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Office on Drugs and Crime

SOUTH ASIA

2005

Regional profile

September

TABLE OF CONTENTS

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UNODC would like to thank ***Maps of India*** for the maps we have used in the section on India.

Map note
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ABBREVIATIONS

AA	Acetic Anhydride
AASRA	An Association for Scientific Research on the Addictions (India)
AIDS	Acquired Immune Deficiency Syndrome
ATS	Amphetamine Type Stimulants
CATW	Coalition Against Trafficking in Women
CBN	Central Bureau of Narcotics (India)
CPI	Corruption Perception Index
CREHPA	Center for Research on Environment Health And Population Activities (Nepal)
CSW	Commercial Sex Worker
DADRP	Drug Abuse Demand Reduction Project (Nepal)
DAMS	Drug Abuse Monitoring System (India)
DGRI	Directorate General of Revenue Intelligence (India)
DNC	Department of Narcotics Control (Bangladesh)
FASHAN	A local NGO
FGD	Focus Group Discussion
FHI	Family Health International
FIR	First Investigation Report
GAP	Global Assessment Programme
HBsAg	Hepatitis B Surface Antigen
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immuno-deficiency Virus
HMGN	His Majesty's Government of Nepal
HRW	Human Rights Watch
ICPO	International Criminal Police Organization
IDU	Injecting Drug Use
IDUs	Injecting Drug Users
ICPS	International Centre for Prison Studies
KI	Key Informant
LTTE	Liberation Tigers of Tamil Eelam
MDMA	Methylene DioxyMethyl Amphetamine
MSJE	Ministry of Social Justice and Empowerment (Government of India)
mt	metric tons (tonnes)
NACO	National AIDS Control Organisation (India)
NASROB	National Assessment of Situation and Responses to Opioid / Opiate use in Bangladesh
NCB	Narcotics Control Board (India)
NCB(M)	Narcotics Control Board (Maldives)
NCC	National Co-ordination Committee (for Drug Abuse Control, Nepal)
NCDAP	National Centre for Drug Abuse Prevention (India)
NDCLEU	Narcotics Drug Control Law Enforcement Unit (Nepal)
NDDCB	National Dangerous Drugs Control Board (Sri Lanka)
NDPS	Narcotic Drugs and Psychotropic Substances Act (India)
NEIHAN	North-East India HIV/AIDS Network
NGO	Non Governmental Organisation
NNCB	National Narcotics Control Bureau (Maldives)

NSEP	Needle Syringe Exchange Program
NSS	National Service Scheme (India)
NYK	Nehru Yuvak Kendras (India)
ODCCP	UN Office on Drug Control and Crime Prevention
RAS	Rapid Assessment Survey
ROSA	Regional Office for South Asia
RRTC	Regional Resource and Training Centre (India)
RSA	Rapid Situation Assessment
SAARC	South Asian Association for Regional Cooperation
SP	Spasmoproxyvon (a narcotic analgesic consumed principally in India)
STIs	Sexually Transmitted Infections
UNDCP	UN International Drug Control Programme
UNDP	UN Development Programme
UNICRI	UN Interregional Crime and Justice Institute (Turin, Italy)
UNODC	United Nations Office on Drugs and Crime

SOUTH ASIA

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Department of Peacekeeping Operations
Cartographic Section

