

**MALDIVES
DRUG CONTROL MASTER PLAN 2006-2010**



National Narcotics Control Bureau



UNITED NATIONS
Office on Drugs and Crime

MALDIVES DRUG CONTROL MASTER PLAN 2006-2010

NATIONAL NARCOTICS CONTROL BUREAU



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FOREWORD

Illicit drugs are a global impediment to the social and economic development of nations. The impact of the drug scourge has been particularly severe on the Maldives, threatening her prosperity, good health, and indeed her whole future.

In the past decade we have intensified our efforts to stop the drug menace. But we, as a nation, need to do even more to ensure that criminals, who put their own interests before those of the nation, do not take our common heritage away from us.

The lesson we learn from other countries is that drug abuse is a hydra-like multifaceted issue. It requires a balanced well-coordinated multi-sectoral approach, encompassing measures to stop illicit drugs from entering the country and to reduce the demand for them. Both these aspects are equally important and need to be given the same, high priority.

We, therefore, call upon all Maldivians, as indeed the international community, to support fully the efforts of the Government to eradicate the scourge of illicit drugs from the Maldives and beyond our borders. This is the challenge and we must commit ourselves to this challenge.



ACKNOWLEDGMENTS

The drug control sector has developed steadily since the establishment of the Narcotics Control Board in 1997. It has attained significant milestones in terms of infrastructure and human resource development as well as program delivery. However, the absence of a Master Plan has made it increasingly difficult to streamline the development of the sector and direct the efforts of the multitude of all relevant government and non governmental organizations towards a unified goal.

The DCMP is the result of hard work by the staff of NNCB, other government organizations, UN agencies, NGOs and numerous private individuals, whose list is too long to reproduce here. However special mention must be made of Mr. Bjorn Franzen, UNODC consultant, and Ms. Shaffa Hameed who undertook the difficult task of compiling the inputs from various contributors and developing the draft Master Plan. I would also like to thank UNODC for supporting the Master Plan exercise.

Dr. Abdullah Waheed



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ACRONYMS AND ABBREVIATIONS

DR	Demand Reduction
DRC	Drug Rehabilitation Centre
GoM	Government of Maldives
MPS	Maldives Police Service
NNCB	National Narcotics Control Bureau
NSS	National Security Service
RSA	Rapid Situation Assessment
SR	Supply Reduction
UNFPA	United Nations Population Fund
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

EXECUTIVE SUMMARY

Drug abuse is a complex and multifaceted problem facing the whole nation, cutting across all age groups and social strata. Hardly a community or a family is free from its harmful effects.

In 2003, a Rapid Situation Assessment (RSA) revealed the seriousness of the situation and prompted the elaboration of this national master plan for drug control. Based on information from about 4,000 individuals, the RSA revealed that the most common drugs of initiation were heroin (43%) and cannabinoids (34%). The most commonly abused drug during the month preceding the survey were opioids (76%) and cannabinoids (12%).

The drug abuse habit started as early as 16.8 years of age. The overwhelming majority of the drug abusers were male (97%). Only 8% reported intravenous drug abuse. The interviewees gave several reasons for starting drugs, of which peer pressure was the most common followed by a desire to experiment.

The information revealed by the RSA provided much of the background information for this master plan. All indications are that the situation since the survey has worsened and today there is all round acknowledgement that drug abuse is the most serious problem facing the nation.

This is the Maldives' first national master plan for drug control. It is the result of a joint effort by a large number of ministries, departments, units and organizations within and outside the Government of the Maldives. The Masterplan exercise was coordinated by the National Narcotics Control Bureau (NNCB), with the support of the United Nations Office on Drugs and Crime (UNODC).

In preparation for the Master Plan a series of seminars were held with representatives from all walks of life, including administrators, law enforcement agencies, health workers, and educators. This was followed by in-depth discussions and interviews with heads of and representatives from a large number of government ministries, departments and units, as well as representatives from the non governmental organizations. Based on the suggestions, observations, opinions and other inputs, a discussion paper, encompassing main reasons for the current situation as well as recommended interventions, was elaborated and first presented at a meeting at the NNCB and then circulated to all relevant ministries, departments, units and organizations for their comments and suggestions.

The Masterplan is aimed at both coordinating and enhancing already on-going and planned activities as well as to add interventions where required. The overall responsibility for the implementation, management, monitoring, coordination and evaluation of all activities lies with the National Narcotics Control Bureau.

The interventions are grouped into six main areas:

- (1) Drug control management and coordination;
- (2) Laws, regulations and the judicial system;
- (3) Supply reduction / drug law enforcement;
- (4) Drug demand reduction;
- (5) Illicit drugs and corruption; and
- (6) Illicit drugs and money laundering.

The overall objective of the Master plan is to substantially control drugs by expanding the knowledge base, enhancing coordination and improving the management of activities to



significantly limit the supply of, as well as the demand for, illicit drugs in the country. The Master plan is built on the belief that the following fundamentals are prerequisite for successfully combating drug abuse:

1. Reliable, comprehensive data and information about all aspects of the problem, encompassing the drug abuse situation and the production and trafficking of illicit drugs;
2. Sufficient capacity, willingness and determination to successfully plan, initiate, manage, coordinate, evaluate all necessary interventions; and
3. Legal frameworks and a judicial system that are sufficient and capable of governing all interventions.

