Rapid Situation Assessment of Drug Abuse in Maldives 2003

Narcotics Control Board
Republic of Maldives
2003

Life is a scale
Put weight on the brighter side
Foreword

In the Maldives, the abuse of drugs is a relatively recent phenomenon and the increasing incidence of drug related arrests and seizures are creating national concern for this issue.

The government of Maldives is alert to the changing trends and patterns of drug abuse and is committed in taking all the appropriate and necessary steps to halt the impact and spread of substance abuse in the country.

To this effect the Narcotics Control Board (NCB) of Maldives, under the guidance of its advisory council took the initiative in conducting a Rapid Situation Assessment of the drug scenario in the Maldives such that the findings of the study would provide policy direction to address the issues of prevention and intervention and ultimately contribute towards the formulation and development of a national master plan.

In conducting a study of this nature many challenges had to be met and overcome. The Narcotic Control Board was fully committed in coordinating with UNESCAP, which was the executing agency with support from UNDP.

Due to the nature of the study it was recommended that an NGO working in the field carry out the study proper. To this end, the NGO, FASHAN, was delegated the authority of implementing this study independently. However, at all stages of conducting the research NCB provided technical and other assistance from its available resources and coordinated with FASHAN in arranging the inter-sectoral discussions.

Further, NCB was proactive in bringing the necessary amendments to the principal legislative act of the Maldives dealing with Narcotic drugs and Psychotropic Substances in 2001 such that confidential interviewing with drug users could be made possible for purposes of research.

The RSA provides essential inputs for the formulation of effective intervention strategies for the future. It is a rich source of information into the drug abusing population of the country and its exploration of certain hidden phenomena’s contribute new insights and challenges that need addressing.

NCB recognizes that conducting this study and formulating this report would have indeed been an arduous task. If not for the cooperation received from various sources NCB would not have been able to extend its cooperation so fully to the agencies, which brought this report into realization.

Hence, we thank all the international, government and nongovernmental organizations that continuously extend their cooperation in developing the resources of NCB.

Finally, the firm commitment in addressing the issue of drug abuse in the Maldives and the guidance and counsel received from His Excellency Mr. Maumoon Abdul Gayoom, the President of the Maldives is gratefully acknowledged.

It is hoped that with the publication of this report NCB is moving towards new challenges in addressing the issue of substance abuse in the country.

Narcotics Control Board Male’ Maldives
Foreword

For Maldives to become one of the top-ranking nations amongst the middle-income developing countries, that focuses on providing the youth with opportunities they need to achieve their full potential, as envisaged by the Vision 2020 it is important that we take a hard look at a sensitive but a critical issue that confronts not only drug users and young people who are most vulnerable to drug use but also parents and families of drug users, leaders and policy makers of the country.

The Rapid Situation Assessment on Drugs provides a window of opportunity for us to observe and assess the drug scenario of the country. The picture it paints is a gruesome one. It tells us that drug abuse is increasing in the country, that the drug offender is usually male who have not achieved their desired level of education and who initiated drug use mostly in their teenage years and initiated mainly due to peer pressure and a desire to experiment. This has caused many drug users and their families significant health, emotional and economic burdens.

Specifically, the high percentage reported of having sex with a commercial sex worker, the high number of sexual partners amongst drug users, the low use of condoms amongst them, and the use of intravenous drugs though limited are alarming and needs to be immediately addressed to maintain the low HIV/AIDS prevalence rate that Maldives has been proud of.

The report highlights gaps in the system, noteworthy amongst them are the reluctance of drug users to use existing services in their attempts to reduce or stop using drugs due to the substantial legal repercussions and the reported availability of drugs in prisons.

The report that is with us today is an expression of the hard work and commitment that has been displayed by the Narcotic Control Board and the NGO FASHAN who conducted the study. I would like here to express my sincere thanks to them and congratulate them on the excellent report produced. Let me also express my thanks to UNESCAP for executing the project, and providing much needed technical support in conducting the study and in writing up the report.

I would also like to highlight here that this study was only made feasible with the amendment of the Law on Narcotics in 2002 that allowed surveying, monitoring and working with drug users possible without being obliged to report them.

Minh.H.Pham  
Resident Representative  
UNDP Maldives
Acknowledgements

The Government of the Republic of Maldives assisted the Rapid Situation Assessment (RSA) at every stage. In particular, the Narcotics Control Board (NCB) provided invaluable guidance and support in both substantive and logistical areas. Lt. Col. Abdul Shakoor Abdulla, the Commissioner of NCB, and Mr. Ahmed Mohammed, Director of NCB, closely oversaw the entire project, which could not have been implemented without their support. The Ministry of Defence and National Security, and the Maldives Customs Service provided essential assistance.

The United Nations Development Programme (UNDP) funded the RSA as project MDV/00/004. The UNDP office for Maldives gave a great deal of attention to the project, helping to identify the executing agency and the organization that carried out the RSA. It served as the focal point for all of the agencies and persons concerned, provided continuous impetus and assisted the fieldwork.

The Foundation for Advancement of Self Help in Attaining Needs (FASHAN) was selected by a competitive process to carry out the fieldwork and prepare the first draft of the report. Ms. Aishath Ali Naaz served as the national consultant to FASHAN and oversaw all substantive issues in conducting, drafting and editing the report. Ms. Pratima Murthy served as the international consultant to ESCAP. She conducted several missions to Maldives to plan and oversee all substantive aspects of the RSA. She revised and edited the draft report and wrote several key chapters.

Valuable assistance to the RSA was provided by the Atoll Chiefs of Addu, Miladhunmadhulu Dhekunuburi and Faadhipolhu Atolls and by the Island Offices and Island Chiefs of Miladhunmadhulu Dhekunuburi Holhudhoo, Miladhunmadhulu Dhekunuburi Manadhoo, Miladhunmadhulu Dhekunuburi Velidhoo, Faadhipolhu Naifaru and Faadhipolhu Hinnavaru. The Supreme Council for Islamic Affairs and the Loyal Taxi Service assisted the study, including the focus groups.

A large number of persons cooperated with the RSA as primary respondents, key informants and participants in focus group discussions. The ESCAP secretariat and FASHAN contributed much to this important research.

The Narcotics Control Board sincerely acknowledges the valuable contributions made by all the concerned persons who aided in conducting this research and expresses sincere appreciations.
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List of local terms and meanings

Local words

1. Afihun – Refers to opium
2. Bhang, Bangu – A derivative of cannabinoids
3. Charas – A derivative of marijuana
4. Cola Water – Refers to eau de cologne
5. Dhivehi – language of Maldives
6. Dunlop – A brand of glue
7. Edhuruge – Traditional school for imparting religious and literacy
8. Joalifathi – locally made seats, kept within or outside house
9. Minikashi – Exhumed dried human bones
10. Oshani – (belladonna), A medicinal herb, which grows wild in the islands
11. Sunni – A sect of Islam
12. Thaana – Maldivian script

Commonly used acronyms and abbreviations

BS – Brown Sugar
CRP – Community Rehabilitation Programme
DCB – Drug Control Bureau
DRC – Drug Rehabilitation Centre
FG/FGD – Focus Group Discussion
FIs – Field Investigators
KI – Key Informants
MOH – Ministry of Health
NCB – Narcotics Control Board
NSS – National Security Service
EXECUTIVE SUMMARY

The patterns and increase of drug abuse and trafficking in Maldives appear to closely parallel the escalation of drug abuse in the region. However, certain local characteristics appear to make the drug problem in Maldives of more serious concern.

The government has responded to the growing concern of drug abuse by enactment of stringent drug laws, by strengthening the supply reduction mechanisms and by setting up the narcotics control board (NCB) in 1997. A Drug Rehabilitation Center was established at Himmafushi in 1997. In addition to treatment, demand reduction activities have also been initiated by the NCB, in conjunction with other agencies.

The RSA employed a combination of quantitative and qualitative methods, including primary interviews with drug users, interviews with key informants, focus group discussions and ethnographic observations of drug use sites. Secondary data from the Maldives customs service and on treatment referrals to the NCB complemented the information obtained from primary sources.

The atolls of Maldives, Miladhunmadulu Dhekunuburi, Faadhipolhu in the north and Addu Atoll in the south were selected for the RSA, based on higher reported drug use in these sites. The assessment included interviews with 1,058 respondents connected with drug use directly or indirectly. Four hundred and seventy-one potential drug users were contacted, of whom 204, above the age of 16 years and reporting drug use in the previous six months, were interviewed on a structured interview schedule. A total of 111 key informant (KI) interviews and 49 focus group interviews covering 443 persons were conducted. In-depth interviews were carried out with 13 drug users and interviewing 19 family members of drug users assessed family burden. Secondary data information was available on 2,304 persons arrested by the drug control bureau and 547 clients referred to the NCB. Thus, drug related information was obtained from 3,909 individuals.

Most KI as well as focus group respondents felt that drug abuse was increasing in Maldives. The Drug Control Bureau data on arrests revealed a peak in the arrests during 1998, coinciding with the maximum seizures of brown sugar. Reports of drug related seizures and arrests indicate that opioids, especially ‘brown sugar’, hashish oil and other cannabinoids are the most commonly available drugs in Maldives. KI from the north reported the frequent abuse of ‘cola water’ (eau de cologne) and ‘Dunlop’ (glue, an inhalant). Cannabis, pharmaceuticals, alcohol, ecstasy (MDMA) and use of the local oshani for intoxication were also reported. Drugs of initiation were mainly opioids, primarily brown sugar (43 per cent) and cannabinoids (34 per cent). A smaller number of respondents, especially from the atolls, had initiated drug use with ‘cola water’ (5 per cent), alcohol (12 per cent), or sedatives/hypnotics (4 per cent). Primary drugs used in the previous month were opioids (76 per cent) and cannabinoids (12 per cent).
Practically all the respondents (98 per cent) reported a history of smoking, with almost half (48 per cent) having initiated smoking between 10 and 14 years of age. Knowledge of drugs was mainly from friends (81 per cent). The age range of drug use initiation was 10-27 years (mean 16.8 years). Almost half (49 per cent) of KI perceived drug use to be commonest among 16-30 years old and 35 per cent believed that children below 16 were also using drugs. Interviews with primary respondents (drug users) revealed that 97 per cent were males, with a mean age of 21.4 years. Almost half (47 per cent) were below the age of 20 years. Most of the drug users (77 per cent) identified were from Male’ Most of them were unmarried (81 per cent) and lived with their families (71 per cent). Most of them (91 per cent) had not achieved the desired level of education. Over half (52 per cent) reported frequent difficulties in school. About a third (34 per cent) held a job at the time of the interview. Most of them depended on their families for financial support. Money spent on drugs (median values) ranged from a minimum of RF 190 (US$ 15) to a maximum of RF 500 (US$ 39). Most of those in employment (72 per cent) earned monthly salaries between RF 1,000 (US$ 79) and RF 4,999 (US$ 394). A small number of respondents (8 per cent) reported having injected drugs. Drug use by a family member was reported by 44 per cent, and was mainly by brothers (68 per cent). Most of the respondents (98 per cent) had drug-using friends.

Most of the KI and focus group participants attributed reasons for drug use as being family problems, experimentation, peer pressure, lack of awareness, psychological problems, easy availability, lack of educational and employment opportunities, boredom and stress as common reasons for drug use. Most of the drug users however, cited the most common reasons for drug use initiation to be peer pressure and a desire to experiment. A smaller number attributed family problems as reasons for initiation.

A majority of the unmarried (171) respondents (75 per cent) reported a sexual experience, and 68 per cent of the married respondents reported an extramarital sexual experience. Age at first sexual experience ranged from 7 to 24 years, with a third having been exposed to a sexual experience by 15 years of age and 92 per cent having had a sexual experience during their teenage years. First sexual experience among the unmarried respondents was mainly with a friend (83 per cent). More than one in four respondents reported having had sex with a commercial sex worker. Experience of group sex was reported by 43 per cent of respondents and 1 per cent reported homosexual experiences. A majority (76 per cent) reported two or more sexual partners in the previous year. Drug use with a member of the opposite sex was reported commonly (65 per cent), and this was usually in the context of a sexual relationship with the partners. Less than one third (30 per cent) of respondents reported consistent condom use. Although many of the respondents were aware of some the common modes of spread of HIV/AIDS, a majority (73 per cent) did not perceive being at risk for the infection. Other health problems reported included genito-urinary infections.

More than one third (38 per cent) of the respondents reported having been jailed in the past. Fifty-nine percent had been under house arrest and 15 per cent had been banished. One third of the respondents who had been in prison reported drugs availability in prison. One fourth of the respondents (24 per cent) reported legal problems prior to drug use whereas 94 per cent reported legal problems after drug use.
While focus groups of drug related offenders in prison suggested that 95 per cent of persons in jail had used drugs, anecdotal reports suggest that more than 800 drug users may be in prison for primarily drug related offences.

Many of the drug users (61 per cent) had attempted to reduce or stop drug use. While about one third did not perceive the need for any external help, others perceived the need for medical facilities, including detoxification (20 per cent). Some of the respondents had already accessed government facilities (37 per cent), hospitals (20 per cent), NGOs (17 per cent) and private clinics (19 per cent).

Focus groups also recognized drug use among females. Very few female users were identified for the primary respondent interview (3 per cent). The findings from the arrest data and NCB referrals suggest that there are more female users than are initially apparent.

Most of the family members of drug users reported a financial burden (98 per cent), sleeping problems (74 per cent) and emotional problems (90 per cent). Media reports on drug abuse have focused mainly on drug seizure and arrest data as well as reporting on awareness programmes on drug abuse.

Although the RSA approach has several limitations, it provides a window into the drug abuse scenario in the country. The findings of the RSA highlight the need for development of a variety of treatment strategies, especially community-based strategies affording confidential and equitable treatment to drug users; awareness building among the young, with a focus on drug refusal and other life skills; programmes for smoking prevention, early sex education, awareness of safe sexual practices, identification and intervention for early school related problems; development of non-drug related peer group activities in communities; sensitization and training of professionals in different sectors; and better liaison and networking between different agencies. In the larger context, drug abuse prevention may also lie in addressing other issues such as providing alternative recreational avenues, improving educational prospects, skill-based training and employment opportunities, strengthening family support, and addressing the sociocultural factors that may increase vulnerability to drug abuse.
I. THE REPUBLIC OF MALDIVES

A. Country profile

Maldives, literally translated as the “Garden of Islands”, is a small archipelago of 1,192, palm-fringed coral islands surrounded by white sandy beaches, scattered across the equator 823 km in length and 130 km at its widest point. Maldives are located in the Indian Ocean, southwest of Sri Lanka and India. They cover a geographical area of more than 90,000 square kilometers, of which the land area is only 300 square kilometers.

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 (administrative) while 111 are used for non-administrative purposes. The remaining 882 islands are uninhabited.

Maldives has a very humid climate with an average annual rainfall of 200 mm. The mean temperature lies between 25° and 31°C.

B. Historical perspective

Historical evidence indicates that the habitation of Maldives dates back more than 5,000 years, and Aryan immigrants are believed to have settled in Maldives during the 4th and 5th centuries B.C. A sea-faring nation for centuries, certain aspects of the culture of Maldives have been significantly influenced by its exposure to traders from Arabia, Persia, China and other South Asian countries.

Except for two brief periods of invasion and control by the Portuguese (1573) and Southern Indian Moplas (1752), Maldives has remained an independent state throughout its history. In 1887, it became a British protectorate and gained full independence on 26 July 1965. The country became a member of the United Nations on 21 September 1965. In 1968, Maldives became a Republic. A new Constitution and Presidential system of governance was adopted.

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

C. Socio-demographic features

The total population of Maldives is 270,101 (Census 2000) and the growth rate of the population is 1.9 per cent. The population of Maldives is unequally distributed. More than a quarter of its population (74,069) lives in Male’, the capital city of just 2 square kilometers, making it among the most densely populated places in the world (in excess of 37,000 persons per square kilometer). In addition to this, there are 29,201 expatriate workers, their dependents and a large floating population visiting Male’. Only three islands have a population greater than 5,000, 54 islands have populations between 1,000 and 5,000 people, 66 between 500 and 1,000 people and 76 islands have a population less than 500 people (Statistical Yearbook 2002).
The population aged between 15 and 64 years has increased to 55 per cent in 2000 from 50 per cent in 1995 (Census 2000). Nearly 44 per cent of the country’s population is less than 15 years of age, and more than one third is between 16 and 35 years (figure 1, Statistical Yearbook 1999). About half the country’s population is female. The 2000 estimate of the total population was 137,200 males and 132,901 females, which is a ratio of 103.2 (Census 2000). At the regional level, the sex ratio in Male’ is 87 females per hundred males, suggesting in-migration of men from other islands (Razee 2000). The Maldivian economy is largely based on fishing and tourism.