GENERAL STATISTICS

COUNTRY	BGD	BHU	IND	MDV	NEP	SRL
GENERAL						
HDI Rank[h]	139	134	127	96	136	93
Surface area, thousand sq. km	144[c]	47[c]	3287[c]	0.3[d]	147[c]	66[c]
POPULATION						
Total population[a] (thousands)	143,809	2,190	1,049,549	309	24,609	18,910
Population density / sq. km	1,042[c]	18[c]	353[c]	957[d]	169[c]	293[c]
Sex ratio[g] (males per 100 females)	104.9	-	106.9	-	102.2	98.8
Annual population growth[h] (%, 2003-2015)	1.7	2.2	1.4	2.4	1.9	0.7
Life expectancy at birth[a]	61	63	64	67	60	73
Life expectancy: females as a % of males[a]	102	103	102	99	98	109
% of population urbanized[a]	26	8	28	29	13	23
EDUCATION						
Total adult literacy rate[a]	40	47	57	97	42	92
Adult literacy rate: females as a % of males[a]	61	55	66	100	40	94
Net primary school enrolment/ attendance[a] (%)	89	53	76	99	73	97
Phones per 100 population[a]	1	3	4	17	1	8
Internet users per 100 population[a]	0	1	1	4	0	1
ECONOMY						
GDP per capita[h] (PPP, US$)	1,770	1,969[i]	2,892	4,798[i]	1,420	3,778
GDP per capita average annual growth rate[a] (%)	3.1	3.6	4.0	3.5	2.3	3.4
Gross National income per capita (US $, 2002)	380[c]	-	470[c]	2170[d]	230[c]	850[c]
% of population below $1 a day[a]	36	-	35	-	38	7
% share of household income – lowest 40% / highest 20%[a]	22/41	-/-	20/46	-/-	19/45	20/43
Per caput food availability[e] (kcals/day)	2,160	-	2,490	2,560	2,440	2,330
Unemployment rate[f]	3.3	-	-	-	-	8.7
HEALTH						
Infant mortality rate[a]	51	74	67	58	66	17
Public expenditure on health as % of GDP[b]	1.7	3.2	-	3.7	1.3	1.7
Physicians per 100,000 population[b]	20	16	48	40	4	36
Population with access to essential drugs[b] (%)	50-79	80-94	0-49	50-79	0-49	95-100

SOURCES:

[a] UNICEF 2004
[b] UNDP 2003
[c] World Bank 2004a
[d] World Bank 2004b
[e] FAO 2003
[f] UN statistics division 2004
[g] IPPF 2001
[h] UNDP 2005
[i] UNDP 2004a

INTERNATIONAL CONVENTION ADHERENCE

COUNTRY	BGD	BHU	IND	MDV	NEP	SRL
DRUG CONVENTIONS						
Single Convention on Narcotic Drugs, 1961	May 1980	Aug 2005	Dec 1978	Sep 2000	Jun 1987	Jun 1981
Convention on Psychotropic Substances 1971	Oct 1990	Aug 2005	Apr 1975	Sep 2000		Mar 1993
Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988	Oct 1990	Aug 1990	Mar 1990	Sep 2000	Jul 1991	Aug 1990
CRIME CONVENTIONS						
Transnational Organized Crime			Dec 2002		Dec 2002	Dec 2000
A. Protocol on Trafficking			Dec 2002			Dec 2000
B. Protocol on Migrants			Dec 2002			Dec 2000
C. Protocol on Firearms			Dec 2002			
Corruption					Dec 2003	Mar 2004
TERRORISM CONVENTIONS						
1. Tokyo 1963	✔	✔	✔	✔	✔	✔
2. Hague 1970	✔	✔	✔	✔	✔	✔
3. Montreal 1971	✔	✔	✔	✔	✔	✔
4. New York 1973		✔	✔	✔	✔	✔
5. New York 1979		✔	✔		✔	✔
6. Vienna 1980			✔			
7. Montreal 1988			✔	✔		✔
8. Rome 1988			✔			✔
9. Rome 1988			✔			

10. Montreal 1991			✔	✔		✔
11. New York 1997			✔	✔	✔	✔
12. New York 1999		✔	✔	✔		✔

Notes on the Organized Crime Conventions

A. Protocol to Prevent, Suppress and Punish Trafficking in Persons

B. Protocol Against the Smuggling of Migrants by Land, Sea and Air

C. Protocol Against the Illicit Manufacturing of and Trafficking in Firearms, Their Parts and Components and Ammunition

Notes on the Terrorism Conventions

1. Convention on Offences and Certain Other Acts Committed On Board Aircraft (Tokyo, 1963)
2. Convention for the Suppression of Unlawful Seizure of Aircraft (The Hague, 1970)
3. Convention for the Suppression of Unlawful Acts against the Safety of Civil Aviation (Montreal, 1971)
4. Convention on the Prevention and Punishment of Crimes Against Internationally Protected Persons (New York, 1973)
5. International Convention Against the Taking of Hostages (New York, 1979)
6. Convention on the Physical Protection of Nuclear Material (Vienna, 1980)
7. Protocol for the Suppression of Unlawful Acts of Violence at Airports Serving International Civil Aviation, supplementary to the Convention for the Suppression of Unlawful Acts against the Safety of Civil Aviation (Montreal, 1988)
8. Convention for the Suppression of Unlawful Acts Against the Safety of Maritime Navigation Rome, 1988)
9. Protocol for the Suppression of Unlawful Acts Against the Safety of Fixed Platforms Located on the Continental Shelf (Rome, 1988)
10. Convention on the Marking of Plastic Explosives for the Purpose of Detection (Montreal, 1991)
11. International Convention for the Suppression of Terrorist Bombings (New York, 1997)
12. International Convention for the Suppression of the Financing of Terrorism (New York, 1999)