Drug control efforts are generally classified under two broad areas:

1. Supply reduction
2. Demand reduction

Supply reduction is further classified into two sub areas: production and trafficking. In the sub area of production, a key concern is the specific problem of precursors, and in both the areas, money laundering and corruption are major concerns.

Demand reduction interventions are divided into three sub areas:

1. Primary prevention, which is aimed at

preventing individuals from initiating to abuse drugs;

2. Secondary prevention, aimed at treating and rehabilitating addicts, and finally;
3. Tertiary prevention, aimed at reducing the harm of drug abuse the abusers as well as the surrounding society.

There are many actors in each main area of drug control. Supply reduction is mainly the task of drug law enforcement agencies such as special anti-narcotic forces, police, customs, immigration, coast guard, the army and others, depending on the specificities of the country.

The area of demand reduction is equally the responsibility of several government ministries and non-government and organizations including the ministries of health, education, social welfare, as well as youth, and NGOs working in the areas of sport, leisure, mass media, as well as those with a specific focus on drug control. Ministry of Justice and the judicial system in general have over-arching responsibilities covering the two main areas.

This multitude of actors and possible intervention areas has heightened the need for a comprehensive, multi-sectoral and forward looking national master plan for drug control.

Illustration 1:

NATIONAL MASTER PLAN FOR DRUG CONTROL											
Police	Customs	Immigration	Coast Guard	NSS	Justice Ministry	Attorney General	Health Ministry	Gender Ministry	Education Ministry	Mass Media	NGO, etc
Preventing Production and Trafficking Precursors, Money laundering, Corruption						Tertiary Prevention		Secondary Prevention		Primary Prevention	
SUPPLY REDUCTION						DEMAND REDUCTION					
KNOWLEDGE				CAPACITY				JUDICIAL SYSTEM			
Overall Coordination : NNCB											

1. GENERAL BACKGROUND

1.1. Country Context

Maldives –literally translated as the “Garland of Islands” –is an archipelago of 1,192 small palm-fringed coral islands surrounded by white sandy beaches, scattered across the equator in the Indian Ocean to the southwest of India and Sri Lanka. While the archipelago covers a vast expanse of sea measuring 823 km in length and 130 km width, the land area is only 300 square kilometres.

The chain of coral islands is grouped into 26 natural atolls. However, for easy administration the country is divided into 20 atolls. Among the islands, 199 are inhabited, while a further 100 are tourist resorts.

Maldives has a very humid climate with an average annual rainfall of 200 mm. The temperature ranges between 25 and 31 degrees Centigrade.

Historical records indicate that the Maldives has been continuously inhabited since the first immigrants –presumably Aryan –settled in the islands more than 5,000 years ago. A sea-faring nation for centuries, the Maldivian

culture has been moulded by its exposure to traders from as far as Arabia, Persia, China and East Africa.

Except for two brief periods of invasion and control by the Portuguese (1573) and South Indian Moplas (1752), Maldives has remained an independent state throughout its history. In 1887, it became a British protectorate and remained so till gaining full independence on 26 July 1965. In 1968, Maldives became a Republic with a Presidential system of governance.

All Maldivians adhere to the Sunni sect of Islam. Islamic Sharia law dictates civil laws and societal norms. The state language is Dhivehi, an Indo-Aryan language written in “Thaana” script.

1.2. Population and development

The total population of Maldives is 270,101 (Census 2000). The population structure and its dynamics have been changing rapidly in recent decades because of rapidly changing rates of population growth. The population grew at a very high rate of 3.2% per annum between 1977 and 1985 censuses. After reaching a peak of 3.4% per annum between 1985 and 1990, it came down to 2.8% in 1995 and further decreased to 1.96 % in 2004. Due to the high growth rate during the eighties, the population remains basically young with 41% of the population under the age of 15 years. Following the slowing of population growth in the 1990s, the percentage of children has been coming down. However, in the current decade when the largest ever birth cohort of the 1980s enters the reproductive age, the possibility of a baby boom is a distinct possibility.

The average life expectancy at birth is 73 years with 74 years for women and 73 years for men in 2002 (Maldives Health Report 2004). The steady increase in life expectancy has increased the percentage of the elderly population. Currently the elderly population over 65 is 6%. This together with the 41% below the age of 15 years gives a very high dependency ratio of 89 dependants per 100 people of working age.

The population of Maldives is unequally dis-



tributed among the islands. More than a quarter of the population (74,000) live in Male', the capital city of just 2 square kilometres, making it one of the most densely populated urban centres in the world with more than 37,000 persons per square kilometre. In addition, Male is also host to 29,000 expatriate workers, their dependants and a large floating population. Thus the capital island is severely over-crowded with an average household size of 8 (Statistical Yearbook 2002). While the city has gained the most from the rapid expansion in economic and social opportunities, the quality of life of its citizens is constrained by severe shortage of physical space, overcrowding, congestion and pollution.