Figure 1: Age Distribution of the Population 2000


D. Indicators of development and health

The Human Development Index (HDI) developed by the United Nations Development Programme is a composite index that measures achievement in terms of human capabilities. The HDI contains three important variables, life expectancy, educational attainment - (computed as adult literacy and enrolment ratios at primary, secondary and tertiary levels) and the standard of living measured by per capita real GDP adjusted for purchasing power parity in dollars.

Maldives has an HDI international ranking at 89 out of 174 countries. This HDI value (0.725) is higher than the average for South Asia (0.716) and South-East Asia and the Pacific (0.691). The country has been able to maintain an economic growth rate of 4.6 per cent in 2000 with gross domestic product (GDP) per capita of US$ 1,961 (UNFPA 2001). This is the highest among South Asian countries and is almost 20 per cent higher than most developing countries.
Life expectancy has increased from 59.5 years for females and 62.2 years for males in 1985 to 72.2 years for females and 70.7 years for males in 2001 (Statistical Yearbook of Maldives 2002). The infant mortality rate (IMR) is down from 157 per 1,000 live births to 62 per 1,000 live births in 1998. (Human Development Report 2000). The crude birth rate (CBR) declined from 27 per 1,000 population in 1995 to 20 per 1,000 population in 2000.

Table 1. Life expectancy, infant mortality and under-five mortality rates

<table>
<thead>
<tr>
<th></th>
<th>Life expectancy at birth (years)</th>
<th>Infant mortality rate (per 1,000 live births)</th>
<th>Under-five mortality rate (per 1,000 live births)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970-1975</td>
<td>51.4</td>
<td>157</td>
<td>255</td>
</tr>
<tr>
<td>1995-2000</td>
<td>64.5</td>
<td>62</td>
<td>87</td>
</tr>
</tbody>
</table>


E. Gender and the sociocultural context

Maldivian women have been described as among the most emancipated in the Muslim world. This favourable situation is reflected in the positive rankings in the Gender Related Development Index, where the GDI ranking for Maldives is 69.

While early marriage was the cultural norm in traditional Maldivian society, rapid socio-economic change with increased mobility, education and employment opportunities have all altered this trend. The mean age of marriage increased from 15 to 18 years between 1985 and 1995. In 1997, the majority of marriages took place among the 20-24 year age group, with 11 per cent occurring among the 15-19 age group for the year 1996. In 1996, no marriages were recorded below 15 years of age (Razee 2000). Historical records indicate that culturally serial
monogamy has been present in Maldives. While polygamy is legal in Maldives only 59 (5 per cent) polygamous marriages took place in 1998.

F. Education

The current adult literacy rate in Maldives is 98 per cent and is comparable to the levels found in many developed countries in the world. Education is given a high priority in Maldives. The traditional system of education consists of teaching young children to read the holy Quran and to learn Arabic. This type of first formal learning at the Edhuruge still prevails. The first government school was established in Male’ in 1927. The current Maldivian school system consists of government schools and private schools, and community/ward schools. In Maldives, primary education is started by 6 years of age. Public primary education is free. Secondary education consists of grades 8-10 (lower secondary) and 11-12 (upper secondary). Lower secondary, once the monopoly of Male’ institutions is now being extended in some Atoll Education Centres (AECs) and Atoll Schools (AS). While Dhivehi is the medium of instruction in most atoll schools, in several Male’ schools, English is the primary medium of instruction. Opportunities for higher education are offered through the Maldives College of Higher Education Institutions. Youth and adults who have not been able to use the formal education system are provided opportunities through a Condensed Education Programme by the Centre for Continuing Education (CCE), which offers opportunities for skills development, literacy and other alternate educational opportunities. University level education is limited in Maldives. Maldivians who aspire to further training travel abroad either through personal funding or joining the Government to gain access to Government facilitated opportunities for further education. Only a limited number of students are able to study up to their desired educational levels and many school leavers find that they lack adequate skills to obtain the desired employment opportunities.

G. Health

Improvements in the health conditions and the availability of better services have lead to improvements in various health indicators. These improvements in the critical health indicators are a result of improved health infrastructure, preventive health service and improved ratio of health personnel to population. Maldives has a doctor to patient ratio of 1:1,195 which compares favourably with any other regional country.

The average hospital bed density in Maldives is about 1 per 1,000 population. This is again comparable to that of regional countries. Health care is delivered through five regional hospitals. In addition, there are 40 health centres, 147 pharmacies and 28 clinics/laboratories involved in providing health care facilities (Health Report 2001). Health care facilities in the private sector are recently emerging.
II. AN ISLAND NATION IN TRANSITION – VULNERABILITIES AND CONCERNS

A. Macroeconomic situation

The macroeconomic situation, like that of other small island nations, remains highly vulnerable. This vulnerability derives from its smallness, remoteness, and narrowness of its economic base, with heavy reliance on two volatile sectors – fishing and tourism. Other complicating factors include a high dependence on imports, dependence on external aid, openness of the economy to external fluctuations and scattered population (Country Population Assessment 2001). The problems of physical vulnerability in terms of its small size, with 80 per cent of the islands barely one meter above sea level, adverse effects of climatic changes, ecological fragility and scarcity of land-based resources, confront Maldives with extraordinary challenges for ensuring sustainable development.

B. Unbalanced population and resource distribution

More than a quarter of the country’s population (74,069 of 270,101) resides in Male’ (Census 2000). In contrast, 40 per cent of the inhabited islands have less than 500 residents. The national average household size is 7, considerably larger than in many other developing nations. In Male’, the average household size is 8 (Statistical Yearbook 2002). Facilities for upper secondary education are present only in Male’. The dispersed 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 lives below the income poverty line defined as RF 600 (around US$51) per capita per month. Nearly 15 per cent of the country’s population lives on an income of less than RF 7.50 per day. Twenty-eight per cent of the atoll population gets less than hours of electricity per day, 40 per cent lives on islands without a health centre, hospital or private clinic, while 12 per cent of the population has no access to safe water.

Other forms of human deprivation prevalent in Maldives include limited opportunities for secondary education while tertiary education is mostly sought abroad. Further, the benefits of growth are uneven in Maldives. While Male’, the capital city has gained the most from the rapid expansion in economic and social opportunities, the quality of life in Male’ is constrained by severe shortage of physical space, overcrowding, congestion and pollution.

C. Young age structure

The Maldivian population is a young population, with a median age of 18.7 years in 2000 (Country Population Assessment 2001). Despite the declining growth rate in recent years, the momentum effect of the young age structure can be expected to cause significant population increase in the years to come. Presently, 44 per cent of the country’s population is less than 15 years of age. The dependency ratio for Maldives is among the highest in the world. The dependency ratio is also higher in the atolls than in Male’. Those aged 16-35 years form more than a third of the population.
D. Education concerns

Current enrolment at the primary level shows a declining trend for boys and girls, which may reflect declining birth rates. Total secondary school enrolment was about 50 per cent for both sexes in 1997, but increased to 51 per cent for girls in 2000. However, serious gender differences emerge at higher secondary level and above. At upper secondary school (grades 11 and 12), a high level of discrepancy exists in male/female school enrolment (36 per cent females to 64 per cent males) (Country Population Assessment 2001). Another 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).

E. Sociocultural context

1. Gender

Although the Constitution does not allow any form of discrimination between men and women, in reality discriminatory practices exist in society. These are mainly in the areas of marriage and divorce, property rights and provision of evidence in courts of law. 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.

2. Marriage and divorce

Relatively early marriages, the accepted practice of serial monogamy and easy divorce procedures have led to a high rate of marriage, remarriage and divorce, loose kinship family structures and weak ties to family units, which in turn contribute to greater instability of marriage (Razee 2000). In 1998 in Male’, there were 70 divorces per 100 marriages. These do not constitute a complete and permanent separation, however, as many of the divorced couples remarry.

Razee (2000) reviewed data from surveys on island women conducted in 1979 and 1991. Both reported 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 latter 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.
3. Mobile populations

Internal and external mobility is another component affecting the lifestyle of Maldivians, especially those living in Male’. With a large expatriate population of skilled and unskilled persons working in Maldives, along with increased overseas travel and increased internal mobility, there is an escalating risk for various lifestyle problems. Constant mobility creates long separations from family members, leaving those individuals more vulnerable to stress, isolation and other psychological strains.

4. Sexual behaviour

Consensual sex between unmarried persons is punishable under legislation. A total of 866 persons from Male’ and the Islands were charged with illegal coital relationship between 1998 and 2001 (Statistical Yearbook 2002). Despite legal restrictions, all sexual behaviours are found in Maldives (Jenkins 2000). Fear of discovery and legal prosecution limits these practices but does not forestall them entirely. Due to its illegal status, the extent of pre-marital or extramarital sex is not known. However, it is estimated that some proportion of young people experiment with sex before marriage. By the age of 21, a very high proportion will have had sexual intercourse at least once (Jenkins 2000). Other sexual behaviours such as homosexuality and commercial sex practices are known to exist and cases of sexual abuse have also been recognized. Foreign and Maldivian sex workers can be found in Maldives, as a large number of workers work away from their homes creating a pool of potential commercial sex clients.

5. Juvenile delinquency

There is concern from the about the growing problem of juvenile delinquency in Maldives. Statistics from Ministry of Defence and National Security indicate an increase in petty crime from 169 cases in 1992 to 462 in 1996. The number of sentenced persons under 19 also increased from 391 in 1988 to 512 in 1998 (Human Development Report 2000). The relationship between crime and drug abuse has not been examined.

6. Other lifestyle-related problems

The threat of lifestyle diseases is also emerging as a major health problem and lack of data makes the observation of trends difficult (National Assessment Report 2002). The 1995 data show that diabetes and cardiovascular diseases accounted for 9 per cent and 31 per cent of the causes of death, respectively. Tobacco consumption (either smoking or chewing) still remains high and a 1995 survey revealed that there is a smoker in 71 per cent of the households. Ninety per cent of smokers are males and 10 per cent are females.

The first positive case of HIV was detected in Maldives in 1991. However, Maldives has enjoyed relative freedom from the HIV pandemic, as HIV prevalence remains very low. Eleven persons of Maldivian origin were detected to be HIV positive between 1991 and 2000. A much higher number of foreigners (85 cases between 1995 and 2000) in Maldives were found to be HIV positive. However, there is no room for complacency as movement of people from Maldives to other countries and back, early marriage and frequent divorces, all support conditions for the spread of HIV/AIDS.

The National AIDS Control Program was established in 1987. In 1996, the Ministry of Health introduced Sentinel Surveillance, enhancing awareness creation and screening of
expatriate workers. Currently, all foreigners who seek employment in Maldives are required to undergo HIV testing before a work permit is granted. Also, Maldivians returning after spending more than a year abroad are required to undergo HIV testing. (Health Report 2001). The Department of Public Health (DPH) carries out the day-to-day operations of the programmes and networks with the small NGO sector in awareness building and offering such other services as counseling.

Drug abuse has been recognized as a growing problem in Maldives. This monograph attempts to present the current scenario of drug abuse in the context of the sociocultural milieu in Maldives.
III. DRUG ABUSE IN MALDIVES

A. Traditional use

There is no available evidence to suggest traditional use of drugs in Maldives. However, a 17th century reference by Francisco Pyrad (1619), a French historian and traveller, indicates that use of opium was prevalent among Maldivians of that time. Although opium use within traditional medicinal practices was known, only a few anecdotal references of opium use are available prior to the latter part of the 20th century. It is only in recent years, in the context of growing drug use in the region, that drug abuse has gained attention as an emerging problem.

B. Drug abuse in the South Asian region

No country in the South Asian Region has been immune to the problems of drug abuse. Heroin use 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 of 1,750 drug users reported that heroin, cannabis, cough syrups containing codeine, buprenorphine and sedatives were the most commonly abused drugs. In Bhutan, as of 1996, apart from cannabis, drug abuse was not considered a main problem. A recent Rapid Assessment Survey of Drug Abuse in India (Suresh and Ray 2002) covering 4,648 drug users reported that heroin; other opiates (buprenorphine, propoxyphene, opium) 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 use (Drug Demand Reduction Report – South Asia 2000). Alcohol abuse was commonly reported in all the countries.

C. Introduction of drugs in Maldives

Maldives lies at a potentially strategic location not too far from the golden triangle, with hundreds of tourists arriving every day by flights from Europe, the Middle East, South Asia and East Asia. It is well connected to the outside world with its international airport and ports. Hence, Maldives is potentially vulnerable as a point for illegal shipments of precursor chemicals or large quantities of drugs meant for other countries. Drug traffickers may conveniently exploit Maldives as a conduit to take the drugs to other parts of the world. Its strategic location makes Maldives ideally suited for the trafficking of regionally available drugs, commonly opiates (especially heroin) and cannabinoid derivatives.

Drug availability was formally identified in Maldives in the mid-1970s. It is believed that tourists first introduced drugs (Drug Demand Reduction Report – South Asia 2000). Subsequently, cannabis use (marijuana and hashish) was noted among tourists. Commonly reported substances since then have been hashish oil and heroin. There has also been growing concern about drug abuse among Maldivian youth. Country reports at SAARC Symposia in 1992 and 1997 (Ahmed 1998, Shakoor 2001, Naaz 2002) indicate the use of benzodiazepines among youth, and a high percentage of young drug abusers between 15 and 25 years of age. Drug abuse in Maldives is reported to have increased 40-fold between 1977 and 1995 (Jenkins 2000).
The Ministry of Defence and National Security has documented cases of drug abuse between 1997 and 2001 (table 2).

**Table 2. Reported drug abuse cases, by age group, 1997-2001**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Under 16</th>
<th>16-24</th>
<th>25-39</th>
<th>40+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>200</td>
<td>16</td>
<td>118</td>
<td>65</td>
<td>1</td>
</tr>
<tr>
<td>1998</td>
<td>320</td>
<td>26</td>
<td>196</td>
<td>93</td>
<td>5</td>
</tr>
<tr>
<td>1999</td>
<td>208</td>
<td>15</td>
<td>118</td>
<td>70</td>
<td>5</td>
</tr>
<tr>
<td>2000</td>
<td>220</td>
<td>0</td>
<td>129</td>
<td>76</td>
<td>6</td>
</tr>
<tr>
<td>2001</td>
<td>216</td>
<td>2</td>
<td>123</td>
<td>87</td>
<td>4</td>
</tr>
</tbody>
</table>

*Source: Statistical Yearbook of Maldives 2002.*

Alcohol consumption is prohibited in Maldives and punishable under Shari’ah law. The Ministry of Justice recorded 44 cases of offences related to alcohol in 1998, 42 in 1999, 27 in 2000 and 46 in 2001 (*Statistical Yearbook 2002*).

Despite stringent drug laws, intensive efforts to prevent drug entry by several agencies (Ministry of Defence and National Security through the Drug Control Bureau (DCB), and Ministry of Customs and the setting up of the Narcotics Control Board, there has been growing concern about the problem of drug abuse. There was a felt need to conduct a detailed assessment of the drug scenario in the country, in order to assist in the formulation of a National Master Plan for Drug Abuse Control.

**D. Responses to the growing drug problem**

1. **Drug control legislation and legal framework**

The principal legislative act of Maldives dealing with narcotic drugs and psychotropic substances is law number 17/77. The amended law of 1995 (Section 2 of the law) awards life imprisonment, and 25 years is given 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. For the offence of consumption of prohibited drugs under section 4 of the law, using or possession for personal use of less than one gram the penalty is 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 a first-time drug offender below 16 years of age, under section 4 of the law, the sentence can be suspended for three years and the person can be handed over to the Narcotics Control Bureau (NCB), and based on the recommendation of the Advisory Board of the NCB, referred for rehabilitation.

After the person completes the period of rehabilitation to the satisfaction of the Advisory Committee of NCB, as long as the person does not commit any further offence within these three years, the person’s sentence can be deemed to be fully served and he/she ‘released’ from the treatment and rehabilitation of NCB. However, if the person for any reason is unable to complete this period of rehabilitation successfully, he/she is handed over to the Department of
Corrections, and the previous sentence enforced. Also, under the law on drugs, the person who uses drugs can make a self-submission to the rehabilitation assessment committee of NCB and request treatment. The committee decides on treatment and checks whether the person has other pending legal sentences for banishment, house arrest or jail. Presence of a legal sentence prevents the person from opting for voluntary treatment.

Further amendments to the law on drugs were made in 2001, facilitating confidential interviewing with drug users for the purpose of research for government.

Alcohol is not included in the law on drugs. It is controlled under the law of Islamic Shari’ah.

2. Institutional framework of drug abuse control

The major law enforcement agencies concerned with drug abuse in Maldives include the Ministry of Defence and National Security, the Maldives Customs Services and the Narcotics Control Board.

The Ministry of Defence and National Security is primarily responsible for arrests and seizures related to illicit drugs in the country. The Drug Control Bureau (DCB) under this Ministry plays a pivotal role in the area of drug intelligence and investigation, narcotics identification, surveillance and seizures and arrests. Further, the police headquarters of the Ministry of Defence and National Security also actively coordinates the demand reduction programmes carried out by the Narcotics Control Board, by participating in their advisory committee and in their prevention and awareness programmes.

