

INDIA LAW & POLICY UPDATE

2012

In collaboration with Indian Harm Reduction Network and Lawyers Collective HIV/AIDS Unit, supported by Open Society Foundation



India Law and Policy Update

By ASIAN HARM REDUCTION NETWORK & Partners

Current situation

International Treaties

India has signed and ratified the three international conventions on narcotic substances: The Single Convention on Narcotic Drugs (1961), the Convention on Psychotropic Substances (1971), and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988). Domestic drug laws have been drafted to comply with international conventions.

Constitution of India

Drug consumption and treatment is arguably most broadly addressed by the Constitution of India. Addressing the role of the State in public health, Article 47 reads:

“The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.”

Article 21 of the Constitution guarantees protection of life and personal liberty to every citizen. The Supreme Court has held that the right to live with human dignity, enshrined in Article 21, derives from the directive principles of state policy and therefore includes protection of health¹. Further, it has also been held that the right to health is integral to the right to life and the government has a constitutional obligation to provide health facilities².

¹Bandhua Mukti Morcha v. Union of India (AIR 1984 SC 802).

² State of Punjab v. Mohinder Singh Chawla (1997) 2 SCC 83.

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Narcotic Drugs and Psychotropic Substances Act (1985), s. 31(A).
4 ibid, s. 64.
5 Juvenile Justice Act (2000), s. 25.
6 Drug information sheet Compiled by P.V. Subba Rao, Joint Director, published by V.K. Singh Kushwah, Additional Director General, National Academy of Customs, Excise and Narcotics, Sector 29 Faridabad

Harm reduction programs, which improve public health while reducing the use of drugs and also has been proven to substantially contribute in reducing morbidity and mortality caused by use of intoxicating drugs, should arguably fall under the scope of both these Articles.

Narcotic Drugs and Psychotropic Substances Act (NDPS Act)

First passed in 1985 and later amended in 1988 and 2001, the NDPS Act is the chief law regulating issues related to the production, cultivation, consumption, and distribution of narcotic substances. The NDPS Act determines punishments associated with drug offenses based on the narcotic's category, type, and quantity. Three categories of quantity are recognized: small, between small and commercial, and commercial. As the Act currently stands, 'quantity' is defined by the weight, not purity, of the whole substance. Generally, convictions for small quantities can include a prison sentence of up to six months and a possible fine of up to 10,000 INR (*USD 179*). 'In-between' quantities garner prison terms of up to ten years and/or fines up to 100,000 INR. Commercial convictions often carry prison terms of a minimum of 10 years and/or fines of over 100,000 INR. Subsequent offenses under the NDPS Act receive increased punishments, including the death penalty for certain drug crimes.³

The Act further defines the conditions under which different law enforcement and government departments may detain, search, seize, and make arrests for narcotics-related offences. Importantly, while punishments for various offenses are elucidated under the NDPS Act, drug users facing charges of possession and consumption of small quantities can, according to the act, receive immunity from prosecution if they agree to attend and successfully complete drug treatment (de-addiction) programs.⁴

A number of common narcotics, their defined quantities, and associated punishments, as defined in the NDPS Act, are listed in the following table⁵:

OFFENCE	PENALTY
Cultivation of opium, cannabis or coca plants without license	R.I./Rigorous imprisonment-up to 10 years + fine up to Rs.1 lakh (1 Lakh = 100,000)
Embezzlement of opium by licensed farmer	R.I.10 to 20 years + fine Rs. 1 to 2 lakhs (Regardless of the quantity)
Production, manufacture, possession, sale, purchase, transport, import inter-export inter-state or use of drugs	Small quantity - R.I. up to 6 months or fine up to Rs. 10,000 or both More than small quantity but less than commercial quantity - R.I. 10 to 20 years + fine Rs. 1 to 2 Lakhs Commercial quantity
Import, export or transshipment of narcotic drugs and psychotropic substances	Same as above
External dealings in NDPS - i.e.,engaging in or controlling trade whereby drugs are obtained from outside India and supplied to a person outside india	R.I. 10 to 20 years + fine of Rs. 1 to 2 lakhs (Regardless of the quantity)
Knowingly allowing one's premises to be used for committing an offence	Same as for the offence
Violations pertaining to controlled substances (precursors)	R.I. upto 10 years + fine Rs. 1 to 2 lakhs
Financing traffic and harbouring offenders	R.I. 10 to 20 years + fine Rs. 1 to 2 lakhs
Attempts, abetment and criminal conspiracy	Same as for the offence
Preparation to commit an offence	Half the punishment for the offence
Repeat offence	One and half times the punishment for the offence. Death penalty in some cases.
Consumption of drugs Cocaine, morphine, heroin	R.I. up to 1 year or fine up to Rs. 20,000 or both Other drugs-Imprisonment up to 6 months or fine up to Rs. 10,000 or both. <i>Addicts (Read: PWUD-People who use drugs) volunteering for treatment enjoy immunity from prosecution</i>
Punishment for violations not elsewhere specified	Imprisonment up to six months or fine or both