The populations of other islands are relatively small, with only three islands having more than 5,000 population. 54 islands have populations between 1,000 and 5,000, and 66 have populations between 500 and 1,000, while 76 have less than 500 population (Statistical Yearbook 2002). Because of their small population, the remote islands remain deprived of basic amenities and incomes and remain poor and insecure.

The Vulnerability and Poverty Survey of 1998 revealed that almost 40 per cent of the rural population live below the income poverty line defined as RF 600 (around US\$ 50) per capita per month. Nearly 15 per cent of the country's population live on an income of less than RF 7.50 per day. Twenty-eight per cent of the atoll population get less than 12 hours of electricity per day. 40 per cent live on islands without a health centre, hospital or private clinic, while 12 per cent of the population have no access to safe water.

1.3. Macroeconomic situation

At the macroeconomic level, the Maldives faces the twin challenges of a narrow economic base and shortage of human resources. The Economy is dependent heavily on two sectors – tourism and fisheries. Furthermore, the small and scattered nature of settlements pose considerable dis-economies of scale; and the domestic market is too small to stimulate economic growth.

Despite these challenges, the Maldives has succeeded remarkably in its economic and social development. The Human Development Index (HDI –UNDP) places the Maldives at the 89th place among 174 countries. Its HDI of 0.725 is higher than the average for South

Asia (0.716) and South-East Asia and the Pacific (0.691).

Largely based on tourism, the economy registered a growth rate of 7.8 per cent in 2004 with a gross domestic product (GDP) per capita of US\$ 2,401 (Statistical Yearbook of Maldives 2005). This is the highest among South Asian countries and is almost 20 per cent higher than most developing countries. The expansion of the tourism, transport and telecommunications sectors contributed to the sustenance of this growth. Over 50% of public revenue is generated from tourism tax and other tourism related services.

Despite the remarkable GDP growth, the Maldives has not succeeded in translating this into employment generation and poverty elimination. The labour force participation rate was 54.8 in 2000. The unemployment rate was 2.0 %. Despite the unemployment, an increasingly large number of expatriates (over 40,000 at the end of 2005) are employed in the country, putting further pressure on the employment prospects of young Maldivians. Over 10,000 students leave school each year and join the job queue.

The Vulnerability and Poverty Assessment (VPA) of 1998 concluded that income poverty exists all over the country. It was estimated that there is a 15% prevalence of income poor in the Maldives earning about US\$ 0.65 per person per day.

1.4. Gender issues

Maldivian women are among the most emancipated in the Muslim world, as reflected in the country's Gender Related Development Index ranking of 69. However they face several disadvantages vis-à-vis their male counterparts.

Although the Constitution bars gender discrimination, in reality discriminatory practices pervade many aspects of the society. These include the areas of marriage and divorce, inheritance and judicial evidence. Other more abstract areas of subordination relate to perceptions held by the society at large concerning the domestic roles of women (Country Population Assessment 2001). Sexual abuse and domestic violence are among the lesser-reported social problems.

1.5. Education

The Maldives school system consists of government schools, and a few government supported private schools and community/ward schools. English is the primary medium of instruction. Children enter free compulsory primary education at the age of 6 years. They progress on to lower secondary education (grades 8-10) and higher secondary education (grades 11-12). Lower secondary education is now available in all atolls, and higher secondary education in nearly all atolls. Maldives College of Higher Education provides opportunities for higher education in some areas.

For youth and adults outside the formal education system, the Centre for Continuing Education (CCE), offers a condensed education program for skills development. University level education is very limited in the Maldives. For further education, Maldivians travel abroad either through personal funding or Government facilitated scholarships.

The Maldives has achieved notable successes in education such as universal primary school enrolment and an adult literacy rate of 98 per cent, which is comparable to the levels found in many developed countries. However significant gaps remain. Only a limited number of students get the opportunity to reach their full educational potential. Most students leaving school have neither job skills nor employment opportunities.

A major cause for concern is the number of students who drop out during or after the secondary level, especially after 15 years of age. The completion rate for secondary education (both sexes) was 33 per 1,000 in 1995. The dropout rate, contrary to the usual patterns in many developing countries, is slightly higher among males (Multiple Indicator Cluster Survey 2001).

1.6. Health

The health system is characterized by the central role of the government in the financing, provision and stewardship of health services. Government health services are supplemented by private clinics ranging from single doctor consultations to poly clinics with laboratory services and in-patient capacity. The system is further complemented by NGO's, a competitive pharmaceuticals market, traditional medicine to some extent and a major private tertiary hospital.

The government health system is organized as a vertical hierarchy; comprising of central, regional, atoll, sub-atoll and island level services. Ministry of Health (MOH) is the policy making body responsible for health planning and development. Administrative bodies under MOH include the Department of Public Health (DPH), Indira Gandhi Memorial Hospital (IGMH), the National Thalassaemia Centre (NTC), the Maldives Water and Sanitation Authority (MWSA) and the Public Health Laboratory (PHL).

DPH is responsible for prevention and control of communicable diseases and health promotion. With a capacity of 236 beds, IGMH is the main tertiary referral hospital. MWSA has the mandate of planning and regulating water and sanitation services. A joint venture company – Malé Water and Sewerage Company Limited – is responsible for water and sewage services in the capital island. The Public Health Laboratory ensures quality of food, water and drugs. It is also the national certifying authority for fish exports.