Together with police headquarters, the Maldives Customs Service (MCS) is responsible for the seizure of illicit drugs. The MCS collaborates with the Narcotics Control Board in their Advisory Committee decision on treatment and rehabilitation and participates in prevention and awareness programmes.

E. Strategies for drug abuse treatment

Although the Ministry of Health was earlier in charge of drug abuse prevention, treatment and rehabilitation, with the establishment of the Narcotics Control Board (NCB), these responsibilities were shifted to it.

The Narcotics Control Board (NCB) was established on 16 November 1997, directly under the President’s Office to bring about a reduction in the demand for and supply of illicit drugs. The primary responsibilities of NCB are demand reduction, awareness building, rehabilitation and liaison with international agencies.

Management of the treatment and rehabilitation of drug dependents through the residential care and community development programme is a function of the Narcotics Control Board. The Drug Rehabilitation Centre (DRC) was established on Himmafushi Island in 1997.

Residential care is provided through a therapeutic community model. The DRC has such facilities as a counselling department, library, computer centre, arts and crafts unit, vocational centre, agricultural unit, gymnasium, medical services and a mosque. Under the community development programme, individual counselling, self-help groups, academic, vocational and language classes are held for clients, along with random urine testing and strict supervision.
and monitoring by NCB staff. The programme also places emphasis on religion and spirituality. NCB also provides assistance to clients in securing employment. The treatment and rehabilitation programme is a system of parole, and once the community rehabilitation programme is successfully completed, the legal sentence gets annulled.

F. Strategies for prevention

Drug prevention education activities fall under the mandate of the NCB. The Board carries out comprehensive and specialized drug awareness programmes for the community on inhabited islands. School based awareness programmes are targeted on students, teachers and parents, while the atoll awareness programmes target atoll chiefs, island chiefs, health care workers, teachers and island community persons.

The Narcotics Control Board collaborates with such other governmental organizations as the Ministries of Education, Women’s Affairs and Social Security, Youth and Sports, Atolls Administration, Information, and Arts and Culture, the Maldives Customs Service and Police Headquarters, and such non-governmental organizations as FASHAN and SHE for awareness generation and prevention.

Currently in Maldives, involvement of the health sector in active drug related treatment and rehabilitation is minimal. Only a few cases of drug abuse with concurrent psychiatric morbidity referred by the NCB are seen at the Indira Gandhi Memorial Hospital (IGMH) and a psychiatrist attached to the Ministry of Health makes regular visits to the Drug Rehabilitation Centre. The Ministry of Health also participates in the advisory committee of the Narcotics Control Board and provides advice on the treatment decisions and rehabilitation of drug dependents.
IV. RAPID SITUATION ASSESSMENT

A. Background

Drug abuse is often a hidden problem in the community, and not amenable to evaluation through conventional epidemiological research methodologies. Patterns of drug abuse and associated consequences vary among different social groups and in different geographical areas. Drug abuse is also a dynamic phenomenon, greatly influenced by sociocultural, economic and political factors. Given these difficulties, a rapid assessment is a more appropriate strategy to understand the drug abuse phenomenon and develop timely and appropriate interventions. Rapid Situation Assessment (RSA) methodology (Drug Abuse Rapid Situational Assessment and Responses 1999) uses multiple indicators and data sources, both quantitative and qualitative, and allows exploitation of existing data. It uses the technique of data triangulation to verify information. It allows direct contact with informants, in order to cross check conclusions and avoid being misled by accepted wisdom about the situation. It allows the problem to be viewed in various contexts – social, cultural, historical – and from public health perspectives. RSAs are increasingly being used for making appropriate interventions for social and behavioural problems.

B. Objectives of the Rapid Situation Assessment

The overall objective of the RSA in Maldives was to study the extent and patterns of drug abuse in the country, and to provide the Government with the necessary policy direction to address issues of prevention and intervention. The RSA included an assessment of the structural, social and cultural factors likely to influence drug abuse in the community and country (contextual assessment); the extent, nature and patterns of drug abuse in the country (problem assessment); evaluation of existing data systems of monitoring drug abuse; identification of the resources available for prevention and treatment of drug abuse (resource assessment), in order to evolve strategies for continuous monitoring and networking among relevant organizations, and to make recommendations for the formulation of the National Master Plan for Drug Abuse Control.

The RSA was conducted by a non-governmental agency, Foundation for the Advancement of Self Help in Attaining Needs (FASHAN), in collaboration with the NCB. The initiative was supported by the United Nations Development Programme (UNDP) and executed by the Economic and Social Commission for Asia and the Pacific (ESCAP). Field staff identified for the RSA were intensively trained in various techniques of fieldwork and data collection. Issues such as confidentiality, sensitivity, ethics, safety and security were discussed. Special sessions on drug-use-related public health problems, especially HIV/AIDS, were discussed at length. Mock sessions for drug user interviews, key informant interviews and focus groups were conducted. Training was provided on ethnographic mapping and staff members were urged to maintain field diaries of their observations. The staff was responsible for collecting both primary and secondary data for the RSA, and was supported by a data entry and statistical team. The field staff also included former drug users, who played a key role in recruiting drug-using respondents. A national consultant was responsible for the planning, conduct and report formulation of the RSA, with regular inputs from an international consultant and administrative monitoring from ESCAP. Periodic inputs were obtained from the advisory board of FASHAN, UNDP and NCB prior to, during and after the completion of the RSA.
C. Preparation for the Rapid Situation Assessment

Questionnaires were prepared in English, suitably modified to the local context and translated into Dhivehi. Necessary modifications were made after field-testing. Most of the interviews, including respondent interviews, key informant interviews and focus groups were conducted in Dhivehi. The primary respondent interview attempted to capture drug use, socio-demographic factors, injecting use, sexual practices, health related problems, legal problems and help seeking for drug abuse problems. The records maintained by the NCB and the DCB were studied, and appropriate questionnaires prepared to capture the information.

The drug law 17/77 mandates the reporting of any person who admits to using drugs. This law was amended in 2001 to allow confidential interviewing with drug users for the limited purposes of research and treatment. However, this change had to be widely publicized prior to the RSA, both to the public and the law enforcement agencies, to overcome the fears associated with being identified as drug users.

D. Types of data collected

Data were collected for the study using different methodologies, as indicated in table 3. A total of 3,909 respondents connected with drug use directly or indirectly, including 471 drug users were interviewed. Of the latter, 204 respondents reporting drug use in the previous six months, at least 16 years of age and consenting to participate completed the detailed interview. Information on those arrested was obtained on through pre-designed structured formats on 2,304 persons arrested by the DCB and 547 drug users who had been handled by the NCB.

<table>
<thead>
<tr>
<th>Type</th>
<th>Activity</th>
<th>No. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary data</td>
<td>- Primary respondent interviews completed</td>
<td>204</td>
</tr>
<tr>
<td></td>
<td>- Primary respondent interviews with only</td>
<td>267</td>
</tr>
<tr>
<td></td>
<td>screening information/incomplete interviews</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Key informant interviews</td>
<td>111</td>
</tr>
<tr>
<td></td>
<td>- Focus group interviews</td>
<td>443</td>
</tr>
<tr>
<td></td>
<td>- In-depth interviews of drug users</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>- Family burden interviews</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>1,058</strong></td>
</tr>
<tr>
<td>Secondary data</td>
<td>DCB Arrest Data</td>
<td>2,304</td>
</tr>
<tr>
<td></td>
<td>NCB Data</td>
<td>547</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>2,851</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Grand total</strong></td>
<td><strong>3,909</strong></td>
</tr>
</tbody>
</table>

E. Choice of sites

Three atolls were initially chosen for the RSA, based on consultation between the project team, the NCB and its collaborating agencies. Male’ atoll, Miladhunmadulu Dhekuwuburi atoll from the north and Addu atoll from the south were chosen as potential research sites. The choice of the atolls was based on the recognition of drug problems at these sites,
including drug seizures and arrests, as well as constraints of travel and time. Another atoll in the north, Faadhinpolhu, was included later, as key informants from Miladhunmadulu Dhekenuburi indicated higher levels of drug use in Faadhinpolhu.

F. Recruitment of respondents

Potential primary respondents were identified primarily through a snowballing method, where one drug user introduces the interviewers to other drug users. Many of the interviews were conducted on the street or at homes, ensuring as much privacy and confidentiality as possible.

A total of 111 key informant (KI) interviews were carried out for the RSA. KI included policy makers from law and health sectors (17), treatment centre personnel and care givers (23), drug users and community key informants (sex workers, taxi drivers, drug dealers, 8), community members (teachers, students, youth club leaders, political leaders, religious leaders, senior citizens, sports persons and others, 63). A total of 49 focus groups were conducted among health personnel and policy makers (9), NGOs (7), youth groups (3), families of drug users (4), taxi drivers (2), schoolteachers, students and parents (11), religious leaders (1) and others (3). Four focus groups each were conducted in resorts near Male’ and in prison.

Table 4. Salient features of data collection

<table>
<thead>
<tr>
<th>Type of data collected</th>
<th>Site</th>
<th>No of respondents</th>
<th>Technique of recruitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary respondent data (204 completed)</td>
<td>Male’</td>
<td>157</td>
<td>Snowballing</td>
</tr>
<tr>
<td></td>
<td>Noonu/Lhaviani</td>
<td>21</td>
<td>Sampling from street observations</td>
</tr>
<tr>
<td></td>
<td>Addu</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Key informants (111)</td>
<td>Male’</td>
<td>54</td>
<td>Identified through FASHAN, NCB, study team and locals</td>
</tr>
<tr>
<td></td>
<td>Noonu/Lhaviani</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Addu</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Focus groups (49)</td>
<td>Male’</td>
<td>24</td>
<td>Identified through relevant organizations, key informants and locals</td>
</tr>
<tr>
<td></td>
<td>Noonu/Lhaviani</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Addu</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>In-depth interviews (13)</td>
<td>Male’</td>
<td>8</td>
<td>Those under 16 and therefore not eligible for primary respondent interview and a few representative drug users</td>
</tr>
<tr>
<td></td>
<td>Noonu/Lhaviani</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Addu</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Family burden interview (19)</td>
<td>Male’</td>
<td>7</td>
<td>Family members of current drug users</td>
</tr>
<tr>
<td></td>
<td>Noonu/Lhaviani</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Addu</td>
<td>8</td>
<td></td>
</tr>
</tbody>
</table>

Three sets of data were available for analysis. The first set of data was obtained from face-to-face primary respondent interviews. The second set of data included qualitative data from key informant interviews, focus group discussions, in-depth interviews, family burden interviews and ethnographic observations. The third set of data was the secondary data obtained from the NCB, Drug Control Bureau and the Maldives Customs Service.

This report discusses the findings of the first two sets of data (primary respondent data and qualitative data) together, and then presents the secondary data in an attempt to provide a comprehensive understanding of the ramifications of drug abuse in Maldives.
G. Locating respondents and ethnographic observations

In any community, there is a great reluctance to self-report drug abuse and to consent to a detailed interview on personal issues. Stigma is a major factor that prevents such self-reporting. In a country with punitive laws against drug abuse, the fear factor makes the problem even more serious. Identifying potential drug users and obtaining consent for an interview was thus one of the most challenging tasks for the field investigators. This section discusses briefly the strategies and experiences in locating and interviewing drug using respondents (see box 1).

Box 1. Excerpts from field investigators’ logs

**Male’**

“From 6:45 pm to 7:10 pm, my partner and I tried to find a respondent. Finally my partner decided to call an NCB (Narcotics Control Board) ex-client who might help us. We went to the nearest telephone booth and called the client. He invited us to his home where we explained about our project. He was more than willing to help us. He took us to his room and drew charts of places where we could find such people and gave us names.”

“We were in Villingili to meet one of the ex-clients. He was very willing to give an interview as a primary respondent. I asked him if he could get another respondent. He said that he had many close friends who are drug dependent, but he didn’t think that they would give an interview. He said that they won’t trust us, instead they will suspect that we are after them”.

“It was noon and there weren’t many people around. So we thought of going to the New Sina Male’ building (housing flats). On our way we saw three youth hurrying towards the deserted area around there. We followed them. When we went the three had disappeared but there were four other youth sitting under a tree smoking cigarettes and looking at something. When we passed them, they tried to ignore us and bowed their heads. They got up and went into the building. We followed them and one of us introduced herself. We then explained about the project and they were willing to give the interviews after talking for sometime...each one of them was drug dependent”.

Noonu, Manadhoo

“Seeing the size of the islands and the information about the island we got from previous interviews with the public, we had lots of hopes that we would get respondents. Right after we landed we had the normal meeting with the island authorities. The island chief said ‘you won’t be able to find even a single addict here.’ We had our doubts and kept on trying till evening. We were unable to find even a single drug user. The chief was right”.

“We found no signs of any drug users in the island so finally I and my partner decided to go to the beach. Unlike in other islands where we found signs of drug use, there were no signs of any cologne bottles, empty medicine bottles or any other material which could be associated with drug abuse activities.”

Lhaviyani Hinnavaru

“There were not many people on the roads. It was at around 7:15 pm. My partner and I went to one of our sources in the island. With the help of our source we went and met up with the other FIs. When we reached the others, there were eight drug users sitting on the ground with the FIs. They had managed to build a good rapport with the group of boys. We were introduced to each other and each one of us took an interview with one of the boys. I interviewed one boy while he was using brown sugar”.

“After giving us some interviews, the respondents took us to a very narrow road saying that they have many more friends that they would like to introduce us to...we followed them...We stopped at a point and the boys called out some nick names, and in a second there were a whole lot of youth coming out from the narrow roads...almost more than 40 youth got introduced to us that night. From those, there where some who became primary respondents. Some doubted confidentiality and denied drug use or refused to be interviewed. Eight drug users helped us in that island. They thanked us saying that they had got something to do since they were so bored in the island”.
not easy to make the respondents agree to the interview. The field investigators had to schedule interviews in isolated places, like vacant houses.

In Hithadhoo island, these were a lot of young people suspected to be drug users. However, in Feydhoo, Maradhoo, Meedhoo, it was difficult to identify persons abusing drugs. In Meedhoo, it was not possible to identify or interview any drug users.

In the northern Noonu Velidhu there were young people using drugs. Suspicious behaviour was observed near the football ground where a match was being played.

The two islands visited in Faadhinpolhu were crowded. People hung around the streets until midnight. According to the local people interviewed in the focus group and key informant interviews, there were drug users on the two islands. A group of about eight young people occupied a joalifathi on the road and spent a lot of time there together. Interviews obtained from them indicated that some of them were currently using some form of drug. Some of the boys were afraid that the field investigators were actually undercover police.

In Faadhinpolhu Naifaru, it was noted that some in the island community were dissatisfied with the island authority’s handling of certain problems. The community seemed to blame the authorities for the increasing use of drugs on the island. Recent incidents of violence and gang rape were reported.
V. KEY INFORMANT AND FOCUS GROUP PERCEPTIONS

A. Extent of the problem

1. Key informant perceptions

Key informants (KI) from all four atolls were near unanimous in their opinion that drug abuse had increased in the country (80 per cent). Thirty-nine per cent agreed that the pattern of drug abuse changes according to the types of drugs that are available (table 5). Law enforcement and health personnel were of the perception that drug abuse is decreasing however.

Table 5. Key informant perceptions on extent of the problem of drug abuse

<table>
<thead>
<tr>
<th>KI perception</th>
<th>Male' (N=54)</th>
<th>Addu (N=34)</th>
<th>Noonu and LH (N=23)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change in the pattern of drug use</td>
<td>No.</td>
<td>Percentage</td>
<td>No.</td>
<td>Percentage</td>
</tr>
<tr>
<td>Pattern of drug abuse emerges according to availability of drugs</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Drug abuse is increasing</td>
<td>21</td>
<td>39</td>
<td>13</td>
<td>38</td>
</tr>
<tr>
<td>Drug abuse is decreasing</td>
<td>42</td>
<td>78</td>
<td>31</td>
<td>91</td>
</tr>
<tr>
<td>Drug abuse is decreasing</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>

2. Focus group perceptions

Most of the focus group respondents across the four atolls believed that drug abuse was increasing in the country.

Box 2. Perceptions of key informants on extent and patterns of drug abuse

Fears shared by key informants regarding the changing patterns of drug abuse included the following.

“Drug abuse is increasing day by day. Also the airport and customs security has got to be checked on a tight basis. This is a problem not only for Male’. It is a problem for the whole country. The islands are being ignored and it is increasing day by day in the islands. Also the punishment should be according to the crime committed.”

“In five years time, nobody will realize, but the problem will explode like a bomb to more areas of the country, maybe more murders and rape cases.”

“Health wise there will be a lot of sickness such as infections.”
“There will be economic drainage of money, as people will be spending a lot of money to buy drugs rather than saving the money.”

