*, compared with socially sanctioned use for religious or medical purposes, was socially looked down upon.

But alongside heroin, drug consumers have a variety of licit and illicit products, including medicines, nicotine and alcohol, to choose from in our industrial and urbanizing civilization. The most significant consequence of spreading heroin addiction in the case of resource-starved developing countries is the creation of a "heroin-industrial complex requiring capital, management, chemicals, supply, equipment and increased profits". (*National Master Plan*, Bangladesh, 1991). This, in combination with state corruption, underdevelopment, uneven development and social strife, creates the sort of drug scenario prevalent in countries like Afghanistan and Myanmar.

On the other hand, countries like Japan, China and South Korea have successfully implemented anti-opium laws with the help of an efficient health care system, rehabilitation and employment programmes, social will and competent state intervention. The rest of Asia has to accept that there can be no preferences in the eradication of drug addiction. The traditional abuse of opium or any other substance for that matter cannot be preferred to heroin addiction, for example. The region can then go on to draw lessons from these determined countries.

References:

1. *Five Year Strategic Plan* (1995), Bangladesh.

2. Goldstein, A. (1976). 'Heroin Addiction: Sequential Treatment Employing Pharmacologic Supports'. *Archives of General Psychiatry*, Vol. 33.

3. Jayasuriya, D.C. (1986). *Narcotics and Drugs in Sri Lanka: Socio-Legal Dimensions.* Nawala, Sri Lanka: Asian Pathfinder Publishers and Booksellers.

4. *National Master Plan* (1991), Bangladesh.

5. *National Master Plan,* Draft (1994), India.

6. *National Master Plan* (1992), Nepal.

7. *The Weekend Observer,* November 8, 1997.

8. Westermeyer, J. (1974). 'Opium Dens: A Social Resource for Addicts in Laos'. *Archives of General Psychiatry,* Vol. 31.

9. Westermeyer, J. (1976). 'The Pro-Heroin Effects of Anti-Opium Laws in Asia'. *Archives of General Psychiatry,* Vol. 33.

10. UNDCP (1997). *World Drug Report*. New York: Oxford University Press.