The Maldives College of Higher Education plays an important role in developing human resources for health. Its Faculty of Health Sci-

Table 1: Health Indicators (2003)

Indicator	value	Units
Infant Mortality Rate	14	Infant Deaths per 1000 Live Births
Child Mortality Rate	18	Child Deaths per 1000 Live Births
Crude Birth Rate	18	Births Per 1000 Population
Crude Death Rate	4	Deaths per 1000 Population
Maternal Mortality Rate	1	Per 1000 Live Births
Still Birth Rate	11	Per 1000 Live Births
Life Expectancy at Birth	73	Years

ences trains a large number of allied health professionals, including diploma level nurses, laboratory technicians, pharmacists, community health workers (CHW), family health workers (FHW) and trained birth attendants (TBA).

At the regional level, six regional hospitals are situated strategically within the country each covering two to five atolls. These hospitals provide curative services including the major specialities. For the curative services they are the first proper referral level.

Each atoll in the Maldives has a mini hospital that functions as the third tier of the health hierarchy. Atoll hospitals provide general consultation and laboratory services as well as health promotion and prevention. They are also equipped with an operation theatre to provide specialized obstetric services. In addition to the atoll hospital, most atolls also have sub-atoll health centres (the second tier of the hierarchy) providing basic curative services. At the island level, family health workers and traditional birth attendants provide very basic health services (first tier). They work either from island health posts or an annex of the island office.

Many NGOs and community groups work in the area of health promotion. Prominent health oriented NGOs include SHE, FASHAN, Care Society, Maldives Eye Society, Maldives Association for the Handicapped and Cancer and Diabetic Society. SHE concentrates mainly on reproductive health and thalassaemia, while FASHAN concentrates on adolescent health issues including HIV/AIDS, and Care Society works in the area of disabilities and mental health.

The Maldives has achieved remarkable success in its health indicators (see table 1). This is the result of the progress in the control of communicable disease, particularly the elimination of childhood diseases through universal immunization.

A notable success in the area of communicable diseases is the eradication of malaria from the country. Other successes include leprosy and filaria elimination. Tuberculosis and AIDS are also under control, while diarrhoeal diseases are on a declining trend. Despite these successes, some communicable diseases still remain to be controlled. These include acute respiratory infections, and dengue fever.

With increasing life expectancy, non communicable diseases are on the rise. Lifestyle-

related diseases, pose a major challenge to the health services. A large percentage of the inpatients in hospitals are admitted with ischemic heart diseases, cerebrovascular diseases and hypertensive diseases. The incidence of renal diseases, diabetes, gastrointestinal diseases and mental disorders is increasing. Cancers are also on the rise.

1.7. Social Context ***Marriage and divorce***

Traditionally, marriage and divorce procedures has been easy. Maldivians married early, divorced frequently and remarried frequently. Serial monogamy is accepted as the norm. Thus, kinship and family structures remained loose (Razee 2000).

Razee (2000) reviewed data from surveys on island women conducted in 1979 and 1991. Both surveys reveal that half of all women married at 15 years or younger. On average, a woman weds four partners, three of them by 30 years of age. The 1991 survey showed that 63 per cent of those married had two or more marriages. The census cohort analysis confirms similar findings and reports that Maldivian women have four marriages on average by the time they reach 50 years of age.

In practical terms, this means that many women spend a significant part of their life without a partner. Given both the instability of marriages and the large number of men working away from home, many of the households are headed by women. They are compelled to bring up children without the support of a partner. The extended family continues to play an important role in providing support to many single mothers and their children. This is especially crucial in urban areas where more women work outside the home.

This situation has improved to some extent with the country's rapid socioeconomic development, increased mobility, education and employment opportunities. The mean age of marriage (including re marriages) increased to 26.5 years in 2003 (calculated from data in Statistical Yearbook 2004). In that year the highest proportion of marriages took place among the 20-24 year age group (41 per cent), while the 15-19 age group accounted for 8.1%. The divorce rate has come down from 86 % of marriages in 1985 to 38 % of marriages in 2003 (calculated from data in Statistical Yearbooks). While polygamy is legal in the Maldives only 59 (5 per cent) polygamous marriages took place in 1998.

Mobile populations

Internal and external mobility is an integral component of the lifestyle of Maldivians, especially those living in Male'. Many Maldivians especially those from small islands travel and work in the capital or in tourist resorts. Most of them remain separated from their families. This leaves them vulnerable to stress, isolation and other psychological strains.

Sexual behaviour

Sexual relations outside marriage are prohibited in Islam and punishable under Sharia Law. Because of these legal implications, the real prevalence of extra-marital sex remains hidden. Ministry of Justice statistics show that convictions for adultery declined from 230 in 2000 to 181 in 2003 (Statistical Yearbook 2004).

Despite this, deviant forms of sexual behaviours are not entirely unknown in the Maldives. It is believed that some proportion

of young people experiment with sex before marriage. By the age of 21, many youngsters would have had sexual intercourse at least once (Jenkins 2000).

Other sexual behaviours such as homosexuality and commercial sex practices are also known to exist and cases of sexual abuse of children have also been recognized. Foreign and Maldivian sex workers can be found in Maldives, as a large number of national and international workers live away from their homes creating a pool of potential commercial sex clients.