BACKGROUND TO THE REGIONAL PROFILE

Mandate of the United Nations Office on Drugs and Crime (UNODC)

The United Nations Office on Drugs and Crime (formerly called the Office for Drug Control and Crime Prevention) was created in 1997, combining the United Nations International Drug Control Programme and the United Nations Centre for International Crime Prevention. It was established by the Secretary-General of the United Nations to enable the Organisation to focus and enhance its capacity to address the interrelated issues of drug control, crime prevention and international terrorism in all its forms. The mandate of the Office derives from several conventions and General Assembly resolutions, and the Office's technical cooperation programme aims to help improve the capacity of Governments to execute those international commitments. The Office is headed by an Executive Director, appointed by the Secretary-General, and is co-located with the United Nations Office at Vienna, of which the Executive Director also serves as the Director-General.

UNODC Regional Profile

The UNODC Regional (or Country) Profile is at the core of the organization's reporting on drug and crime matters in the region (or country) covered by each Field Office. The profiles include relevant information and analysis on drug and crime trends and are prepared on the basis of a joint Headquarters-Field Office effort. The views of key stakeholders in the Member States are sought during this process. The Regional Profile serves as the basis for programme planning, in consultation with the countries served by the Field Office. This programme planning is contained in the Strategic Programme Framework.

Strategic Programme Framework

The purpose of the Strategic Programme Framework (SPF) is to clearly spell out the strategic direction and UNODC's priorities, based upon consultation with the countries served by the Field Office in a geographic context. The SPF focuses on the priority problems identified through the gap analysis in the Regional Profile. It sets out UNODC's strategic, long-term objectives to address these problems and established UNODC operational targets to the end of the biennium 2006-2007, which is the current timeframe for the United Nations' planning activities. The SPF thus serves as a strategic management tool for UNODC but is drawn up in consultation with partners, in particular, recipient governments.

BANGLADESH

1. EXECUTIVE SUMMARY

- Consumption of both opium and cannabis are traditional in Bangladesh. Other drugs such as heroin began to be smuggled into the country only in the 1980s.
- The smuggling, diversion and abuse of pharmaceuticals originating from India is considered the single largest drug problem in Bangladesh. Commonly abused pharmaceuticals are Phensidyl® (a codeine-based cough syrup), Tidigesic® (buprenorphine) and pethidine injections.
- There are approximately 20,000 - 25,000 IDUs in the country. The most commonly injected drug is buprenorphine (commonly known by the trade name[1] Tidigesic®). Poly drug use is common.
- Bangladesh is considered a "low prevalence, high risk situation" for HIV/AIDS. However, recent trends indicate that in certain areas the HIV/AIDS prevalence among IDUs may be approaching the concentrated epidemic mark (5%).
- According to research, certain outreach interventions have been effective in reducing the size of the sharing group (of needles and syringes) among IDUs. In areas where such interventions occurred, 25% of IDUs shared with three persons or more against a much higher 40% in areas where no outreach programme existed. In contrast to 87% of the current IDUs from intervention sites, only 66% of IDUs in districts without outreach interventions knew that syringe and needles sharing could spread HIV.
- Recently, a new heroin trafficking route has opened up from the north central states of India eastwards into Bangladesh. A portion of this product is consumed in Bangladesh while some is destined for overseas.
- Bangladesh is a source country for women and children being trafficked for the purpose of sexual exploitation, involuntary domestic servitude and debt bondage.
- The estimated number of women and girls trafficked annually out of the country is 10,000 – 20,000. Some reports indicate that 40,000 children from Bangladesh are involved in prostitution in Pakistan. There is also significant internal movement within the country to urban centres for the same purposes.