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Ministry of Finance, Department of Revenue. National Policy on Narcotic Drugs and Psychotropic Substances (2012), s. 70.

National AIDS Prevention and Control Policy

The National AIDS Control Organization (NACO) is responsible for HIV/AIDS programming in India. While the Ministry for Social Justice and Empowerment (MSJE) holds the mandate for reducing narcotics demand, most harm reduction programs, such as needle and syringe exchange programs (NSP) or opioid substitution therapy (OST) are run under the auspices of HIV/AIDS prevention and are thus under the jurisdiction of NACO. In 2002 the National AIDS Prevention and Control Policy (NAPCP) was approved, emphasizing the needs to recognize human rights within public health. The NAPCP clearly endorses and supports harm reduction interventions such as needle exchange and created separate approach for addressing HIV/AIDS amongst people who inject drugs (PWID). It is important to note that healthcare in India is under the jurisdiction of the state. While NACO can create policy and make strong suggestions for programs and services, healthcare policy and implementations are ultimately left up to the state, as enshrined under the articles 21 and 47 of the Indian Constitution. This often has the potential to lead to miscommunication, disorientation and incoherence as the epidemics come directly under purview of the central government.

National AIDS Control Policy (NACP)

Harm reduction is unequivocally supported by NACO and is clearly employed as a strategy to reduce HIV/AIDS prevalence. NACO's operations are guided by the National AIDS Control Program (NACP), a strategic framework covering the organization's priorities and interventions for a five-year period. NACO is currently concluding NACP III (2007-2011), which was recently extended for a number of months as preparations for NACP IV are finalized. Under NACP III, programs targeting high-risk groups, including injecting drug users (IDU), were been expanded. NACP III provides guidelines for targeted interventions (TI) for a number of high risk groups (HRG): Female sex workers, men who have sex with men, and IDU. Activities under NACP III's TI for IDU include

needle and syringe exchange programs and scaling up opioid substitution therapy (OST). Targeted interventions are implemented both through partnerships with local non governmental and community-based organizations and linkages with local community health services. Article 21, 41 and 47 of the Indian Constitution impose an obligation on the State to safeguard the right to life, and provide medical care and treatment for every person, including PWUD. NACO must therefore clearly mention of such obligation in its NACP and the failure to do by the State is violation of a person's right to life.

Juvenile Justice (Care and Protection of Children) Act

The Juvenile Justice Act of 2000 governs the framework for all matters concerning youth justice issues. Children found violating the NDPS Act are referred to the Juvenile Justice Board. Under the Juvenile Justice Act, "whoever gives, or causes to be given" narcotic drugs or psychotropic substances is subject to imprisonment or a fine. While this is ostensibly to prevent children from accessing illegal substances, it could also have implications for organizations providing opioid substitution therapy to children and youth, opening them to prosecution under the Act and reducing the likelihood of intervention services for this sub-population in general.⁶

Recent developments

New National Policy on Narcotic Drugs and Psychotropic Substances

In February 2012, the Ministry of Revenue introduced the New National Policy on Narcotic Drugs and Psychotropic Substances. Approved by the Union Cabinet in January, the policy claims to address a dissonance found between the many ministries that have a mandate related to drug consumption. With regards to harm reduction, the Ministry of Revenue emphasizes the need to employ such strategies only to the extent that they help to de-addict PWUD. While allowing for the continuation of NSP and OST programs (including both buprenorphine and methadone), the policy rejects the establishment of shooting galleries and harm reduction programs in prisons. Of further concern is its insistence that