Juvenile delinquency

There is concern about the growing problem of juvenile delinquency in Maldives. A total of 490 persons under the age of 20 were convicted in 2003 (Statistical Yearbook 2004). Most of these were for drug abuse, assault, theft and robbery. Drugs are closely linked to other crimes committed by young offenders.

1. DRUG ABUSE AND TRAFFICKING SITUATION

2.1 Geopolitical context

The Maldives is strategically located within easy reach of the golden triangle and the poppy fields along the Afghan-Pakistani border, where opiates (especially heroin) and cannabinoid derivatives are abundant. It is well connected to the outside world through its international airport and sea ports. Hence, the Maldives is potentially vulnerable for exploitation as a conduit for illegal transshipments of precursor chemicals and large consignments of drugs meant for other countries.

Drug abuse is widely prevalent in South Asia. Heroin abuse was first reported from Nepal in 1976, Sri Lanka in 1981 and India in 1986 (Drug Demand Reduction Report – South Asia 2000). Since then, abuse of various drugs has been commonly reported from all South Asian countries. Bangladesh, in a Rapid Assessment Survey in 1997 reported abuse of heroin, cannabis, cough syrups containing codeine, buprenorphine and sedatives. A similar Rapid Assessment Survey in India (Suresh and Ray 2002) covering 4,648 drug users reported that heroin, other opiates and cannabis were the most common drugs of abuse. Injecting drug use was observed in every one of the 14 sites of the survey throughout the country.

Nepal conducted a Rapid Assessment Survey in 1996, covering 573 drug users. Cannabis and codeine containing syrups were the most commonly abused drugs, followed by sedatives, buprenorphine and heroin. Sri Lanka reported a substantial problem with cannabis and heroin, and some reports of psychotropic drug abuse (Drug Demand Reduction Report – South Asia 2000). Alcohol abuse was commonly reported in all the countries.

2.2. Historical context

According to historical references, drug abuse has been prevalent in the Maldives for at least the last four centuries. Francois Pyard, a French historian and traveller, writing in 1619 hints that opium abuse was prevalent among Maldivians of his time. In more recent times, anecdotal evidence indicates the continued abuse of opium during the first half of 20th century. However it did not become a social issue till the modern context of growing drug abuse in the region.

Drug availability was formally identified in Maldives in the mid-1970s. Although this period coincided with the introduction of tour-

ism, there is no hard evidence to link the two. Further, the period also coincided with the introduction of drugs into other South Asian countries. Therefore it is equally –if not more –plausible that drugs came with young students returning from neighbouring countries. Subsequently, cannabis abuse (marijuana and

the drug abuse situation is worsening despite stringent drug laws, intensive efforts to prevent drug entry by several agencies (National Security Services, the police, Customs and others).

Alcohol consumption is prohibited in Maldives and punishable under Shari’ah law. Records of the Ministry of Justice between 2000 and 2003 indicate a very low and declining trend of alcohol abuse in the Maldives, with just 17 cases reported in 2003 (Statistical Yearbook 2004).

The seizure statistics from the Maldives Customs service show an increasing trend in seizures. Seizures were very low during

2002 (11.25 g of cannabis) and 2003 (14.84 g of cannabis, 26.44 g of heroin and 21 g of psychotropic substances). In 2004, seizures increased considerably (58.82 g of cannabis products, 461.65 g of heroin, 0.5 g of cocaine and 1.184 of psychotropic substances). The statistics for the first eight months of 2005 show a continuation of the rising trend with seizure of heroin (449.69 g) and cannabis products (0.48 g). All the seizures in 2005 have been made at the airport, while most drug addicts and drug law enforcement officers consider the main entry points to be the sea ports.

Table 2: Reported cases of drug abuse 1995 to 2004

Age Group	All ages	<16	16-24	25-39	40+
1997	200	16	118	65	1
1998	320	26	196	93	5
1999	208	15	118	70	4
2000	220	9	129	76	6
2001	216	2	123	87	4
2002	302	8	168	119	7
2003	125	1	80	40	3
2004	116	4	63	44	1

hashish) took root among the youth. Commonly reported substances since then have been hashish oil and heroin.

2.3. Current drug abuse and trafficking trends

It has not been easy to document the exact prevalence of drug abuse in the Maldives. Since any self confession of drug abuse could result in prosecution, not all addicts would reveal their true status. Thus only indirect and anecdotal evidence is available on the situation. In general, the observation is that drug abuse has become more open and visible on Male streets and even some cafes. There are also some instances of reported intravenous drug abuse.

Drug abuse is closely linked to the rising rate of thefts and robberies in the capital and other large islands. Jail authorities unofficially estimate an 80% prevalence of drug addiction among inmates.