“In the workforce the number of expatriates will increase, as drug abusers cannot be included in the working population. Workforce will include more expatriates than local people.”

“Maybe have to experience more HIV cases. There will always be a cover up of these issues, so the problem will explode without realization.”

However, respondents from the northern island of Miladhunmadulu. Manadhoo were of the opinion that their island was free from narcotic drugs and that drug addiction is decreasing. Respondents from two other islands reported that heroin abuse is decreasing although the abuse of pharmaceutical drugs may be increasing. The reason for this was attributed to a police raid conducted just prior to the data collection period. Focus groups from Miladhunmadulu Dheknuburi. Holhudhu also reported absence of any abuse. However, the youth focus group reported the presence of drug abuse on the island, though it was not presently surfacing. In some of the islands in Miladhunmadulu Dheknuburi, like Velidhu, drug abuse was perceived to be increasing. Schoolteacher focus groups in Male’ and other atolls were not aware of drug users in schools, because students were likely to be expelled if drug abuse was confirmed.

“In 1980 we had a drug incident in our school. We expelled all the children involved. Education Ministry has rules that say that drug users should be expelled from school.”

Source: Focus group with teachers and supervisors of schools in Male’.

In the four focus groups conducted in the prison all the respondents agreed that a majority of the jail population had a history of drug abuse. According to one of the focus group respondents, 95 per cent of the prisoners in jail are drug users.

B. Profile of drug users

1. Key informant perceptions

Among key informants, a majority (49 per cent) perceived that drug use is most common among persons aged 16-30 years while 35 per cent believed that children below age 16 years were also using drugs. In the north, drug abuse is perceived to be higher among those under 16 (49 per cent of key informants). Twelve (11 per cent) key informants believed that elderly persons and those with psychiatric problems were also abusing drugs.

2. Focus group perceptions

In seven of the focus groups, respondents opined that drug abuse is most common among those over 15 years of age, while two groups reported that children as young as 12 years initiate drug use with smoking. Students in Grades 9 and 10 were thought to be at maximum risk. NGO participants believed that drug abuse was a problem from the age of 11 years. In
the northern atoll, it was believed that young children abuse drugs, whereas in the south, the perception was that more youth are involved in drug abuse. Taxi drivers were of the opinion that there were girls abusing drugs in addition to male youth. There was a unanimous perception that drug users were absent within the school system. The student groups perceived that drug users are mostly boys who are school dropouts from Grade 7 or 8. They were also aware of girls using drugs.

According to the focus groups, vulnerable groups for drug abuse were considered to be those with limited educational opportunities (surfers focus group), those working in resorts (fishermen’s focus group), youngsters hanging out in gangs (shopkeepers’ and waiters’ focus group), those unemployed (resort staff focus group), island children who stay in Male’ without proper guidance (teachers’ focus group), and young children who are sent abroad for studying (policy makers’ focus group).

C. Types of drugs available

1. Key informant perceptions

Although a majority of key informants agreed that heroin (brown sugar) was the most commonly available drug, key informants from the north were of the opinion that “cola water” and “dunlop” were the drugs abused the most.

Table 6. Key informant perceptions on types of drugs abused

<table>
<thead>
<tr>
<th>Drug type</th>
<th>Male' (N = 54)</th>
<th>Addu (N = 34)</th>
<th>Noonu and LH (N = 23)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>Percentage %</td>
<td>No.</td>
<td>Percentage %</td>
</tr>
<tr>
<td>Heroin and brown sugar</td>
<td>43</td>
<td>80</td>
<td>22</td>
<td>64</td>
</tr>
<tr>
<td>Cola water and Dunlop</td>
<td>8</td>
<td>15</td>
<td>19</td>
<td>56</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>8</td>
<td>15</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Cannabis</td>
<td>6</td>
<td>11</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Others (Oshani, alcohol, ecstasy)</td>
<td>9</td>
<td>17</td>
<td>6</td>
<td>18</td>
</tr>
</tbody>
</table>

Some key informants also reported the abuse of alcohol, local brews such as Oshani and adulteration of brown sugar with human bones and other substances (from the north islands).

2. Focus group perceptions

In the focus group discussions of the policy makers, the law enforcement personnel were of the unanimous opinion that heroin or brown sugar is the most abused drug, followed by cannabis, “cola water” and pharmaceutical drugs (diazepam, valium) and afihun (opium). Focus groups conducted in Miladhunmadulu Dhekimuburi Vellidhoo reported people abusing cola water, hair tonics and forms of tablets. Health personnel focus groups from the north reported cases of self-medication with analgesics (panadol) and abuse of cough syrup. Some of the health category focus group respondents also mentioned people abusing
substances such as hair tonics, *oshani*, and dead human bones. “*They perceive that these substances can make one lose control over their mind*”. Focus groups from Faadhinpolhu Atoll reported occasional cases of persons abusing cola water. However, it was not seen as a very big problem.

Some of the respondents perceived dunlop as an intoxicating substance. “Now we hear more frequently about it in the island. Dunlop sniffing has increased after the awareness programme.”

The focus groups of NGOs conducted in the south atoll (Addu) believed that brown sugar and hash oil were the most abused form of drugs followed by medicines like cough syrups. Local brews made from *oshani* were also reportedly abused in this region. In one of the youth focus groups conducted in Addu Atoll (S. Hulhudhu) respondents were of the unanimous opinion that people on the island were using cola water, dunlop, prescription drugs (valium, alprax, proxyvon) and brown sugar. According to youth in a focus group in Addu (S. Hulhudhu), about 10 per cent of the people on that island abused drugs, with a majority of them abusing heroin (brown sugar), followed by abuse of prescription drugs, cola water and dunlop.

**Box 3. Locally abused substances**

<table>
<thead>
<tr>
<th>Smoking of the roots of the breadfruit tree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tender dried roots of the breadfruit tree are smoked for intoxication and create a very strong pungent burning sensation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sniffing and chewing of dunlop</th>
</tr>
</thead>
<tbody>
<tr>
<td>A few anecdotal reports were available of chewing “dunlop” glue with dried tender coconut. This was reported to give a quicker high when sniffed. There were also references to making and smoking cigars made of No. 4 fabric rolled up with dunlop glue.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Oshani</th>
</tr>
</thead>
<tbody>
<tr>
<td>This locally available medical herb is used in different ways to get intoxicated. The small <em>oshani</em> fresh fruit is mixed with fresh fruit juices and swallowed, or it is cooked in rice porridge and swallowed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cola water</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eau de Cologne with varying alcohol content (up to 70 per cent or more) is either mixed with soft drinks, tender coconut juice or fresh fruit juice, or swallowed straight.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Brown sugar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impure heroin is further adulterated with “Minikashi” or dried human bones or sawdust to increase the quality.</td>
</tr>
</tbody>
</table>
D. Reasons for drug use

1. Perceptions of key informants

“Most people start using drugs out of curiosity these days. Also it is seen as a fashion. Like now most people in Male’ changed their hairstyles after seeing Ronaldo’s hair in the World Cup. Similarly, people use drugs because somebody they admire is using it. Also not getting the care and attention from parents and girlfriends are reasons that lead to drugs.”

Key informant: Pharmacist

Table 7. Key informant perceptions on primary reasons for drug abuse

<table>
<thead>
<tr>
<th>Reason</th>
<th>Male’ (N=54)</th>
<th>Addu (N=34)</th>
<th>Noonu and LH (N=23)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due to family problems</td>
<td>26</td>
<td>9</td>
<td>13</td>
<td>48</td>
</tr>
<tr>
<td>Percentage</td>
<td>48</td>
<td>26</td>
<td>57</td>
<td>43</td>
</tr>
<tr>
<td>Due to experimenting</td>
<td>6</td>
<td>6</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Percentage</td>
<td>11</td>
<td>18</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Due to peer pressure</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Percentage</td>
<td>9</td>
<td>6</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td>Lack of awareness</td>
<td>9</td>
<td>9</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>Percentage</td>
<td>17</td>
<td>26</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>Due to easy availability</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Percentage</td>
<td>6</td>
<td>3</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Lack of recreational activities</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Percentage</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Due to psychological problems (excessive</td>
<td>18</td>
<td>2</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>worrying, anxiety, sadness, sexual</td>
<td></td>
<td>6</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>dysfunctions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Many of the key informants (43 per cent) were of the perception that people abuse drugs due to family problems, while 20 per cent attributed drug abuse to lack of awareness.

Twenty (18 per cent) of the key informants perceived that psychological problems such as excessive worrying, anxiety, sexual dysfunction and sadness were the main reason for abusing drugs. This was a common perception in Male’.
Others perceived reasons for abusing drugs to include a desire to experiment (13 per cent), followed by peer pressure (10 per cent), easy availability (6 per cent) and lack of recreational activities (3 per cent).

2. Focus group perceptions

Focus group respondents from different backgrounds cited several different reasons for drug abuse. These are summarized in table 8. The responses are not ranked.

Table 8. Focus group perceptions on reasons for drug abuse

<table>
<thead>
<tr>
<th>Reason for drug abuse</th>
<th>Type of focus group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of awareness</td>
<td>Most</td>
</tr>
<tr>
<td>Availability of drugs</td>
<td>Taxi drivers, students, prisoners, users and families, shopkeepers/waiters, prisoners</td>
</tr>
<tr>
<td>Inadequate security at airports and ports</td>
<td>Taxi drivers</td>
</tr>
<tr>
<td>Family problems</td>
<td>Users and families, teachers, students, NGOs</td>
</tr>
<tr>
<td>Inadequate parenting and monitoring</td>
<td>Policy makers, students</td>
</tr>
<tr>
<td>Unemployment</td>
<td>Policy makers, users and families, students, religious leaders</td>
</tr>
<tr>
<td>Academic problems, including dropout</td>
<td>Prisoners</td>
</tr>
<tr>
<td>Children sent abroad with a lot of money</td>
<td>Policy makers</td>
</tr>
<tr>
<td>Lack of educational opportunities</td>
<td>Surfers</td>
</tr>
<tr>
<td>Fun and pleasure</td>
<td>Students, surfers</td>
</tr>
<tr>
<td>Lack of recreational activities</td>
<td>NGOs</td>
</tr>
<tr>
<td>Peer pressure</td>
<td>NGOs teachers, students, prisoners</td>
</tr>
<tr>
<td>Glamorization of drug use</td>
<td>Students, shopkeepers/waiters, resort staff</td>
</tr>
<tr>
<td>Lack of life skills and lack of assertiveness</td>
<td>Users and families</td>
</tr>
<tr>
<td>Low self esteem, stress, depression</td>
<td>Resort staff</td>
</tr>
<tr>
<td>Boredom, experimentation</td>
<td>Students, religious leaders</td>
</tr>
</tbody>
</table>

Lack of awareness of the dangers of drug abuse and easy availability were cited as the most common reasons for drug abuse in most of the focus groups. The role of the media in providing information about drugs, awareness programmes increasing people’s curiosity to use (teacher and health focus groups), the lucrative business for traffickers (NGO, prisoner and policy maker focus groups) were considered factors leading to increased abuse by some groups. Student focus groups perceived working on resorts as a risk for drug use. Fishermen believed that expatriate workers were involved in drug peddling and trafficking. A decrease in spirituality was one of the reasons attributed to increasing drug use by the religious focus groups.

Some of the focus group respondents felt that banishment (sending to a different island as punishment for drug abuse) actually resulted in the spread of drug abuse to the more remote islands.
VI. CHARACTERISTICS OF DRUG ABUSERS
PRIMARY RESPONDENT INTERVIEWS

A. Social and demographic characteristics

1. Age, marital status, migration

A total of 471 potential respondents were approached for interview. Of this group, 319 admitted to having used drugs (68 per cent), among whom 208 reported use in the previous 6 months. Of the 208, 204 primary respondents completed interviews. Seventy-seven per cent were from Male’, 10 per cent from the northern atolls Miladhunmadulu Dhekunuburi and Faadhinpolhu and 13 per cent from the southern Addu atoll.

As not all questions were uniformly answered by all the respondents, either the specific number of responses or valid percentages are indicated for each parameter in the text below.

Most of the respondents (197, 97 per cent) were male and 7 were female. Mean age of the respondents was 21.4 years (range 15 to 42 years). Almost half the respondents were below 20 years of age (95, 47 per cent), 66 (32 per cent) were 20-24 years of age and 27 (13 per cent) were in the age group 25-29 years. Only 16 (8 per cent) were above 30 years of age (figure 3).

Most of the respondents (164, 81 per cent) were unmarried, 21 (10 per cent) married and 17 (8 per cent) divorced. Of the latter two groups, more than half (59 per cent) reported having 1-2 children. Thirteen per cent had 3 or more children.

Sixty-four respondents had moved residence, mainly into Male’, two thirds for education (63 per cent), 5 per cent for employment, and the remaining for other reasons.
2. Educational status

Ninety-four (46 per cent) respondents had reached secondary school (Grades 8-10) and 48 (24 per cent) studied up to “O” level or “A” level. About a quarter (26 per cent) had only attained primary level of education (Grades 1-7).

Most of the respondents (91 per cent) had not achieved the desired level of education. Reasons cited for this included drug use (27 per cent), financial difficulties (21 per cent), disciplinary problems in school, or lack of interest in studies (21 per cent). Over half (52 per cent) reported repeated difficulties while they were in school. Among this group, problems were mainly related to discipline (43 per cent) and attendance (19 per cent).

3. Occupational status

Sixty-eight (34 per cent) held a job at the time of the interview. Occupations included business (19 per cent), tourism-related work (15 per cent), construction work (13 per cent) and engineering (10 per cent). Mean age at first job was 17.5 years with a range from 12 to 23 years.

4. Current living arrangements

Of 203 respondents, 114 (71 per cent) said that they lived in their own house or family house. Twenty-nine (14 per cent) were living with their friends and 26 (13 per cent) lived in rented houses. Four (2 per cent) had other means of accommodation. Eighty-eight (44 per cent) were living with both parents, 53 (26 per cent) were with single parents, and 27 (13 per cent) stayed with other relatives. Seventeen (8 per cent) lived with siblings, 12 (6 per cent) with others and only 6 (3 per cent) were living with spouses. Fifty-nine per cent of the respondents’ parents were married at the time of interview and 31 per cent reported that their parents were divorced or separated.

5. Income
Many of the respondents did not have any personal income. Sixty-seven respondents provided information on their income at the time of interview. Of those, 72 per cent had monthly income of RF 1,000 to RF 4,999, 16 per cent received an income of RF 5,000 to RF 9,999 and 9 per cent earned RF 10,000 to 99,990 per month. Only 3 per cent of the respondents with incomes earned at least RF 100,000 per month (12.7 RF = 1 US$).

B. Drug use

1. Smoking initiation

Two hundred respondents (98 per cent) reported being smokers. Almost half (48 per cent) had initiated smoking between 10 and 14 years of age, and 42 per cent between 15 and 19 years of age. Five per cent of those who smoked started before they were 10 years of age. Thus 95 per cent of drug using respondents had started smoking by 20 years of age. Eighty-eight per cent smoked tobacco in the form of cigarettes, 6 per cent smoked bidis, and 4 per cent cigars. Fun (66 per cent) and fashion (9 per cent) were cited as the most common reasons for initiation of smoking.

![Figure 5: Age of smoking initiation](image)

2. Drug use initiation

Mean age of first use of any drug apart from tobacco was 16.8 years with an age range from 10 to 27 years at onset of drug use. One hundred and thirty respondents (64 per cent) had initiated drug use between 15 and 19 years of age, 40 (20 per cent) between 10 and 14 years and 27 (13 per cent) between 20 and 24 years. Only a minority (2 per cent) had initiated drug use after 25 years of age.

First drug use closely mirrors onset of tobacco use as is evident in figures 5 and 6, and appears to follow a couple of years after onset of smoking.
Knowledge about drugs was mainly obtained from friends (81 per cent) or relatives (9 per cent). The rest (10 per cent) had heard about drugs from other sources. This was a common pattern across sites, with 80 per cent of respondents from Male’, 85 per cent from the northern atolls and 85 per cent from the south reporting that they had first learned of drugs from friends.

Age of first drug use was fairly similar among the different sites (figure 7). In Male’, more than half the respondents had started drug use by 16 years of age. In the north and south, half of the drug users had initiated drug use by the age of 17 years.

3. Reasons for initiation

Peer pressure was the most common reason for initiation (38 per cent), followed by desire to experiment (26 per cent). About a fifth of respondents had initiated drug use for fun. Ten per cent cited family problems as the reason for initiating drug use.

4. Employment status at initiation
Of the 197 who responded, 73 (37 per cent) were employed at the time of initiating drug use. At the time of starting drugs, 64 per cent of respondents from Male’, 50 per cent from the North and 62 per cent from the South were unemployed.