2. MAJOR CHARACTERISTICS OF THE COUNTRY RELEVANT TO THE DRUG AND CRIME PROBLEM

Despite recent strong economic growth, poverty in Bangladesh continues to be pervasive. Nearly half of its 130 million population live below the poverty line. Bangladesh features the third highest number of poor people living in a single country after India and China. These

[1] Note: the trade names under which drugs are sold in the market are not intended to imply a pejorative connotation.

challenges are magnified by a population density of roughly 800 people per square kilometre—one of the highest in the world. Such poverty fuels many high-risk behaviour patterns, including commercial sex work. This is obviously a risk factor for the spread of HIV. While, as an Islamic country, Bangladesh proscribes the consumption of alcohol, there is significant abuse of this substance. Porous borders with India and Myanmar permit trafficking in drugs and other contraband.

3. DRUG SITUATION

3(a) Production and cultivation

Cannabis is still cultivated, particularly in the districts of Naogaon, Rajshahi, Jamalpur and Nerrokona in the northwestern region, as well as the hilly districts near Cox's Bazaar, Banderban, Khagrachhari and Rangamati in the southeast (bordering Myanmar). Reliable figures for the total area of cannabis production in Bangladesh are not available, but cultivation in the Chittagong Hill Tract region is reportedly on the increase. The army and the Bangladesh Rifles in the southeastern hilly region have reported that the overall cannabis production has increased significantly in recent years. This increase in production is not apparent in the table below, which depicts only the seizures carried out by the field staff of DNC.

The seizures of 1-2 metric tons of cannabis herb per year in Bangladesh represents about 0.03% of the global seizures of an average of 4,741 metric tons of cannabis herb per year (UNODC 2004). Crop eradication appears not to be undertaken systematically, and information on seizures by the army and Bangladesh Rifles is not regularly reported to DNC.

There are anecdotal reports of small quantities of opium cultivation in Bandarban district along Myanmar border.

3(b) Manufacture

Bangladesh is not believed to manufacture any narcotic drugs or psychotropic substances illicitly. It also does not manufacture any precursor chemicals except hydrochloric acid and sulphuric acid.

3(c) Trafficking

Bangladesh seizures (in kg)

Drugs	1999	2000	2001	2002	2003
Heroin	28.8	8.0	42.0	15.7	34.0
Cannabis herb / Ganja	724	2658	1,421	1,721	1,906
Phensidyl (ltrs.)	42,900	N/A	384	290	28,288

Source: Department of Narcotics Control, Bangladesh; World Drug Report, 2004 and ARQ 2003.

Bangladesh is a transit country for drugs produced in the Golden Triangle and, to a much lesser degree, the Golden Crescent. Reports from the Indian Narcotics Control Bureau also indicate that heroin is smuggled from India to Bangladesh through the porous Indo-Bangladesh border. There were seven seizures of heroin hidden in fresh vegetable shipments from Dhaka into the UK in 2003 (INCSR 2003). Dhaka airport and the seaport of Chittagong appear to be preferred exit points. Heroin seizures have been about 30-40 kg per year during

the past four years except during 2000 and 2002. During 2003, law enforcement agencies seized 34 kg heroin, 1,906 kg ganja (cannabis herb) (ARQ 2003), 28,288 litres of Phensidyl®, 1,276 ampoules of pethidine and 2,898 ampoules of Tidigesic® (INCSR 2003).

Nonetheless, the smuggling in, diversion and abuse of pharmaceuticals originating from India is considered to be the largest drug problem in Bangladesh. Commonly abused pharmaceuticals are Phensidyl® (a codeine-based cough syrup), Tidigesic® (buprenorphine) and pethidine injections.

3(d) Diversion of drugs and precursors[2]

Bangladesh does not manufacture any substance listed in Table I and Table II of the 1988 Convention other than Sulphuric Acid and Acetic Acid. It imports a number of precursors for use in domestic industry. There is no recorded misuse of precursors for illicit manufacture of drugs in the country. Ephedrine, pseudo-ephedrine, ergometrine, toluene and potassium permanganate are imported by the country for industrial, scientific and research purposes. Even though the Narcotics Control Act, 1990 includes sanctions against diversion of precursor chemicals, Bangladesh does not have a very effective system for control except the issuance of permits for the import of precursors and pre-export notifications of these substances. Although the new rules for exercising more effective controls are now in place, their effectiveness is hampered due to a shortage of trained law enforcement personnel. It has been observed that the level of coordination between agencies dealing with precursor controls is not optimal.