Drug abuse in Maldives increased 40-fold between 1977 and 1995 (Jenkins 2000). Country papers at SAARC Symposia (Ahmed 1998, Shukoor 2001, Naaz 2002) report a very high percentage of young drug abusers between 15 and 25 years of age. Table 2 shows the increasing trend in cases of drug abuse reported to the police, which has increased from 200 in 1997 to 697 in 2004. It must however be pointed out that reported cases are merely the tip of the iceberg. All indications are that

2.4. Social/cultural determinants of substance abuse

Fast changing values and norms

Maldivians remained isolated and sheltered from the outside world till the last quarter of the 20th Century. With increased connectivity in transport and communications during the past two decades, they suddenly found themselves exposed to cultural forces ranging from the hip-hop culture of the West to the Wahhabi culture of the Middle East. Many young Maldivians remain torn between these two extremes.

Failure to regulate the rapid expansion of the economy has led to social disparity and deprivation. Since the islands are small, it is common to see unemployed poor youth living

side by side with extremely rich neighbours. The result is often a feeling of being "lost", particularly among the vulnerable youth. In order to escape this, many of them experiment with drugs, which have become a common denominator for a group that substitutes for the family and/or the school. A "we" and "they" situation has developed and new norms and values established that are different and opposed to what used to be acceptable and what parents and authorities still consider to be the only acceptable way. There is a growing concern that drug abuse is becoming more and more accepted and that this permissiveness is spreading and contributing to the current trend.

The new issues facing the youth, such as drugs and premarital sex, are new to the parents themselves. Unwittingly finding themselves in an unfamiliar situation, they lack the skills to guide their children. Children and the youth are left to test, experiment and find out for themselves. The old norm that parents talk and the children listen is gone and in many families the communication between parents and children has broken down.

Lack of coping skills in the "modern world"

Many youngsters lack the skills and knowledge needed to cope "in the new world". They also lack the guidance to find their way in this uncharted territory. Old role models like parents, uncles, teachers and elders are no longer considered 'in' and have been replaced with youth icons from the "modern world": actors, pop and film stars, sports heroes. The new idols often lack the kind of qualities and habits parents would like their children to emulate. Instead they are often seen on TV taking drugs, singing about the glory of violence and crime or bragging about their sexual adventures.

Family related problems

The families are also facing new problems due to the rapid transformation of the society. In many families one of the parents, often the father, is away working on another island. In the past, the fathers used to be out on the sea fishing but returned home for the night. Now they are away for longer periods working in resorts. The mothers are left alone to handle their, sometimes, rebellious teenagers.

In the capital itself, the social controls that helped to maintain norms and values have all

but disappeared. In the new and more cosmopolitan Male of today, neighbors prefer to look the other way when children misbehave. This is partly because the neighbors themselves have 'problem' children of their own and struggling with the issue of drug abuse within the family.

2.5. Job market related issues

The new world has also brought a new job market. Traditional jobs are not "cool" and therefore despised. Everyone wants to get a "white collar" job and become rich fast. A sense of failure can easily prevail when a youth fails to attain his/her over ambitious goals. Today's 'Jet set' has redefined quality of life in its own terms. Instead of seeking a harmonious, stable job that brings satisfaction, respect and a secure life, youngsters now look for opportunities that promise a lot of wealth no matter at what cost.

In sharp contrast to the ambitions of youngsters, available opportunities are few. There is a scarcity of jobs in general and "attractive" jobs in particular. This leaves an increasing number of youth as well as adults unemployed, with all the attending problems. Drug abuse can then become one way of coping with the situation, to escape the reality if only for the short duration the "drug high" lasts. For those initiated into drugs the temptation to earn "fast bucks" through drug dealing is immense, not only to pay for the habit, but also to acquire the riches they could not earn legally.

2.6. Drug abuse and crime

Increasing drug abuse has spawned other crimes in its wake, such as burglary, petty theft, and violence. It is this aspect of the drug problem that has led to increasing public frustration and disillusionment with the law enforcement agencies and their ability to cope with the drug situation. It is also the same aspect of the problem that has over stretched the limited resources of the law enforcement agencies.

The RSA reported that almost a third of the drug abusers were also involved in dealing in drugs and many admitted to stealing from their homes. Almost 80% of the prison inmates are, or have been drug abusers, adding several problems to the already difficult situation facing the penitentiary system, such as overcrowding and in discipline.

2.7. The relationship between drug abuse and disease

Observations on Drug Rehabilitation Centre clients point to direct and clear linkages between drug abuse and mental disorders such as depression. Systematic research is required to define the linkages and causative factors.

HIV/AIDS is not a major problem in the

Maldives and the few cases detected so far have not been linked to drugs in any way. There are, however, some recent indications that intravenous drug abuse might be on the increase. In addition, it is believed that drugs are sometimes used as an aphrodisiac and that drug users might adopt risky sexual behaviours, thereby increasing the risk of contracting AIDS. Heightened vigilance is therefore necessary to avoid the two problems from converging as in several other parts of the world.

3. NATIONAL RESPONSE: NORMATIVE AND INSTITUTIONAL FRAMEWORKS TO ADDRESS DRUG CONTROL IN THE COUNTRY

3.1. United Nations Drug Conventions

The Maldives is party to the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol, the Convention on Psychotropic Substances of 1971, Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988, as well as the Convention of the Rights of the Child.

3.2. Sub-regional cooperation

The Maldives drug law enforcement authorities liaise and cooperate actively with their colleagues in neighbouring countries as well as with the Interpol and the World Customs Organization. The GoM is also active in the South Asian Association for Regional Co-operation (SAARC) and has ratified the SAARC Convention on Narcotic Drugs and Psychotropic Substances, aimed at ensuring the proper implementation of the provisions of the 1988 UN Convention.