5. Location of first use

Drug use was initiated most commonly at home (30 per cent), in a friend’s house (27 per cent) or a public place (18 per cent). Less commonly, it had been initiated in a resort (11 per cent) or a secluded place (11 per cent).

Thirty-four per cent of drug users in Male’ had first used drugs in their homes. This was followed by 28 per cent who used drugs at their friend’s home. In the north, 25 per cent had first used drugs at a public place and another 25 per cent had first used at resorts. In the south 35 per cent had used drugs first in a secluded place and 27 per cent had used them at a friend’s.

Most respondents in all the research sites had initiated drug use with friends (87 per cent). They had mainly acquired the drug through friends (72 per cent). A smaller number had bought it on the first occasion (19 per cent) and a few (8 per cent) had stolen the drug for first use.

6. Type of drug used at initiation

The drugs used at initiation are summarized in table 9. Opioid was the drug of initiation for 43 per cent of respondents, followed by cannabinoids by 34 per cent. Alcohol and ‘cola water’ (eau de cologne) were initiating drugs for a smaller number of respondents (12 and 5 per cent, respectively). The opioid was brown sugar (adulterated heroin) for 100 of 108 users. Eight reported initiation with Corex D syrup (cough syrup containing codeine). The cannabinoids category meant hashish oil for 58 of 68 cannabinoid users. The other 10 users reported using grass (5), hash (2), marijuana (2) and ganja (1). A small number had initiated drug use with tablets (Advil and Actifed, antihistaminics; and Valium, diazepam). Two users had started drug use with dunlop, and one with cocaine. Forty-three per cent had initiated by chasing and 30 per cent by smoking the drug of initiation.

Figure 8. Type of drug used first time, by site
<table>
<thead>
<tr>
<th>Drug of initiation</th>
<th>Number (N)</th>
<th>Valid percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids (mainly brown sugar)</td>
<td>87</td>
<td>43</td>
</tr>
<tr>
<td>Cannabinoids (mainly hashish oil, ganja, bangu, charas)</td>
<td>69</td>
<td>34</td>
</tr>
<tr>
<td>Alcohol</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>“Cola water” (eau de cologne)</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Sedative/hypnotics</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Inhalants</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1</td>
<td>0.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mode of initiation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chased</td>
<td>87</td>
</tr>
<tr>
<td>Smoked</td>
<td>60</td>
</tr>
<tr>
<td>Swallowed</td>
<td>48</td>
</tr>
<tr>
<td>Sniffed</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for initiation</th>
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<td>Peer influence</td>
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</tr>
<tr>
<td>For experimenting</td>
<td>60</td>
</tr>
<tr>
<td>For fun</td>
<td>46</td>
</tr>
<tr>
<td>Due to family problems</td>
<td>23</td>
</tr>
<tr>
<td>Due to psychological problems</td>
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</tr>
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<table>
<thead>
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<td>Secluded place</td>
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<table>
<thead>
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<th>Initial use with</th>
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<td>174</td>
</tr>
<tr>
<td></td>
<td>Alone</td>
</tr>
<tr>
<td>----------------</td>
<td>-------</td>
</tr>
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<table>
<thead>
<tr>
<th>Age at first drug use</th>
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<tbody>
<tr>
<td>10-14 years</td>
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<td>15-19 years</td>
</tr>
<tr>
<td>20-24 years</td>
</tr>
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<td>25-27 years</td>
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<table>
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<tr>
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<tr>
<td>From friends</td>
</tr>
<tr>
<td>Bought</td>
</tr>
<tr>
<td>Stole</td>
</tr>
<tr>
<td>Others</td>
</tr>
</tbody>
</table>

In Male’, 47 per cent started drug use with opioids and 36 per cent with cannabinoids (figure 8). In the north 33 per cent started with cola water and 29 per cent started with alcohol. In the south 42 per cent started with opioids and 35 per cent with cannabinoids.

Following the initiation of drug use, 91 per cent of the respondents had used opioids, 79 per cent cannabinoids, 47 per cent alcohol, 30 per cent sedatives/hypnotics and 15 per cent cola water. Cocaine use was reported by 5 per cent.

7. Primary current drug

Figure 9. Primary drug used in the previous month

Of 159 respondents, 121 (76 per cent) reported current use of opioids and 19 (12 per cent) reported cannabinoids. The remaining 19 (12 per cent) reported the use of alcohol, cola water, inhalants/solvents, sedative/hypnotics, or others. More than half the respondents used drugs with companions (52 per cent), while 43 per cent used them alone. The others used drugs both in company and when alone. Sixteen per cent of the respondents reported that they had last used drugs on the day of the interview, 16 per cent had used them the day prior
to the interview, 6 per cent two days prior to the interview, 9 per cent within the prior week, and the remaining 53 per cent more than seven days prior to the interview.

All the current users (159) were daily users, with 21 per cent using the drug once a day, 34 per cent twice, 26 per cent thrice and 19 per cent four or more times per day. Chasing was the most common (74 per cent) mode of current use, followed by smoking (13 per cent) or swallowing (11 per cent).

**BOX 4. CASE ILLUSTRATION: COLA WATER USER**

I started smoking when I was 12 years old. At Grade 9, I stopped studying because there were some problems at home. When I was 16, I smoked brown sugar for the first time. I was aware during that time that my brother was also using brown sugar. My sisters knew I was using. They never tried to stop me, but always told me that I should do whatever I do at home and nowhere else. I got a monthly allowance of RF 500 from my sisters. Four months ago, (2002), I used eau de cologne for the first time. My sisters were low on money. My friend and I took a bottle of cologne from a friend’s shop on credit. At first we mixed it with coca cola to tolerate the bitter taste. After two weeks, we got used to the bitter taste and used it without coca cola. After drinking I felt like there were no thoughts or worries in my mind.

**BOX 5. DUNLOP USER**

I sniffed dunlop for about a week. Once I went to the jungle, and saw two friends sniffing from a dunlop tin. They offered me and I also sniffed with them. We used it from morning to evening. My friend is now in Maafushi Home for Juveniles. One of my relatives saw me and told my mother. My mother advised me and I stopped it.

13 year old boy from the south

Another 14-year old described the effects of sniffing “We kept it close to the nose, covered one nostril, and sniffed for about 30 minutes. It felt minty and I felt dizzy and could not make sense of anything afterward.”

8. Money spent on drugs
The current minimum amount spent per day on drugs (median value) was RF 190 (US$ 15) with a range from RF 0 to RF 3,500. The maximum amount spent per day on drugs was (median) RF 500 (US$ 39), with a range up to RF 198,000 (figure 10).

### Primary support for drug acquisition

Of the 195 current users, 80 (41 per cent) said primary support for drugs came from a job or employment; 56 persons (29 per cent) obtained their money for drugs primarily by ‘pushing’ - (selling drugs), 24 (12 per cent) were supported by friends, and 23 persons (12 per cent) by family members. A small number 9 (5 per cent) said that they were stealing from home (figure 11).

### Drug use in family

...
With regard to family drug use, 88 out of 200 persons (44 per cent) reported drug use by a family member, mainly brothers (68 per cent) and cousins or nephews (22 per cent). A smaller number reported drug use among sisters (7 per cent), mothers (5 per cent) and fathers (5 per cent). Opioids (70 per cent) were the most common drugs used by family members followed by cannabinoids (17 per cent). Other drugs used reported by family members included alcohol, sedative/hypnotics, cola water and cocaine.

11. Drug use among friends

Most respondents (98 per cent) had drug-using friends. Around half of them had 9 or fewer friends using drugs while the other 50 per cent had 10 or more friends who used drugs.

12. Injecting drug use

Of 199 respondents who answered this question, 65 (33 per cent) said they had seen drugs being injected. The median age at which injecting drug use had been observed was 17 years. With regard to having ever injected drugs themselves, 14 (8 per cent) of respondents reported having done so. More than half of the respondents reporting injecting use had initiated it prior to 17 years of age. Reasons for injecting included desire to experiment, to get a quick high, peer pressure and to handle withdrawals. Brown sugar was the drug reportedly injected. Some had initiated injecting while abroad. Among the 14 persons who reported ever having injected, only two persons had injected within the last 6 months.

Injectors reported cleaning needles with clean water or hot water (unsafe methods) or obtained new needles. They obtained needles from other drug injecting friends or a pharmacy. One out of nine persons reported always having shared syringes and another reported occasional sharing. Seven reported never having shared syringes. However five respondents reported sharing other injection equipment, such as a cooker, cotton filters, common water pot, common rinse water, etc. Only three persons reported sharing syringes and needles the last time they injected.

Box 6. Key informant perception of injecting drug use

About 5 per cent of the key informants had actually seen drugs being injected in the Maldives. One third per cent of the key informants from Male’, 15 per cent from Addu and 30 per cent from the north islands felt that drug injecting was not common in the Maldives.

Injecting drug use exists, though, in the Maldives. According to a key informant from law enforcement, “At some places of drug seizures, I have seen blood-stained needles in the houses known to drug users”.
VII. SEXUAL BEHAVIOUR AMONG DRUG USERS

“Now in this island many youth are involved in sexual intercourse. Those who are in Grade 6 also get involved in sexual intercourse. Some adults abuse small children to have sex with them. They give the child chocolates. In this island a group of thirty boys had sexual intercourse with one girl. They do that in the sandy beaches of the island. Mostly they use higher drugs before indulging in sexual intercourse”.

Student focus group in Naifaru

One hundred and twenty nine of the 171 unmarried respondents (75 per cent) reported experience of sex. Of this group, 121 (94 per cent) said the sexual experience was voluntary, while the other 6 per cent said it was forced. Among the 37 married respondents, 25 or 68 per cent reported a sexual experience with someone other than their spouse and 32 per cent did not have a sexual relationship outside their marriage.

Among 148 respondents, age at first sexual experience ranged from 7 to 24 years. A third reported sexual exposure by the age of 15 years. More than half (54 per cent) had a sexual experience by 16 years and almost three quarters (72 per cent) had sex by the age of 17 years. Ninety-two per cent had a sexual experience prior to completion of their teenage years (figure 12).
Of the respondents reporting premarital sex, 83 per cent reported first sexual experience with a friend, 6 per cent with an acquaintance and 5 per cent with a family member or a relative. The remaining 5 per cent reported first sexual experience with neighbours, strangers or a commercial sex worker (figure 13). Following the first sexual experience, 26 per cent reported having had sex with a sex worker (paid sex).

Of 148 respondents reporting sexual exposure, 5 (3 per cent) reported sexual intercourse with a member of the same sex. Sixty-four respondents (43 per cent) said they had experience of group sex (defined as more than two persons having sex at the same time).

Upon examining the age distribution for different sexual behaviours, the age range of respondents reporting sex with same-sex partners was 13 to 20 years. For those reporting sex with a sex worker, the age range was 11-27 years. Half of this group was aged 16 years or below. The age range of respondents reporting group sex was 11 to 23 years, of whom more than half were under the age of 16 years (figure 14).
On the question on the number of sex partners during the last year (138 responses), the number equalled one (24 per cent), two (17 per cent), three (14 per cent), four (13 per cent), or five (12 per cent). The remaining 20 per cent had 6 or more sex partners (ranging from 6 to 25 sex partners) during the last one year (figure 15). Thus 76 per cent of the respondents reported multiple sex partners during the last year.

A total of 158 persons responded to the question on whether they had ever used condoms. Half of this group reported ever using a condom. On the frequency of condom use, 30 per cent reported use always, 22 per cent most of the time, 36 per cent rarely, and the rest sometimes (figure 16). Forty-eight per cent said they always used condoms when they had sex with sex workers, 21 per cent reported condom use during most sex worker encounters, 3 per cent more than half the time and 28 per cent used condoms less than half the time or rarely during sex with sex workers.

It may be noted that while 129 unmarried respondents had reported sexual experience, only 79 respondents reported ever using a condom.
Many of the respondents reported drug use in the company of members of the opposite sex. One hundred and two out of 157 (65 per cent) reported drug use with members of the opposite sex and, of this group, 62 per cent also had sex with the drug-using partner. All of the 65 per cent of respondents who reported drug use with the opposite sex were between the ages of 10 and 27 years. More than half of this group was 16 years of age or below. Similarly, more than half the respondents who reported having a sexual relationship with their drug-using partner of the opposite sex were below 16 years of age.

Box 7. Case illustration: poly-drug use and sexual behaviour

“I started smoking at the age of seven on a holiday in Malaysia. I caught a cousin sister smoking. She got afraid that I might tell her parents, so she offered me a cigarette. I smoked without really inhaling just for the fun of it. I gradually learnt how to smoke properly and when I was 11 years old, I started smoking daily.

I have a brother who is a dealer and many times have observed him using. When I was 14 years old, I stole brown sugar from my brother and tried it by myself. I went to Sri Lanka to study. There I met a driver who introduced a drug called weed to me. I used to roll it into a joint and smoked it before going to parties with my friends.

The same driver told me about heroin and took me to a dealer. The dealer taught us how to use the new drug. He told us how to mix the solution and how to inject. We bought the syringes from the pharmacy and went home to my room. We mixed the heroin with the solution given with it. Then we heated it on a spoon and made the solution and injected it into a vein in our hands. We
The same driver told me about heroin and took me to a dealer. The dealer taught us how to use the new drug. He told us how to mix the solution and how to inject. We bought the syringes from the pharmacy and went home to my room. We mixed the heroin with the solution given with it. Then we heated it on a spoon and made the solution and injected it into a vein in our hands. We all wanted to try the effects and test it. After that day we all needed to use it regularly... it became a habit. I used it everyday mostly with my friends.

It was difficult for me to go out since the house I was staying in had strict rules. What I did was that I bought all the drugs (heroin) I would need for a week by cutting school one day. And later my friends and me got together and used it – on average twice a day.

After that when the same dealer introduced cocaine to me I started using cocaine. I used cocaine by snuffing it. Most of the time I kept it on a glass slab and used a small aluminium pipe to sniff the drug. Once when we were doing a work experience project in a lab with cocaine leaves, my friends and I stole the leaves. We dried them after putting them in a drying agent under a laboratory lamp and we made cocaine powder. We then sold it.

I feel troubled by an incident that happened to one of my friends who was using drugs with me. We both got withdrawals while in class one day. So we went into the toilet to use. We always had heroin in syringes on us. My friend was in such a hurry that he took too much too quickly and overdosed. He got a seizure and collapsed on the floor. I left the scene quickly knowing that if I stuck around I would get caught too. When he didn’t show up for the school the next day, all the students searched and found my friend... he was dead.

I felt the first real effect of withdrawal when I decided to come to Male’ and did not use that day. While I was going to the airport in Colombo I got a slight fever. I thought that it was just a normal fever. But on the plane I started shivering violently. Once in Male’ I asked a friend why it happened. He told me to use brown sugar. I did but wasn’t affected by it. I had used heroin by injecting for nearly two years then and brown sugar wasn’t working for me. I left for Sri Lanka at once. From the Colombo airport I went straight to the dealer and bought drugs and used it there. After that I realized that I was addicted. So I used carefully so that my dose would be just enough so that I would not get any withdrawals.

I first had sexual intercourse with a prostitute in Male’ the day before I was to leave to Sri Lanka for the first time. Later she called and told me that she had a couple of friends with her and she would be interested in me if I gave some cigarettes. So my friends and I went to them and we all had group sex together.

In Sri Lanka I had a girl friend from UK but broke up with her when she told me to quit using drugs. I slept with her frequently. Then I started sleeping with her sister and we started going out together. This girl was a drug user. I always used drugs before sex because it made sex last longer. I have never suffered from any sexually transmitted disease”.

17-year-old drug user from Male’

VIII. HEALTH AND LEGAL ASPECTS OF DRUG USE

A. HIV/AIDS knowledge and status

Two hundred and two respondents said that they have heard of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). One hundred and seventy eight (88 per cent) respondents stated that having sex with an infected person would spread HIV/AIDS. Ninety-six (48 per cent) said HIV/AIDS could spread through blood or blood transfusion, 56 (28 per cent) said through sharing needles and syringes. Six (3 per cent) mentioned homosexuality as a mode for HIV/AIDS spreading. Five respondents (2 per cent) were completely unaware of how it would spread.
Among the 200 respondents to the question on how likely he/she might be to get HIV/AIDS, 73 per cent said it was not likely at all, 15 per cent said it was unlikely, 9 per cent said it was somewhat likely and 4 per cent said it was likely that they may get HIV/AIDS. However, only 52 (26 per cent) reported having undergone testing for HIV/AIDS. Forty-five of the 46 who knew their HIV/AIDS test results were willing to share the result of the testing, which was negative in all these cases.

Of 200 respondents, 50 (25 per cent) knew someone with HIV/AIDS, commonly a friend or acquaintance.