3(e) Drug prices

Comparable to information provided in sections on India and Nepal.

3(f) Demand

Bangladesh has clearly moved from being a transit country to one where so-called 'hard' drugs are used. The number of drug users is increasing in both urban and rural areas. The number of injecting drug users (IDUs) is also on the rise, with the majority using buprenorphine. The drug most frequently used by drug-dependent persons reporting to treatment centres is heroin. Phensidyl®, a codeine-based cough syrup imported from India, is generally considered to be the most widely abused drug. There are approximately 20,000 - 25,000 IDUs in the country (Reid and Costigan 2002). The most commonly injected drug is buprenorphine (commonly known by the trade name Tidigesic®). Polydrug use is common and may include marijuana, Tidigesic®, Phensidyl®, alcohol, codeine, nitrazepam, 'brown sugar' (heroin 'cooked' with vitamin C) and diazepam.

The National Assessment of Situation and Responses to Opioid / Opiate use in Bangladesh (NASROB) was conducted in 24 districts by the Family Health International and Care Bangladesh (Panda et al 2002). The survey included a collection of both secondary as well as primary data, which comprised of observations, key informant interviews, focus group discussions and interviews with drug users. In most districts both heroin smokers and drug injectors were found. Ten percent of all drug users who reported ever having smoked heroin started doing so at the age of 17 or earlier. Three percent of all injectors started injecting

[2] Most of the information in this section on precursors is derived from the country presentation BGD Paper 2004 as cited in the bibliography.

before the age of 18 years. The mean age of onset for heroin smoking was 24 years, while the mean age of onset for IDU was 28 years. The dynamics of switching to injecting from heroin smoking were also studied and the finding that 87% of current IDUs had once been heroin smokers and many drug users went back and forth from one type of drug use to another, suggests that the drug use pattern keeps changing. More than 25% of IDUs in districts with outreach interventions, 99% of IDUs in districts without outreach interventions and 99% of all heroin smokers in all districts were not in contact with any outreach programme. The study also reported that a spillover of illicit drugs occurs around the drug trafficking network. Along with injecting-related risk behaviours, several sexual risk behaviours were also noted and are described in the section below.

Among recent studies, Rahman (2004) investigated the patterns of drug abuse among 196 drug users who had been admitted to a drug-dependence treatment centre in Dhaka. The mean age was 25.3 years, while age at onset of drug use was about 21 years. The mean duration of addiction was 42.1 months. Common drugs of abuse were: codeine-containing cough syrups (about 65%), heroin (about 45%), cannabis (about 45%), sedatives (about 17%), injectable opioids (11.7%).

3(g) Costs and consequences

In the study cited above, Rahman (2004) analysed the money spent by addicts on drugs and found that the amount spent per year was much higher than the average per capita income of Bangladeshis. Applying the findings of the study to the total population of drug users in Bangladesh, the author estimated that the total amount spent by drug users in Bangladesh would be extremely high if compared with the annual expenditure for healthcare or drugs or the allocation for development programmes in Bangladesh. The study suggests that growing criminal activities in Bangladesh could be partly attributable to drug abuse.

The NASROB cited above (Panda et al 2002) also reported many social/legal adverse consequences of drug use. About 28% of heroin smokers had been arrested or had had encounters with local law enforcement. Similarly, IDUs at two kinds of sites – those with outreach interventions (17%) and those without (22%) – reported that police had arrested them. Human rights activist groups have also reported and expressed concern over instances of extortion and abuse of IDUs by police in Bangladesh (HRW 2003).

Among health-related consequences, one-fifth of heroin smokers and one-fourth of current IDUs reported a drug overdose in the NASROB (Panda et al 2002). Other consequences reported were those related to use of contaminated injection equipment. Between 11% to 36% of IDUs reported the occurrence of abscesses within the previous month. Those with a longer duration of injecting drug use were more likely to report abscesses. IDUs recruited from districts with outreach interventions reported a significantly lower occurrence of abscesses.

Behaviours related to the sharing of injection equipment were also studied. Of note was the finding that IDUs in areas with interventions reported significantly lower sharing of injecting equipment (19%) than those in non-intervention areas (67%). Interventions have been effective in reducing the size of the sharing group (of needles and syringes) among IDUs. In areas where such interventions occurred, 25% of IDUs shared with three persons or more against a much higher 40% in areas where no outreach programme existed. In contrast to

87% of the current IDUs from intervention sites, only 66% of IDUs in districts without outreach interventions knew that syringe and needles sharing could spread HIV.