3.3. National Legislation

The principal legislative act of Maldives dealing with narcotic drugs and psychotropic substances is law number 17/77 as amended in 1995 and 2001. The 2001 amendments facilitated confidential interviewing with drug users for the purpose of research. Currently some key amendments to the law have been proposed, including the issues of precursors and money laundering. However, these reforms may still take a few years for implementation. Alcohol is not included in the law on drugs. It is controlled

under the law of Islamic Shari'ah.

The current law (Section 2 of the 1995 amendment) awards life imprisonment for offences of trafficking of prohibited drugs by either, cultivation, manufacture, exportation, importation, selling, buying, giving or possession for sale of one gram or more of a banned substance. Under section 4 of the law, using or possessing for personal use of less than one gram of a banned substance attracts a penalty of imprisonment, banishment or house arrest for a period between 5 and 12 years, or referral to rehabilitation with the possibility of a suspended legal sentence.

For first-time drug offenders, the sentence may be suspended for three years while they undergo rehabilitation under the supervision of NNCB. If an offender undergoes satisfactory rehabilitation and remains within the law for the 3-year period, the suspended sentence is deemed to be fully served and he/she is set free. If on the other hand, the offender is unable to complete this period of rehabilitation successfully, he/she is handed over to the Department of Penitentiary for endorsing the sentence.

The Law also allows a drug addict to make a self-submission to the rehabilitation assessment committee of NCB and request for treatment. This opportunity is available for those with no other offences or cases pending against them.

4. NATIONAL INSTITUTIONS CHARGED WITH DRUG CONTROL

The major law enforcement agencies concerned with drug abuse in Maldives include the Maldives Police Service, National Security Services, Maldives Customs Services and the National Narcotics Control Bureau (NNCB).

The Police and National Security Services are primarily responsible for arrests and seizures related to illicit drugs in the country. The Drug Control Bureau (DCB) is the specialized unit of the Police responsible for drug intelligence and investigation, narcotics identification, surveillance and seizures and arrests. Further, the police also actively partner with NNCB in demand reduction programs.

Together with the police, the Maldives Customs Service (MCS) is responsible for the seizure of illicit drugs. The MCS is the principal agency responsible for prevention of entry of illegal substances into the country.

The National Narcotics Control Bureau is responsible for overall coordination of all aspects of the response against drugs. It is the single agency responsible for drug rehabilitation and the main agency responsible for drug prevention. The primary responsibilities of NNCB are demand reduction, awareness building, treatment, rehabilitation and liaison with international agencies. It is advised by three high level policy committees, one focusing on treatment, one on supply reduction and the other on more general drug control matters.

The work of the NNCB falls under four main sections:

- Section A: administrative, legal;
- Section B: training, finances, and foreign relations;
- Section C: treatment and rehabilitation; and
- Section D: drug prevention.

5. NATIONAL EFFORTS FOR DRUG DEMAND REDUCTION AND CAPACITY BUILDING

5.1 Prevention

Drug prevention education activities fall under the mandate of the NNCB, which implements comprehensive and specialized drug awareness programs for the community on inhabited islands. School-based awareness programs target students, teachers and parents, while the atoll awareness programs target

atoll chiefs, island chiefs, health care workers, teachers and island community members.

The NNCB collaborates with such other governmental organizations as the Ministries of Education, Gender and Family, Youth and Sports, Atolls Development, Information and Arts, the Maldives Customs Service and the Maldives Police Service, and such non-governmental organizations as FASHAN and SHE for awareness generation and prevention.

5.2. Treatment and Rehabilitation

Secondary prevention programs originated in 1997 under the Ministry of Health, following amendments to the drug law that year, mandating rehabilitation for eligible addicts. With the establishment of the Narcotics Control Board (NCB) these



responsibilities were shifted to the board and later its successor, NNCB.

Currently the involvement of the health sector in drug related treatment and rehabilitation is relatively small. Psychiatrists attached to the Indira Gandhi Memorial Hospital (IGMH) share their expertise with NNCB as and when requested and also provide consultation services to drug addicts with co-morbid psychiatric conditions. The Ministry of Health also participates in the advisory committee of the NNCB and provides advice on the treatment decisions and rehabilitation of drug dependants.

The Drug Rehabilitation Centre (DRC) was established on Himmafushi Island in 1997. It provides residential care using the therapeutic community model. Facilities at the DRC in-



clude a counselling department, library, computer centre, arts and crafts unit, vocational centre, agricultural unit, gymnasium, medical services and a mosque.

Clients graduating from the DRC are transferred to the Halfway House in Male for the community component of their rehabilitation. Programs of the Halfway House are designed to help clients to re-integrate themselves into their families and the community. This includes individual counselling, self-help groups, aca-



demographic programs, religious guidance, and vocational and language classes. While undergoing the programs clients remain under close supervision, and their drug status is monitored through random urine testing. NNCB also provides assistance to clients in securing employment.

The treatment and rehabilitation program is similar to a parole system. When the residential and the community phases of the program are successfully completed, the legal sentences are annulled.