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*"If drugs for oral consumption or drug paraphernalia (such as syringes) are distributed freely on the streets, it will be seen as an official sanction and patronage to drug addiction and can promote drug addiction. If any NGO or person is allowed to promote 'harm reduction', there is a great risk of it being used as a cover to actually push drugs or promote them. Hence, harm reduction will be allowed only as a step towards de-addiction and not otherwise."*⁷

The policy further threatens organizations providing harm reduction services. According to Section 73, only centers in hospitals and those "supported by or recognized by the Central Government or any State Government" may provide harm reduction treatments.⁸ Any other organizations will be "treated as abetting consumption of drugs."⁹ The policy also requires that centers offering harm reduction keep records of those seeking services. In addition to its focus on drug consumption and treatment, the policy provides prescriptions for handling the large illicit cultivation of opium poppy in India and proposes the production of concentrate of poppy straw and low or no-alkaloid poppy varieties so as to keep up with demand for legal opium substances while discouraging the expansion of illicit production and cultivation.¹⁰

Mandatory death penalty for repeat drug-related offenses overturned

Following a case brought by the Lawyers Collective and IHRN, the Bombay High Court overturned the mandatory death sentence for repeat offenses of certain narcotics crimes in June 2011. However, it refrained from overturning the law in its entirety, focusing instead on the *mandatory* nature of the death penalty. Judges may still sentence repeat offenders to death but are no longer legally obligated to do so. In response to the ruling, Finance Minister Pranab Mukherjee recently announced a proposal to change the NDPS Act in accordance with the ruling. If the changes are implemented, "shall be punishable with death" will be replaced with "may be punishable with death" in Section 31A of the

NDPS Act.^{11 12} Some activists, including Anand Grover, the Lawyer's Collective attorney who argued the case and the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, are dissatisfied with this development, feeling it reflects not a desire for justice, but rather an effort to prevent further challenges to the death penalty for drug-related cases. Indeed, after years of almost no death sentences handed down under the existing NDPS (until this year there were only two persons on death row for drug-related crimes), two more individuals have been sentenced to execution in 2012 alone.^{13 14}

Ongoing changes to the NDPS Act

The government is currently reviewing possible changes to the existing NDPS Act. In September of last year, the NDPS (Amendment) Bill was introduced in the lower house of Parliament, the Lok Sabha, and is currently being considered by the Parliamentary Standing Committee on Finance.¹⁵ In addition to the changes to mandatory death sentencing described above, proposals include inserting phrasing that emphasizes that quantities of narcotics are based on preparations and not purity, limiting prison sentences for consumers to six months, expanding the scope of illegally acquired property, and including 'management' in the scope of government treatment centers.¹⁶ While the bill makes some improvement by limiting prison sentences for consumers to six months from the current maximum of one year, it does little to address the more fundamental flaws of the existing NDPS Act. Drug consumers and drug dependants can still be treated as criminals, and the ambiguous wording around treatment in the current Act - including a requirement that only drug *addicts* can receive treatment instead of punishment - will go unchanged. Further concerns have been raised about the regulation of treatment centers.¹⁷ With private treatment centers currently beyond the scope of existing regulation, quality varies widely, with numerous accusations of substandard treatment, including physical abuse. This situation would remain unchanged based on currently proposed amendments.

⁷ *Ibid.*, s. 73(d), ⁸*ibid.*, s. 15, 16, 19; ¹⁰ NDPS Act (1985), s. 31(A).