Box 8. Case illustration: HIV-positive drug user

“I went to Male’ at the age of 17 in search of a job and worked as waiter in a resort. Later, I got an opportunity to go abroad with a foreign lady, and worked as a waiter there too. I started using drugs only after I returned to Maldives. I started with brown sugar, as my friends here said that it helps to relax. Gradually I started to get withdrawals like coughing if I did not use. So I thought of stopping and went abroad for treatment, and while I underwent medical tests they found out I was HIV positive. Now I suspected that my foreign lady friend suffered from HIV/AIDS.

I was married before, at the age of 18 years and got divorced after two years. Before marriage I had sex with at least six persons. I had sex with at least two foreigners. Since the time of my diagnosis I have been trying on and off to stop using brown sugar. Now it is a long time since I have used drugs. But I get a lot of pain and there is no one to care. I am an illegitimate son and am very much alone. But I am careful not to transfer my illness to anyone else”.

41-year-old male drug user from the south

B. Other health problems

One of the respondents had suffered from tuberculosis, and 9 out of 199 (5 per cent) reported jaundice. Weight loss was reported by 161 respondents (81 per cent), and chronic diarrhoea by 4 (2 per cent). Six of the 202 respondents (3 per cent) reported a growth around the anus, 6 (3 per cent) reported ulcers over the genitalia, 34 (17 per cent) had pus with burning urination. Eight (4 per cent) had swelling (of lymph nodes) around the groin (figure 17). Seventeen (9 per cent) reported a history of abscesses, and 6 (3 per cent) reported abscesses in the previous month.
C. Legal problems

Common legal problems included being jailed, placed under house arrest or banishment (figure 18). One hundred and eleven of 201 respondents (55 per cent) reported having been under police lock up during the last one year. Seventy-seven (38 per cent) had been jailed, with 35 (17 per cent) jailed during the last year.

A third of the respondents (32 out of 92) reported that they could get drugs within the prison.

Past house arrest was reported by 114 out of 193 respondents (59 per cent). Over a third (36 per cent) reported having been under house arrest during the last year.

Of 196 respondents who answered the question on banishment, 32 (15 per cent) reported having been banished. Respondents commonly reported assaults, 40 per cent involving parents or relatives, 28 per cent during custody, 12 per cent on the road, and 5 per cent at school.

Fifty-four per cent of key informants perceived an increase of both drug use and crime. Focus group respondents felt that criminal acts related to drug use included peddling, theft, sexual offences, dishonesty and violence.
Forty-nine out of 202 respondents (24 per cent) had been involved in legal problems prior to initiating drug use. Common offences were violence (37 per cent), traffic violations (25 per cent), theft (22 per cent) and vandalism (10 per cent). Thirty-five per cent of the respondents had been involved in non-drug related offences after initiation of drug use (figures 19 and 20).

Fifty-four per cent of key informants perceived an increase of both drug use and crime. Focus group respondents felt that criminal acts related to drug use included peddling, theft, sexual offences, dishonesty and violence.
Box 9. Case illustration: drug use and legal problems

“I was dependent on brown sugar by the age of 16 and started stealing from home and outside. I used to steal from shops, mug people on the streets, cheat people for money and even begged on the streets. I continued like this until I was caught robbing a shop and sent to jail for two weeks and the brought to house arrest. I was sentenced within a week and was banished. During my banishment, I used cologne and alcohol. I was brought back to house arrest after one year and then released after six months.

19-year-old male from the north
IX. TREATMENT SEEKING FOR DRUG USE-RELATED PROBLEMS

A. Help seeking and accessibility of services

Fewer than half the respondents (45 per cent) had consulted a doctor at hospital, 32 per cent had received no treatment and 13 per cent had self-medicated. Fifty-six (28 per cent) had been to hospital for physical or psychological illnesses since they started using drugs. There were a total of 64 consultations, the most common reasons being detoxification (17 per cent), fever (17 per cent), psychiatric problems (11 per cent), physical injury and urinary infection (9 per cent). Most of the respondents (70 per cent) who had sought help were satisfied with the treatment.

One hundred and twenty four (61 per cent) respondents had tried to reduce drug use and related harm during the last six months. Very few had used professional help to do so (table 10).

<table>
<thead>
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<th>Number of Respondents</th>
</tr>
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<td>Stopping by self/self-medicating</td>
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<tr>
<td>Reducing the amount/frequency</td>
<td>31</td>
</tr>
<tr>
<td>Professional help</td>
<td>13</td>
</tr>
<tr>
<td>Environmental change</td>
<td>8</td>
</tr>
<tr>
<td>Others</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>124</td>
</tr>
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B. Respondents’ felt needs

Of 179 responses volunteered, 66 (37 per cent) did not feel the need for any help, and felt they could stop by themselves. Thirty-five (20 per cent) perceived the need for detoxification facilities and medical treatment. Others felt it was necessary to increase awareness (8 per cent), education and employment opportunities (6 per cent), family supervision and monitoring (5 per cent), build up community support systems (4 per cent), reduce supply (3 per cent), and have community-based rehabilitation (2 per cent).

For the few who had sought help for drug related problems, facilities accessed included government facilities (37 per cent), hospitals (20 per cent), NGOs (17 per cent) and private clinics (19 per cent). Detoxification (30 per cent) and rehabilitation (41 per cent), counselling (15 per cent) and maintenance medication (11 per cent) were common types of help obtained. About one third of the respondents who had sought help had gone out of the country for it. It was the family who mainly facilitated the respondent’s reaching the helping organization (44 per cent).

Of 67 respondents who had tried to obtain help, 70 per cent reported no difficulty, while 26 per cent found it difficult to obtain help. The main difficulties perceived were a lack of
private treatment (19 per cent), lack of support from family (19 per cent) and lack of medical assistance for detoxification (14 per cent).

Thirty-five respondents (of 175) reported being in touch with programmes related to drug use. Most of these (79 per cent) mentioned the NCB and the DRC. A small number were in touch with NGOs or youth counsellors (8 per cent) and 13 per cent were in contact with other organizations.

Eighty-one per cent of respondents were aware of treatment facilities provided by NCB or DRC. Most (53 per cent) believed that no treatment facilities were available at the island level (table 11).

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<th>Not available (percentage)</th>
<th>NCB/DRC (percentage)</th>
<th>Hospital/clinic (percentage)</th>
<th>NGOs (percentage)</th>
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<td>8</td>
<td>5</td>
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<tr>
<td>Atoll level</td>
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<td>50</td>
<td>6</td>
<td>1</td>
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<tr>
<td>Country level</td>
<td>11</td>
<td>81</td>
<td>6</td>
<td>1</td>
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Many of the respondents (67 per cent) were aware of treatment centres abroad. An additional 31 per cent were familiar with treatment centres in the neighbouring countries. A minority (2 per cent) was not aware of any treatment place abroad.

**Box 10. Key informant impression of need for acute treatment services**

“Most of the drug dependents are coming to us. But when they come to us there is some sort of pressure on them. For example, family or spouse may come to know about their drug habits, and there is the fear of losing their job. Due to this lot of problems arise. Sometimes they come to get help with their withdrawals e.g. body ache and lack of sleep. Sometimes drug users are brought to the emergency room late at night rather than to the out-patient in the mornings. I have seen about 45 a year brought with extreme aggressive behaviour”.

Key informant health worker
X. CARER BURDEN AND RESPONSES

“I pray at home, I pray at the mosque and I prayed at Haj. I pray for my children that they may find the right path”.

– Mother of three substance using children from Addu

In order to understand the burden that drug abuse imposes on family members, 19 family members of drug users were interviewed in detail. Thirteen were females and 6 were males. Twelve were parents, two were ex-spouses and five were other relatives. Seven were employed in the government, three were employed in the private sector, five were housewives, and four were not employed. The age of the care-givers ranged from 24 to 76 years. The drug users were mainly using brown sugar, alcohol or cola water. Seven of them had been involved with crime.

Almost all family members perceived a financial burden (figure 21), with 37 per cent rating the burden as severe, 26 per cent moderate and 37 per cent slight. Problems sleeping were reported by 74 per cent of the family members, and emotional problems were experienced by 90 per cent.

![Figure 21. Perception of burden by family members of drug users](image)

Most of the family members (90 per cent) had tried to obtain assistance for the drug user. Many of the verbatim responses provided by the family members convey more than the numbers outlined earlier, in terms of the perceived distress and helplessness. These are categorized under different headings.
Helplessness

“We grounded him! We locked his bicycle and motorbike! We checked his room late at night to see if he was there. Gave advice constantly! Sent him to DRC for counselling when he was 16 years old. Arranged for police officials to convince him to quit! Got people to recite Quran at our house every day! We sent him to an electronic workshop for training to occupy his time! Discussed with him the legal issues related to treatment! Tried very hard to get him in for voluntary treatment. And since they didn’t accept volunteers when the situation was at its worst, his father arranged for the police to come and pick him up! He was sent for treatment through the court!!”

Fears for the drug user

“I don’t want to treat him any differently from my other kids, but the fear is always there, that he will go back to it again…that his urine might be positive, and he will be taken back to jail again.”

“Watching my child go through withdrawals was horrific. We just couldn’t do anything to take away the pain! The father only witnessed it the last time he went through the withdrawals and he couldn’t believe that I had been going through this stress alone!”

Confusion about how to handle the drug user

“If he’s in the wrong, he gets angry very easily. If we suspect him to be on drugs, we are always afraid to confront him. On the other hand, if he is clean and if we suspect him, he will feel sad thinking we don’t trust him!”

Reactions to a punitive response to drug use

“My son was charged for using drugs when he was 13 years old. As soon as he turned 18 he had to go to jail. But the person who introduced him to drugs who was much older than him got away. No one even bothered to ask why he used!! When you are young you can be tempted into things so easily.”

“He was taken to jail (for having gone out while under house arrest). I had no shame after that, I pleaded and begged everyone not to send him to jail because it was the opening of a far worse road for him. When he was brought back from jail, he was using brown sugar again, and worse than that, he had learnt to deal because he was with dealers! They destroyed my child’s life!!”

“I feel that once the client is released from the community rehabilitation programme, she should not have to go through her remaining sentences, as the sentences were related to her drug usage days. There should be a way to pardon them if they have not committed any crime after the rehabilitation process.”
Disillusionment with the system

“Punishment should be given to dealers. And children should be given punishment too, but in such a way that they see a future in front of them. They are destroying the youth knowingly.”

“There is no law enforcement office in Male’, which I haven’t been to, to find justice for my son. I wrote so many letters to people of the highest posts, and even met with them personally, only to be rejected and humiliated.”

“Can’t rely on the NCB for help. If I call for help, they will destroy the child’s life and the child will hate the parent for life. For example, if the child relapses, NCB should look into the reason why he relapsed instead of quickly rushing him over to jail.”

Inequities in the system

“No change will come unless all the loopholes are taken care of. Those who have money will send their children abroad (for treatment or to keep them away from drugs).”

“Rehab should give everyone the same opportunity. The system is so unfair. It is only in favour of the RICH people. I’ve seen it happen in front of me! Parents like us have to face so much more than them. For example our children need to be given second chance at rehab.”

Box 11. Case illustration: burden of drug abuse

“On those days when my husband had taken a lot of drugs I ask my children not to irritate Dad. Not to make him promise to do anything for them or give anything to them. Because I know that he will not be able to keep the promises he makes to the children.

Sometimes I felt like killing all of my children and myself. There were days when I was not able to afford basic needs. Like a sanitary napkin when I have my periods. I go out in the night and collect plastic bags and make pads for myself. On such occasions people approach me thinking that I am a prostitute. I had no way of supporting my three children and myself so I had two affairs. They were with people who approached me when I go out at night to collect ‘things’.

My in-laws blame me for my husband’s drug use. They say that he uses drugs because of me.

I feel very heavy inside as I feel that there is nobody who understands me. The fact that I do not have my husband by my side makes the hurt more. After my husband was taken away this time I felt lonelier than ever before. We were much close physically and mentally this time than any other time.

Wife of a brown sugar and hashish oil abuser
XI. FEMALE DRUG USERS

Drug use itself is a hidden phenomenon in Maldives. Drug use among women is even more hidden, but certainly exists, as revealed by key informants. Information on the seven (3 per cent) female drug users interviewed as primary respondents is presented here. Although the number is too small for generalizations to be made, certain preliminary observations are recorded.

The women were between 18 and 27 years of age, with a mean age of 20.7 years. One female had not reached secondary education, four had reached secondary education, and two had completed their O levels. Two were doing computer related work, one was involved in business and the other four were unemployed, with no independent income. Smoking had been initiated at a mean age of 14.9 years. Age of initiation of first drug use was 15.6 years. Four females currently abused hashish oil and three brown sugar. Reasons for initiation were mainly peer pressure and family problems.

When compared to the entire group of primary respondents (97 per cent males), females are comparable in terms of current age (20.7 years and 21.4 years) and age of drug initiation (15.6 years and 16.8 years, respectively). While 10 per cent of the whole group cited family problems as initiating factors, this was higher among female drug users, with more than half attributing drug initiation to family problems.

Box 12. Case illustration: female drug user

My mother first introduced me to sex. A family friend abused me for money to support her mother’s drug usage. I was abused at the age of nine years. As my mother was an addict she sent me with a man asking me to do whatever he says. There I was abused. I came and told my mother about it and she pretended that she didn’t know that he was such a bad person. After that I heard mom encouraging him for the act saying that I might deny, as I was a child. My abuse was one main reason I had to use drugs in order to avoid stress. Thereafter sex is nothing precious for me. I had sex when I was 12 years old with my boyfriend. Later as I started using drugs I wanted to support my addiction so I got into a relationship with a dealer. My boyfriend does not allow me to be with many addicts or to go and buy drugs from others. I mostly use in my room at home with my boyfriend.

Key informant: female drug user

The number of female drug users captured during the RSA is likely to be very much under-representative. This can be inferred from the primary respondent data where 102 of 157 respondents (65 per cent) reported drug use with a member of the opposite sex. Even granting that this may constitute a smaller common pool of female drug users, the number still is likely to be much higher than those identified in the RSA.

The RSA was unable to capture the extent of the use of sex as a means of financing the drug habit among females. However, case illustrations are provided to highlight the interface between drug use and sex among females.
XII. COUNTRY-LEVEL SECONDARY DATA

Sources for secondary data collection included data on clients referred to the Narcotics Control Board and drug seizure data from the Customs Service.

A. Narcotics Control Board

Information on clients referred to the NCB was collected retrospectively from the case records. While case records were available for 832 cases, only those with completed information (547) were considered for analysis.

1. Referrals

Among the 547 clients, 119 (22 per cent) constituted voluntary referrals while the other 428 (78 per cent) were referred by court. Three hundred and fifty clients (64 per cent) were with NCB, 86 (16 per cent) had been released after completion of treatment, 63 (12 per cent) terminated from NCB, and 48 (9 per cent) had been sent to the Department of Corrections (figure 23).

Terminated clients included those who had committed other crimes for which they had been sentenced to jail or banishment. Those who were sent to the Department of Corrections were those with problems of discipline. Technically, both these groups could come back for treatment to the NCB at a later stage. In a comparison of referrals between 1999 and 2001, there had been an overall decline in the number of cases. There was no demonstrable increase in the number of voluntary referrals.

Figure 22. Referrals to NCB, 1998-2001
2. Characteristics of drug users referred to NCB

The sex of the client was recorded in 797 out of 832 NCB records. Among these, 94 per cent were male and 6 per cent female. NCB data highlight the point of there being a higher proportion of women users than was identified in the primary respondent interviews (3 per cent).

Ages of the clients ranged from 13 to 49 years (recorded in 681 cases). Forty-four (7 per cent) were 16 years and below. One hundred and fifty (22 per cent) were 17-19 years of age. Thus 29 per cent were below 20 years of age. Three hundred and eighty-two (56 per cent) were in the age group 20-29 years. Ninety-five (14 per cent) were aged 30-39 years. Only 10 (2 per cent) were above 40 years of age.

Five hundred and fifty (64 per cent) of 801 were from Male’ or Kaafu Atoll, 120 (15 per cent) were from Addu. The following table provides a comparison between referred drug abusers (NCB) from different regions of the country with respect to the population. The
northern atolls appear to have relatively fewer drug abusers, a perception supported by focus group data, ethnographic observations and key informant interviews.

In June 2003, there were 380 persons who were clients of the Narcotics Control Board, including some for whom records were not complete (table 12). The largest category of these (172) was persons under house arrest awaiting a place in the Drug Rehabilitation Centre (DRC). The DRC had 126 residents at the time. Eighty-two clients were receiving community rehabilitation treatment. Of the total number of clients, 82 per cent had been referred by courts and nearly 97 per cent were males. These data would imply that the drug rehabilitation programme should be expanded, as more clients were awaiting a place in the DRC than the DRC could accommodate. The DRC could handle more clients if some low-risk clients underwent shorter rehabilitation programmes there.