5.3. Harm reduction

The Maldives has so far not introduced any harm reduction programs although the need for them has been identified as an important issue by the health authorities.

Currently intravenous drug injection is relatively uncommon and there is no immediate and pressing need to introduce such programs. However it is important to study and learn from harm reduction programs in other countries in order to be prepared for such an eventuality.

6. DCMP VIEWED AGAINST NATIONAL DEVELOPMENT OBJECTIVES

It is universally acknowledged that drug abuse is the main social problem facing the Maldives. It is a hindrance to the continued economic and social development of the nation. Thus the national development plan includes drug control issues although not as comprehensively as in the DCMP. The two plans, therefore, complement each other and must be considered simultaneously when national budgets and programs are elaborated.

The National Drug Control Master Plan will foster investor confidence by ensuring that measures will be taken to counteract the negative effects of drug abuse on sustainable

human development in the Maldives. It will reassure them those economic crimes such as corruption and money laundering, which goes hand in hand with drug trafficking, would be counteracted. Criminal activities linked to drug abuse and illicit drug trafficking, such as public violence and theft will be minimized, ensuring that the Maldives would continue to be safe for its citizens, tourists and investors alike. The National Drug Control Master Plan will provide for education and assistance with regard to drug abuse, which will improve productivity and quality of life for the work force in the Maldives.

7. BROAD STRATEGIES OF DRUG CONTROL MASTER PLAN

The goal of DCMP is to control drugs and drug related crime to such a level by 2010 that they no longer pose a serious threat to the society. This takes into account the stark reality that 'a drug free Maldives' is unattainable in the DCMP period, and will remain an aspirational goal, a desirable ideal, but one that is unlikely to be ever achieved. However the DCMP is confident that it is possible and feasible to minimize the harmful effects of drugs on the Maldivian society. To achieve this end, the Master Plan proposes the following interventions.

7.1. Intervention Area 1: Drug Control Management and Coordination (NNCB)

NNCB will be responsible for managing and coordinating all drug control measures. It will be guided by its advisory council, whose mandate and representation will be expanded to cover the implementation of the DCMP in cooperation with all drug control related ministries, departments, and services.

A special post of DCMP Coordinator will be established at NNCB to ensure that all components of the DCMP are initiated and implemented according to schedule. DCMP will be monitored and evaluated periodically by a senior NNCB staff member, who will make recommendations on program changes as and when such changes are deemed necessary.

The responsibility to control precursors rests

with the NNCB and it is, therefore, necessary to formalize this function at the NNCB by nominating one senior staff member to take the prime responsibility for this, in close collaboration with other government entities. Finally, two new mechanisms, Maldives Epidemiological Network on Drug Abuse and Maldives Drug Control Project Database, will be put in place to provide NNCB with much needed tools to follow the drug abuse trends as well as to coordinate the many planned and on-going interventions.

7.2. Intervention area 2: Laws, Regulations and the Judicial system.

Three interventions will be made to enhance the current legal system. The most urgent is to ensure harmony and concordance between drug laws –existing as well as proposed –and the DCMP. Secondly, and in view of both the introduction of new legislation as well as the DCMP, all magistrates and judges need to be trained and informed on drug control legislation including the objectives and policies behind them. Thirdly and in order to facilitate smoother implementation of drug control related laws, regulations and procedures, a single document will be developed to deal with the many procedural issues that are now found fragmented in multiple separate documents.

7.3. Intervention area 3: Supply Reduction / Drug Law Enforcement

Reducing the supply of illicit drugs is a key component of the DCMP. One of the most urgent interventions is to reduce smuggling illicit drugs into the country via the seaports by a possible reorganization of the related logistics and improving search and detection capacity. These efforts will be complemented by measures to strengthen the use of drug control intelligence. In view of the critical role the drug law enforcement agencies play, an assessment of a possible re-organization will be made, aimed at establishing a joint, multi agency drug law enforcement unit.

7.4. Intervention Area 4: Drug Demand Reduction

Interventions in the area of drug demand reduction will focus on drug abuse prevention targeting school children, parents, and the citizens in general. This will include imparting life skills to school children, teaching parenting skills and promoting drug free workplaces. These programs, particularly those targeted at schools, will be closely coordinated with Ministry of Education. Particularly vulnerable groups, such as prison inmates and former drug abusers will also receive special atten-

tion. Recovering drug addicts will be given the opportunity to play a role in these programs. Drug treatment and rehabilitation will be strengthened through training and a possible introduction of new rehabilitation methods, targeted at both adults and children.

7.5. Intervention Area 5: Illicit Drugs and Corruption

Although corruption is not considered a major drug related problem, experiences from many other countries suggest that closer vigilance is necessary. Responsible authorities need to be aware of the possibility and consequences of drug related corruption.

7.6 Intervention Area 6: Illicit Drugs and Money Laundering

Similar to the corruption situation, money laundering is apparently not a major problem in the Maldives. Experiences from other countries in general and those with substantive tourism businesses in particular, suggest that it is necessary to assess the situation so that authorities are better prepared and vigilant. This may also be considered as one of the international responsibilities that all countries must undertake in the area of curbing international crime in general and drug crimes in particular.