¹¹ *Hindustan Times* (2012 May 8). *Govt may relax 'death penalty' clause under Narcotics Act.*

¹² Grover, A. and Lines, R. (2012 February 23). *Say NO to death for drugs. The Hindu.*

¹³ Sharma, A. (2012 March 27). *Drug dealer on death row. The Times of India.*

¹⁴ <http://www.lawyerscollective.org/vulnerable-communities/drug-use/ndps-amendment-bill-2011.html>

¹⁵ *The Narcotic Drugs and Psychotropic Substances (Amendment) Bill, (2011).*

¹⁶ The Lawyers Collective. *Re: Comments on the Narcotic Drugs and Psychotropic Substances (Amendment) Bill, 2011.*

¹⁷ UNGASS. (2010). *Country progress report: India*, p. 72.

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¹⁹Sinha, K. (2012 March 24). Plan panel bats for merger of AIDS control with NRHM. *The Times of India*.
²⁰Ibid.

²¹Nabi Azad, G. (2011 July 5). Five yrs on, HIV Bill's fate in a limbo. *The Times of India*.

²²Ministry of Law and Justice. *The HIV/AIDS Bill. (2007)*, s. 21.

²³Lawyers Collective. (2009 April 22). Court admits pleas for scientific and human rights standards for drug dependence treatment. Retrieved from

NACP IV

Though initially intended to begin in April 2012, the next round of the National AIDS Control Programme (NACP IV) has been postponed, likely until the end of the year. Civil society groups were last year highly critical of the drafting process, condemning a perceived lack of transparency and exclusion of civil society and community based groups in the consultation process. While they have since been included in the planning process, there is still a high level of uncertainty surrounding the next five-year plan. Importantly, NACP IV will include a drastic shift in funding, with nearly 80% of the upcoming program funded by domestic sources and World Bank loans. This contrasts greatly with previous funding for HIV/AIDS initiatives - according to the 2010 UNGASS Country Progress Report, external aid accounted for 69% of the NACP III budget.¹⁸ Domestic funding accounted for less than 5% of NACO's budget.¹⁹ Some stakeholders have raised concerns that under NACP IV, the mandate of NACO will be increasingly merged with that of the National Rural Health Missions (NRHM). Though opposed by both NACO and the Ministry of Health, a merger between the two, was proposed by the Planning Commission earlier this year.²⁰ Many are concerned that the transfer of competencies from a vertical organization like NACO to a comprehensive program such as NRHM would have a drastic effect on program quality. Critics fear that the lack of capacity and familiarity with the sensitive issues surrounding HIV/AIDS will markedly affect services. It appears that at least those programs most affecting PWUD, targeted interventions, will likely stay under control of NACO for the time being.

HIV Bill

Drafted in 2006 by the Lawyers Collective and the Ministry of Health, the HIV/AIDS Bill is essential to protecting the health and human rights of people living with HIV/AIDS in India. As it was drafted, the HIV/AIDS Bill would make discrimination based on HIV/AIDS status illegal. In the past five years, however, it has

largely stalled within the government and is currently stuck between two ministries: The Ministry of Health and the Law Ministry. According to Anand Grover, founder of the Lawyer's Collective and one of the drafters of the bill, the Ministry of Health has resisted the inclusion of a provision guaranteeing free access to treatment, one of the key provisions of the bill.²¹ The bill would also protect harm reduction interventions and their recipients from prosecution for their actions.²² While the fate of the bill remains uncertain, the need for such legislation is unambiguously clear.

Rehabilitation centers

Despite the overwhelming government support for de-addiction over long-term harm reduction maintenance, the number of drug treatment or rehabilitation centers is far less than demand. While both the Ministry of Social Justice and Empowerment - *responsible for demand reduction* - and the Ministry of Health both run de-addiction centers, the absence of an adequate number of facilities has led to the proliferation of private rehabilitation centers. This is of great concern as regulation for private drug treatment centers is virtually nonexistent, leading to numerous cases of abuse and even torture in the name of treatment. Following the death of a drug user while in the care of one such facility, the NGO SHARAN, along with the Lawyer's Collective, brought a case against the state, *Talwinder Pal Singh v. State of Punjab* in 2008. The outcome of the case has mandated certain standards for drug treatment centers in the state, including adequate levels of sanitation, medical treatment, and family visits. Centers must be inspected and receive approval by the state in order to operate.²³ Nevertheless, such rulings remain the exception rather than the rule. Most centers continue to operate unregulated, with deplorable practices and failed results.

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