<table>
<thead>
<tr>
<th>Means of referral Status</th>
<th>Volunteer</th>
<th>Court</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All statuses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>68</td>
<td>299</td>
<td>367</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Both sexes</td>
<td>70</td>
<td>310</td>
<td>380</td>
</tr>
<tr>
<td>House arrest pending a place in DRC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>169</td>
<td>169</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Both sexes</td>
<td>1</td>
<td>171</td>
<td>172</td>
</tr>
<tr>
<td>Resident at Drug Rehabilitation Centre (DRC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>31</td>
<td>90</td>
<td>121</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Both sexes</td>
<td>32</td>
<td>94</td>
<td>126</td>
</tr>
<tr>
<td>Undergoing community rehabilitation treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>37</td>
<td>40</td>
<td>77</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Both sexes</td>
<td>37</td>
<td>45</td>
<td>82</td>
</tr>
</tbody>
</table>

3. NCB expenditures

NCB had spent about RF 18.4 million on food, accommodation and related services, RF 12.6 million on infrastructure, RF 12.0 million on salaries and wages, and RF 2.1 million on machinery, equipment, furniture, fixtures and motor vehicles during the five-year period 1997-2001. The total expenditure of RF 45 million over five years averaged RF 9 million per year.

B. Maldives Customs Service
Data on drug seizures by the Maldives Customs Service do not show any discernable trend over time (table 13). Large seizures provide a spike in the time series that is not necessarily sustained. Heroin seizures appear to have declined between 1997 and 2001, however.

Table 13. Percentage distribution of NCB referrals and of population by region

<table>
<thead>
<tr>
<th>Drug abusers</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male’ &amp; Kaafu Atoll</td>
<td>64.29</td>
</tr>
<tr>
<td>Thiladhunmathhee Uthuruburi</td>
<td>1.00</td>
</tr>
<tr>
<td>Thiladhunmathhee Dhekunuburi</td>
<td>1.25</td>
</tr>
<tr>
<td>Miladhunmadhulu Uthuruburi</td>
<td>0.87</td>
</tr>
<tr>
<td>Miladhunmadhulu Dhekunuburi</td>
<td>2.87</td>
</tr>
<tr>
<td>Maalhosmadhulu Uthuruburi</td>
<td>0.5</td>
</tr>
<tr>
<td>Maalhosmadhulu Dhekunuburi</td>
<td>0.87</td>
</tr>
<tr>
<td>Faadhippolhu</td>
<td>1.62</td>
</tr>
<tr>
<td>Alifu Alifu Atoll</td>
<td>0.25</td>
</tr>
<tr>
<td>Alifu Dhaalu Atoll</td>
<td>0.87</td>
</tr>
<tr>
<td>Felidhi Atoll</td>
<td>0.12</td>
</tr>
<tr>
<td>Mulaku Atoll</td>
<td>0.62</td>
</tr>
<tr>
<td>Nilandhi Atoll Uthuruburi</td>
<td>0.00</td>
</tr>
<tr>
<td>Nilandhi Atoll Dhekunuburi</td>
<td>0.00</td>
</tr>
<tr>
<td>Kolhumadulu</td>
<td>2.62</td>
</tr>
<tr>
<td>Handhunmathi</td>
<td>0.75</td>
</tr>
<tr>
<td>Huvadhu Atoll Uthuruburi</td>
<td>1.5</td>
</tr>
<tr>
<td>Huvadhu Atoll Dhekunuburi</td>
<td>3.62</td>
</tr>
<tr>
<td>Foamulah</td>
<td>1.37</td>
</tr>
<tr>
<td>Addu Atoll</td>
<td>14.98</td>
</tr>
</tbody>
</table>

Table 14. Drugs seized by the Maldives Customs Service, 1997-2001

<table>
<thead>
<tr>
<th>Year</th>
<th>Type of drug</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>Cannabis</td>
<td>19.51 gms</td>
</tr>
<tr>
<td></td>
<td>Hashish oil</td>
<td>16 gms</td>
</tr>
<tr>
<td></td>
<td>Heroin</td>
<td>130 gms</td>
</tr>
<tr>
<td>1998</td>
<td>Cannabis</td>
<td>68.13 gms</td>
</tr>
<tr>
<td></td>
<td>Hashish</td>
<td>28.25 gms</td>
</tr>
<tr>
<td></td>
<td>Hashish oil</td>
<td>0.05 gms</td>
</tr>
<tr>
<td></td>
<td>Heroin</td>
<td>80.18 gms</td>
</tr>
<tr>
<td></td>
<td>Opium</td>
<td>1.01 gms</td>
</tr>
<tr>
<td></td>
<td>L.S.D.</td>
<td>2 dozen</td>
</tr>
<tr>
<td></td>
<td>Ecstasy</td>
<td>1 tablet</td>
</tr>
<tr>
<td>1999</td>
<td>Cannabis</td>
<td>21.63 gms</td>
</tr>
<tr>
<td></td>
<td>Hashish</td>
<td>4.21 gms</td>
</tr>
<tr>
<td></td>
<td>Heroin</td>
<td>33.39 gms</td>
</tr>
<tr>
<td></td>
<td>Cocaine</td>
<td>0.39 gms</td>
</tr>
<tr>
<td></td>
<td>Diazepam</td>
<td>140 tablets</td>
</tr>
<tr>
<td>2000</td>
<td>Cannabis</td>
<td>7.37 gms</td>
</tr>
<tr>
<td></td>
<td>Hashish oil</td>
<td>74.52 gms</td>
</tr>
</tbody>
</table>
Heroin 0.01 gms
2001 Cannabis 13.01 gms
Hashish 9.43 gms
Heroin 20 gms

Source: Data provided to RSA by the Maldives Customs Service.

XIII. RECOMMENDATIONS OF KEY INFORMANTS AND FOCUS GROUPS

A majority of the key informants (60 per cent) perceived the need to strengthen the prevention and awareness programmes, while 50 per cent also perceived the need for strengthening supply reduction, especially by improving vigilance at seaports and other entry points (table 15). Twenty key informants (18 per cent) felt the need to strengthen treatment and rehabilitation programmes, while 21 (19 per cent) felt the need to make new amendments to the law.

Table 13. Key informant recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Male’ (N=54)</th>
<th>Addu (N = 34)</th>
<th>N &amp; LH (N = 23)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCB, Customs, NSS - develop stronger networking</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Strengthen prevention and awareness program</td>
<td>32</td>
<td>17</td>
<td>18</td>
<td>67</td>
</tr>
<tr>
<td>Strengthen the treatment and rehabilitation program</td>
<td>12</td>
<td>6</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Develop the technical expertise of NCB</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Law needs further amendments</td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td>Develop alternative education system with vocational / recreational training</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Start treatment centers in other zones of the country</td>
<td>4</td>
<td>13</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Strengthen supply reduction by bringing sniffer dogs, machines and hence increase the surveillance at air and sea ports</td>
<td>32</td>
<td>14</td>
<td>9</td>
<td>55</td>
</tr>
</tbody>
</table>
Twenty key informants (18 per cent) also perceived the need to start treatment and rehabilitation centres in other zones of the country. Key informants from the south and north atolls particularly expressed this need.

Thirteen (12 per cent) felt the need to improve the technical expertise of NCB while 5 (5 per cent) were of the opinion that NCB, Customs and NSS need to develop stronger networking. Another concern expressed by key informants in order to contain drug abuse was the immediate need to find vocational avenues for the youth after completing their education.

**Box 13. Some specific recommendations by key informants**

“The customs, police, attorney police have to increase seizure and decrease availability in the market. Surveillance and entry points should be strengthened. Dogs, electronic methods and intelligence have to be used and improved.”

*Key informant: policy maker*

“The gap is lack of technical expertise and shortcoming of manpower. Professional skills are lacking in NCB.”

*Key informant: policy maker*

“Currently counsellors have gone through basic counselling and attend short seminars and workshops. The counsellors are young being teenagers to 22 years and skilled people are less, therefore competence level would be less.”

*Key informant: policy maker*

Recommendations emanating from focus groups to improve the drug situation are presented in box 14.

**Box 14. Focus group recommendations**

**Focus group category**

**and numbers**

**Recommendations**

<table>
<thead>
<tr>
<th>Health personnel – 8</th>
<th>1. Introduce drug education programmes targeting youth, parents.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Have police placed in the islands.</td>
</tr>
<tr>
<td></td>
<td>3. Do not banish people with history of substance abuse to the islands.</td>
</tr>
<tr>
<td></td>
<td>4. Increase religious awareness among people.</td>
</tr>
<tr>
<td></td>
<td>5. Have facilities for HIV/AIDS and STD testing at Health Centres.</td>
</tr>
</tbody>
</table>
6. Allow the health personnel to be involved in the awareness programmes conducted in the islands so that they could continue with follow-up.

7. Improve discipline of the students.

8. Initiate parenting skills programmes.

9. Create awareness among the students.

10. Focus on supply reduction.

11. Increase spirituality.

12. Have harsher punishment for drug traffickers.


Policy makers – 1

1. Increase awareness for school children, youth.

2. Create opportunities for youth.

3. Do not banish to the islands.

4. Create employment for the youth.

5. Decriminalize drug use.

NGO forums – 7

1. Increase awareness for school children, youth.

2. Create opportunities for youth.

3. Do not banish to islands.

4. Create employment for youth.

5. Decriminalize drug use.

Youth groups – 2

1. Train drug counsellors and place them in health centres to give counselling for the drug users.

2. Focus on supply reduction by increased checking at the sea ports and airports.

3. Create awareness by including ex-addicts and experts in the prevention and awareness programmes.

4. Increase religiosity and spirituality of people.

5. Start rehabilitation centres in other zones of the country.

Taxi drivers – 2

1. Develop a family support programme.

Users and family of

2. Improve the current treatment and rehabilitation programme by
users – 4
starting a half-way house.
3. Allow recovering addicts to help by means of self-help groups.
4. Increase awareness among the parents.
5. Separate drug users in prisons from other criminals.
6. Introduce detoxification.
7. Increase focus on spirituality.
8. Start rehabilitation in prison for those serving sentences.
9. Create responsible jobs for clients rehabilitated.
10. Teach parenting skills.

Surfers and divers – 1
1. Create awareness.
2. Provide harsher punishment for drug traffickers.
3. Create a parent support system.

Fishermen – 1
1. Improve the supply reduction.
2. Increase awareness.
3. Provide harsher punishments for traffickers.

Shopkeepers and waiters – 1
1. Create awareness by developing different types of programmes for different target groups.
2. Develop parenting skills.

Religious persons – 1
1. Increase religious and spiritual awareness.
2. Conduct parenting skills programmes.
3. Increase job opportunities for youth.
4. Have proper networking among all the concerned organizations.

Resort staff – 4
1. Focus on supply reduction.
2. Increase religious and spiritual awareness of people.
3. Do not banish people with drug history to the islands.

Prisoners – 4
1. Segregate drug addicts from hard-core criminals.
2. Introduce prison based rehabilitation and opportunity for reform for drug dependents serving sentences in the jail.

XIV. FINDINGS OF THE RAPID SITUATION ASSESSMENT – IMPLICATIONS

A. Rationale for the Rapid Situation Assessment

While drug abuse in Maldives has been an area of growing concern, lack of an in-depth understanding of the problem has been a limiting factor in developing comprehensive strategies to deal with this complex and dynamic problem. The need for a formal assessment of the drug problem was realized in 1998, when a preparatory mission was undertaken to determine in-country capacity to conduct the assessment (Ahmed 1998). The assessment was delayed for several reasons, including the legal requirement of notifying drug users, a certain impediment for any in-depth confidential interviewing.

The seriousness of the Government in facilitating such an assessment, a key step in the development of a National Master Plan, is very clearly reflected in the amendment that was brought about in the principal drug law 17/77, allowing confidential reporting of drug use for purposes of approved research.

Drug abuse, being a hidden phenomenon, cannot be assessed by routine epidemiologic surveys. Being a complex and dynamic phenomenon, no single strategy is able to effectively capture the various facets of drug abuse and factors influencing drug taking. Quantitative and qualitative data, primary and secondary data, existing and newly acquired data all need to be collated and interpreted to provide a comprehensive understanding of the drug problem.

Rapid Situation Assessment (RSA) is better suited for socio-behavioural problems like drug use. Such an assessment encompasses a variety of strategies (ODCCP Studies on Drugs and Crime Guidelines 1999). The Rapid Situation Assessment was used to provide an in-depth understanding of drug abuse in Maldives. Information was collected from four different research sites Male’, two north atolls (Miladhunmadulu Dhekunuburi and Faadhinpolhu) and Addu in the south. The assessment involved collection of primary data on drug use and related behaviour from drug using respondents through a snowballing method, analysis of secondary data of treatment records, drug seizure and arrest data, and qualitative information on various aspects of drug use, obtained through key informants, focus groups and ethnographic observations by field investigators. An attempt was made to triangulate the data collected to provide a clearer picture of drug use in the country.

B. Limitations of the RSA approach and findings
Owing to constraints of time and resources, it was possible to collect information from only three atolls apart from Male’. This may not provide a completely representative picture of the entire country. The sites were chosen in consultation with the NCB and the law enforcement authorities, based on greater reporting of drug abuse in these sites. While this approach cannot generate actual numbers of drug users in the entire country, it can provide a rough indication of the problem. Thus a crude estimate of the extent of the drug problem in the country was made.

The study was not able satisfactorily to address the magnitude of alcohol, cola water, dunlop and psychotropic medication, and abuse in society. These still appear to be hidden problems.

There was a great reluctance of respondents to participate in the study. Fear of arrest was the main reason for this reluctance. This occurred despite reassurance, sensitization of the NSS, and publicizing of the study prior to initiation. Despite the constraints, most of the potential respondents, once they admitted to drug use, were willing to provide fairly personal information.

The experience in Addu exemplifies some of the difficulties encountered during the assessment. Four boys interviewed by field investigators were arrested within 48 hours of the interview. Although these arrests were apparently coincidental, it was a great setback to the study and very demoralizing for the research team. However, upon intervention, those arrested were subsequently released and offered rehabilitation. This example amply illustrates the difficulties of drug abuse research, especially in an environment where drug use is criminalized.

A dedicated, well-trained and properly sensitized team is crucial for such research. Having ex-users in the team was especially useful to reach out to peers. However, they needed to be continually supported and additionally helped during the study.

A major lacuna was the lack of data from prisons, which would have provided a complementary perspective to the existing information. Despite several attempts of the research team, the information was not provided.

Very little information was obtained from the health sector, raising speculation that drug related information is not adequately documented in this sector, or is underreported owing to legal repercussions.

Despite these limitations, many useful observations emerge from the assessment and should be put into a context.

C. Salient RSA findings

1. Social and demographic characteristics

Drug using respondents were mainly in their early twenties (mean age 21.4 years) and had mostly (64 per cent) initiated drug use in their teenage years. The perception of key informants also suggests that drug users are mainly adolescents and youth less than 30 years of age. The reports of the focus group that youngsters as young as 11 may be abusing drugs should not be overlooked. This recommendation is supported by the data from the Ministry of Defence and National Security indicating that there is a small portion of children below 16
years of age abusing drugs (Statistical Yearbook of Maldives 2002). Though much of the initiation occurs in the teenage years, the younger children must not be overlooked, and prevention efforts need to be targeted at younger children. This group was not adequately captured in the primary respondent interviews, as the interviews mainly focused on 16 years old and above (to avoid ethical problems such as consent).

The primary respondent interviews captured mainly male users (97 per cent). However, the focus group report that more females are using drugs needs to be taken cognizance of, and is supported by the higher percentage of women being arrested (9 per cent), as well as the report from drug using male respondents that 65 per cent shared drugs with the opposite sex. No generalizations can be made from the small group of female drug using respondents. However, this group needs to be addressed as female drug users have distinct vulnerabilities and consequences compared with male users.

Some of the health sector key informants also identified the mentally ill as a vulnerable group for substance abuse. Very little is known about this group, which is yet another important need to be addressed.

Although almost half of the respondents (46 per cent) had reached secondary school levels (Grades 8-10), a majority felt that they did not receive the desired level of education. This felt need must be addressed. Opportunities for education and career advancement are critical for youth. It must be emphasized that half the respondents reported difficulties in school. Many of these may be directly related to drug use or its consequences (truant, indiscipline). Early conduct difficulties may also be a risk factor for drug use. The teacher/supervisor key informant and focus groups indicated that there are no drug abusers in the school system. This report is significant, and indicates that drug abusers are not captured within the school system because the current education system debars those with such problems from remaining in school. There is a need to develop mechanisms for early identification and intervention for students with early problems, both academic and non-academic (problems with attendance and discipline) and a need to develop programmes for the large number of school dropouts. A focus on functional literacy and skill building rather than only academic achievement may be important to address the frustration of youth unable to achieve their desired level of education.

A majority of the respondents (66 per cent) did not hold a job at the time of the interview. Those who did work were involved in business or tourism, the most common sources of employment. As most of the respondents were single and living with families, for those unemployed, the family met the need for money to support their drug habit. This indicates an enormous financial burden placed on families, in addition to emotional and health repercussions on family members. A majority of the respondents indicated that their parents are currently married. On the surface, this appears to dispel the myth that drug users come from broken families, and seems to contradict the opinion of key informants and focus groups, who attribute broken homes as an important cause for drug abuse. However, this finding has to be read in the context of the frequency of divorce and remarriage, and decreasing parental influence, both in Male’ and other atolls. In Male’, many of the youth appear to be away from direct family influences, because of employment/educational opportunities. In the atolls, there is a preponderance of females (male:female ratio being 83:100 in some of the atolls) as men are away at work. These findings raise the need for an in-depth evaluation of the family unit, its strength and weaknesses and the influence of role modelling and parental influence in youth withstanding or succumbing to the pressure to use drugs.

2. Drug use initiation
It was striking that 5 per cent of the sample had started to smoke before the age of 10 years, 48 per cent between the ages of 10 and 14 years and most by the age of 17 years. A health survey in 1995 by the Ministry of Health revealed that 71 per cent of the households in Male’ had a smoker. In addition to the public health problems posed by tobacco use, the role of smoking as a gateway to other drug use has long been proposed. Therefore, strategies to address smoking among the young may help not just in preventing direct tobacco related health problems, but prevent youth from graduating to other drug use.

Peer group pressure (39 per cent) and curiosity and experimentation (26 per cent) were reported as the main reasons for drug use initiation. This is indeed a universal observation and has been repeatedly documented in other countries (Suresh and Ray 2002). There is a need to develop and strengthen group activities for children and youth, both within and outside institutional settings. Physical, intellectual and recreational pursuits involving peers may be vital in developing alternatives to drug use. A life-skill based education needs to be integrated into these activities. Such an approach also needs to be used in schools, where students are empowered to communicate better, have opportunities for career/vocational counselling, improve self esteem, learn to resist pressure, including peer pressure to use drugs, and learn to handle stress and solve problems without resorting to drug use. Teachers need to be sensitized to these issues, so that they are able to be active participants in prevention of problems including drug abuse. They need to be trained in early detection of high-risk groups, and provide timely interventions. They need to facilitate referral of students with early drug problems for counselling and offer ongoing support, rather than banish students with drug abuse problems from schools. Alternative methods for engaging students with difficulties, including a shift in focus from purely academic achievement to vocation guided training needs to be developed.

3. Drug availability and use

Opioids, primarily brown sugar, constitute the primary drug abused in the country. This was repeatedly confirmed by the primary respondent interviews (43 per cent initiated with opioids, 76 per cent currently used opioids), and drug seizures, as well as the key informant and focus group interviews. This was followed by the abuse of hashish oil and other forms of cannabinoids. Lack of brown sugar appears to have driven drug users to other drugs to handle withdrawal, including cologne (‘cola water’) and alcohol. These drugs and solvents (dunlop) have also become the more commonly used drugs in the atolls. Many other drug categories have been reported, either by primary respondents, or by key informants and focus groups. These include psychotropic drugs, cocaine and amphetamines (ecstasy). The seizure data support the presence of these drugs in Maldives. Drug availability certainly seems to influence drug use patterns. In addition, once the demand is created, many other mind-altering substances begin to be abused. The most dangerous among these are the sniffing of inhalants (dunlop) and the abuse of eau de cologne, both extremely toxic substances, with serious health consequences.

The current system of treatment does not cater to individuals who use such indigenous substances as inhalants and cologne.

4. Drugs and crime

While drug trading is a very lucrative business and many persons are primarily involved in peddling, many of the drug users are involved only in petty crime, with 5 per cent reporting stealing from home, and almost one third (29 per cent) reporting involvement in drug pushing to support their habit. More than half the respondents (55 per cent) reported having been in
police lock up, and more than a third reported having been arrested. However, in most of the instances, the crime appears to have been related to drug use (including petty thefts and violence).

Some rough estimates suggest that there may be more than 800 drug users currently in prison. These persons have no access to counselling or rehabilitation. Many of the drug-using incarcerated population reported drug use in prison. Thus, this method of deterrence does not seem to be effective. Families fear that their young and impressionable relatives will actually become more criminal by their being jailed along with other criminals. A lack of any therapeutic intervention means that very little is done to motivate drug users to quit their habit. Banishment of drug users to different islands was felt to be counter-productive by many of the key informant and focus group respondents, because it only displaced the problem from one region to another.

Drug seizures indicate that a variety of drugs apart from brown sugar (heroin) and hashish oil (cannabinoids) is available. Arrests indicate that a majority are local nationals. From the primary respondent, key informant and focus group interviews, it appears that many of those arrested are drug users.

5. Drug injecting

Drug injecting is a relatively less common practice in Maldives as corroborated both by key informant and primary respondent interviews. Eight per cent of the respondents reported ever injecting drugs, and only two respondents reported injecting drug use in the previous six months. The small numbers should be no reason for complacency, as reports are emerging of injecting use in nearby countries (Suresh and Ray 2002). The patterns of drug use in Maldives are increasingly being influenced by drug use patterns in the region.

6. Sexual behaviour

A recent report (Jenkins 2000) suggests that all kinds of sexual practices exist in Maldives. This was confirmed by the RSA on drug use. The RSA findings revealed that 75 per cent of the single respondents reported a history of premarital sexual exposure, mostly of a voluntary nature. More than two thirds of married drug using respondents (68 per cent) reported extramarital sexual experiences. These are startling findings. Reports of group sex were forthcoming from almost one third (31 per cent) of the respondent group, and 2 per cent reported homosexual relationships. One in five respondents (19 per cent) reported a sexual encounter with a commercial sex worker. The onset of first sexual experience was as low as 7 years of age. One third of the respondents had been initiated into sex by 15 years of age, almost three quarters (72 per cent) by the age of 17 and nearly all respondents (92 per cent) by 19 years of age. Half the respondents never used condoms and 48 per cent reporting using condoms only while having sex with sex workers. Less than one third of the respondents (30 per cent) used condoms regularly. A majority of respondents (65 per cent) reported drug use with a member of the opposite sex, with most of this group (79 per cent) also having a sexual relationship with the drug-using friend of the opposite sex. A majority of the respondents did not perceive being at risk for HIV/AIDS (73 per cent) and only a quarter (26 per cent) had been tested for HIV/AIDS.

This pattern of very frequent reporting of pre- and extramarital sexual encounters, with a very young age of initiation into sex, report of group sex and multiple partners, low condom usage and low risk perception is to understated the point, an alarming trend. In a culture where cohabitation outside marriage is punishable under law, with subsequent underreporting, this
indicates that sexual behaviour among the young is a serious issue. Although the extent of HIV/AIDS is still minimal in the country, it must not be forgotten that the heterosexual mode of transmission is the most common mode of spread of this infection. Although HIV sero-positivity was encountered in only 0-2 nationals annually between 1997 and 2000 as compared with 17-19 foreign nationals annually (Maldives Health Report 2001), this may be a reflection of testing procedures. Given the patterns of sexual behaviour among substance users, HIV/AIDS can very easily spread in this vulnerable population. Drug programmes need to address HIV/AIDS awareness issues, as do other programmes for the young. Such an attempt has been initiated by the NCB, but needs to be further strengthened.

Drug abuse and the associated high-risk behaviours, especially sexual behaviours, make people more vulnerable not just to HIV/AIDS but to hepatitis B and C as well as other sexually transmitted illnesses. These problems must not be overlooked and surveillance methods and interventions for these problems need to be developed.

7. Help seeking and accessibility

Over the previous six months, more than two thirds (66 per cent) of the respondents had tried to reduce drug use with 42 per cent trying to stop drug use by themselves with self-medication. This indicates that many of them are motivated to come out of drug use. Sixty per cent felt the need for treatment, while the rest felt that they could stop by themselves.

With regard to access to treatment and rehabilitation, 81 per cent stated that they were aware of the services provided by NCB/ DRC, and 67 per cent of them were also aware that there were treatment centres abroad. One in four expressed difficulty in obtaining help. One in five respondents perceived the need for detoxification, medical treatment and private treatment. Some of the key informants and focus groups of users and their families also expressed a similar need.

Dealing with drug abuse primarily within the confines of the law brings with it a great deal of resistance to seek help, both from users and their families, because of the stigma, and consequences of being labeled a drug user, or being convicted. Mechanisms for dealing with drug abuse from a therapeutic rather than penal perspective and a more active diversion of drug users from incarceration to voluntary treatment need to be explored.

Several recommendations were made by the key informant and focus group respondents in order to address the current drug problem. Most of the opinions were to strengthen prevention and awareness programmes, followed by further strengthening the supply reduction activities.

8. Service development

The setting up of the Narcotics Control Board has been the primary response to the drug abuse situation in Maldives. This Board has been involved in providing treatment and rehabilitation to those addicted to drugs at the Drug Rehabilitation Centre at Himafushi, monitoring discharged clients, and liaising with law enforcement agencies. It has initiated awareness programmes in schools, awareness in the atolls through NGO collaboration, workshops on parenting skills, training for counselors and a workshop on substance use and HIV/AIDS. The primary mandate of the NCB has been service delivery. However, it appears that the public perception of the NCB is that of a monitoring organization, rather than a therapeutic organization. Referrals to the NCB do not appear to have increased, as evident from available statistics. There is fear about the NCB redirecting clients back to the penal system, if ever they are found to be test positive for drugs.
The major thrust of the programme offered by the NCB is residential treatment, adopting a single treatment approach – the therapeutic community. More recently, however, a community care programme has been initiated. Little is known of the longer-term outcomes of NCB clients and the cost-effectiveness of the programme.

Whether a primary coordinating role rather than a primary treatment role should be the mandate of the NCB requires serious consideration. This shift would inevitably be linked to the development of alternative treatment options for drug users, including opportunities for detoxification, medical assistance, rehabilitation, aftercare and workplace programmes. The involvement of non-governmental organizations, the private sector and workplaces in both preventive and intervention activities needs to be strongly explored. Drug users in prison need to be urgently segregated and rehabilitated.

The resolutions of the WHO regional committee for South East Asia (WHOSEA 2001) express concern at the increasing number of persons becoming dependent on narcotics and alcohol in the member countries in the region, and the need for active health sector involvement. However, the involvement of the health sector is presently minimal. Active involvement of the health, welfare and education sectors, in addition to law enforcement agencies, is crucial for the development of pro-active responses to minimizing drug use and its consequences. The coordinating role of the NCB needs to extend to all these sectors, in order to develop a coherent and comprehensive plan of prevention and respond to drug use related problems.

9. Larger issues

Larger sociocultural issues have a bearing on many socio-behavioural problems, including drug use. Issues such as physical space; facilities for recreation; opportunities for educational advancement, employment and personal growth; family bonding and support; family stability; religious and spiritual values; and cultural norms for behaviour all have a bearing on drug use and need to be addressed in the long run.
XV. SUMMARY AND RECOMMENDATIONS

Vision 2020 of Maldives envisages Maldives becoming one of the top-ranking nations amongst the middle-income developing countries. The vision includes providing youth with the opportunities they need to achieve their full potential. It also envisages improving awareness among people and commitment to healthy lifestyles (Country Population Assessment 2001).

Drug abuse is a serious lifestyle problem with a propensity to affect the very young, the citizens of tomorrow. Its prevention and treatment forms a crucial agenda in realizing this vision for the people of Maldives.

Lack of a formal assessment on the patterns or extent of the drug use situation has prevented a coherent response to the situation, although many steps have already been taken to address this complex problem. The Rapid Situation Assessment undertaken by FASHAN in collaboration with the UNDP, UNESCAP and NCB was the first initiative to obtain a more comprehensive understanding of the extent of drug use, its related problems and adequacy of responses. The assessment attempted to obtain information from a variety of primary and secondary data sources, including primary drug using respondent interviews, narrative life histories of drug users, burden on family members, ethnographic observations of drug use, key informant and focus group interviews; and secondary data from the Drug Rehabilitation Centre of the NCB, and drug seizure data from the Maldives Customs Service.

Despite the several limitations of the findings and difficulties in generalization, certain consistent patterns emerge from the different modalities of enquiry. Opioids, primarily brown sugar, are the most frequently seized drugs and the most frequently abused, followed by hashish oil and other cannabinoids. In the more distant atolls, reports of use of cologne ("cola water"), inhalants (dunlop) and alcohol are common. Drug use is initiated at a very young age, primarily among males. Drug use among females appears to be even more hidden than among males.

Most drug users interviewed in the RSA were single, and obtained money for drugs either from their employment, friends or illegal means. Peer influence was the most frequent reason for initiation. Intravenous drug use is reported, though uncommon. A significant number of users were involved in selling drugs to support their habit and had been involved with law enforcement agencies through imprisonment, banishment or house arrest.

Sexual activity was initiated by drug using respondents at a very young age. Various kinds of sexual activities, including pre-marital sex, group sex and homosexuality were reported. Many of the drug users reported contact with commercial sex workers. Consistent condom use was low. Risk perception of HIV/AIDS was low despite unprotected sex. There is no idea of the extent of such other diseases as Hepatitis B and C and other sexually transmitted illnesses.
Families of drug users perceived significant financial, health and emotional burdens owing to drug use.

The significant legal repercussions appear to make drug users hesitant to accept existing services, mainly offered by the NCB, although many of them reported attempts to reduce or stop drug use. Key informant drug users and focus groups of drug users and families expressed the need for a wider range of treatment facilities including detoxification, medical treatment, private treatment, and rehabilitation. Most key informants and focus group respondents perceived the need for awareness programmes, imparting of parenting skills, and improving religious and spiritual values, in addition to improving supply reduction (drug availability).

Though the law enforcement agencies have consistently tried to focus attention on supply reductions as evidenced by frequent seizures, they are continually challenged by newer and more ingenious ways of bringing in drugs. There is thus a need to improve methods of surveillance, and better networking and data sharing across agencies.

The Narcotics Control Board, in addition to its primary mandate of running the Drug Rehabilitation Centre, has initiated programmes of community care, training of manpower, awareness and education programmes in schools, atolls, and workshops to address HIV/AIDS problems among substance users. Non-governmental agencies have only recently begun to address this problem, but are constrained by issues of confidentiality. Public perceptions appear to indicate a hesitation in utilizing the current facilities, probably indicating a fear of legal repercussions.

Development of a range of intervention services to encourage drug users to obtain help in a confidential, least restrictive and therapeutic setting is suggested as an urgent need. A much greater involvement of the health sector to address several of the public health aspects of drug abuse is necessary. Coordination with the welfare and education sectors, in addition to the law enforcement agencies needs to be strengthened. Drug users in prison need to be separated from other criminals and offered a rehabilitation programme.

The specific areas that merit immediate action include the following:

- Setting up of a national and regional monitoring mechanism for changes in drug use patterns.

- Sex education and awareness at all levels, and active encouragement of safe sex practices, is crucial. Such education should be provided for the general population as well as vulnerable populations such as children with scholastic difficulties, unemployed youth and school dropouts. Those in formal settings such as schools, clubs (recreational and otherwise) should also be provided with such education.

- Unconventional, interactive modes of reaching out to young children, adolescents and youth outside formal institutions need to be developed.

- Services for female users, including drug abuse treatment, preventive education, and HIV/AIDS information including the relationship between high-risk sexual behaviour and drug use, need to be provided.
• Development of a range of treatment services for drug users in different settings and different regions of the country.

• Encouragement of non-governmental organization participation in treatment, rehabilitation and preventive education activities.

• Better networking between all organizations involved in supply and demand reduction.

• Active coordinating role for the NCB in the collation of information relating to supply reduction.

• Improvement in the documentation and the data management system at the DRC and NCB.

• Recording of co-morbid drug use in hospital consultation and emergency room referrals.

• Sentinel surveillance for HIV/Hepatitis B/C among drug users in treatment.

• Improvement of training for law enforcement personnel, specialists, treatment providers, community leaders, teachers, youth etc.

• Greater sensitization of law enforcement personnel to demand reduction issues.

• Involvement of local leaders and religious leaders in evolving strategies to prevent drug use and related harm.

• Strengthening of monitoring mechanisms for sale of prescription drugs and regular training programmes for pharmacists and chemists.

• Training of primary health care, welfare and education personnel for early recognition and referral.

• Education and active community participation to reduce stigma associated with drug abuse and provision of information on drug use and its consequences.

• Adequate recreational activities for different social groups.

• Intervention programmes for persons abusing drugs apart from opioids and cannabinoids, including alcohol, cologne (cola water) and inhalants (dunlop) in the existing treatment and rehabilitation regime.

• Strengthening of supply reduction and reporting activities.

The realities of the situation and some of the suggestions offered may serve as the basis for the development of a National Master Plan for Drug Abuse Control. In the larger context the country needs to address several issues, including living, environmental and health
conditions, sociocultural practices, educational and vocational avenues, psychological aspects and issues of welfare, all of which can impact on drug abuse.

**A drug free Maldives... A not too distant vision!**

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