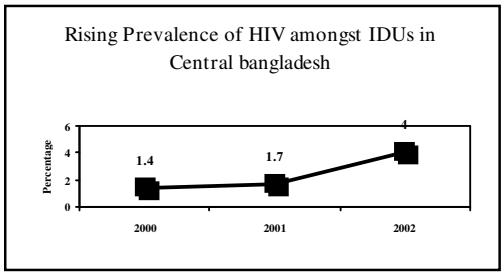
Regarding high-risk sexual behaviours, about 70% of unmarried drug users had been sexually active within the previous month. Over 70% of all drug users reported sex with sex workers. A noticeable observation was that there was little difference condom use practices among current IDUs from intervention and non-intervention sites. It was also noted that a high proportion of drug users (over 90%) were unaware of the risk of HIV/AIDS through male-to-male sex or sex with '*hijras*' (transgenders). This is of concern as 10% of the male respondents reported sex with male/*hijras* and condom use in those situations was very low.

In a study on IDUs in treatment in Bangladesh, Felsenstein et al (1997) studied IDUs under treatment and reported that all the subjects shared needles, although most were aware of the health hazards of such practices. Similarly, Sarkar et al (1998) interviewed 234 IDUs in the Dhaka city after extensive ethnographic observations. Eighty-two percent shared their needles/syringes, and 48% shared with more than ten persons, in spite of a reasonable degree of knowledge of HIV/AIDS. Sixty percent had heard about HIV/AIDS, and one-fourth knew that needle sharing might transmit HIV/AIDS. Ahmed (2000) reported similar findings, stating that out of 100 IDUs enrolled in an NSEP, 95% had demonstrated an understanding of HIV/AIDS and its mode of transmission and the method of its prevention. Despite having knowledge of the risks of needle and syringe sharing, 92% of the respondents continued the practice.

Shirin et al (2000) investigated the prevalence and risk factors of HBV and HCV infections among drug users attending a drug-addiction treatment centre in Dhaka, Bangladesh. Of the 266 addicts, 129 were IDUs, and 137 were non-IDUs. The sero-prevalence of HbsAg, anti-HBc, anti-HBs, and anti-HCV antibodies among the IDUs was 6.2%, 31.8%, 11.6% and 25% respectively. Corresponding figures among the non-IDUs were 4.4%, 24%, 6.6% and 5.8% respectively. Although the prevalence of HBV infection did not significantly differ between the IDUs and the non-IDUs, the prevalence of HCV infection was significantly higher among the IDUs. Among the IDUs, the prevalence of both HBV and HCV infections was associated with sharing of needles and longer duration of injectable drugs used. The sero-prevalence of HBV infection in both IDUs and non-IDUs was significantly higher among those who had a history of extramarital and premarital sex.

Islam et al (2003) studied not only the risk behaviours but also the prevalence of HIV/AIDS among 250 IDUs and 255 non-IDUs. Among IDUs the sero-prevalence rate was 5.6%. Among non-IDUs it was 1.96%. The sero-positive drug users used multiple drugs for longer periods of time and also had higher prevalence of sexual risk behaviours.

Bangladesh is still considered a "low prevalence, high risk situation" for HIV/AIDS. However, recent trends indicate that in certain areas the HIV/AIDS prevalence among IDUs may be approaching or even exceeding the concentrated epidemic mark (5%). The national AIDS/STD programme (2003), while reporting the results of fourth round national HIV and behavioural surveillance, noted with concern the finding



Source: National AIDS/STD program 2003

of a dramatic rise in HIV prevalence amongst IDUs in Central Bangladesh (from 1.4% to 4% within 3 years). At the same time, however, the prevalence has remained low (<1%) amongst other at-risk groups. In the same report concern was expressed on sexual risk behaviours and mobility of IDUs in Central Bangladesh, which may lead to a spread of the epidemic in the general population. The IDUs in this region are more likely to have a sex worker as a sex partner. In addition, 10% of them have sex with other men including male sex workers.

3(h) Money laundering

Bangladesh enacted anti-money-laundering legislation in 2002. The Act (see below) appears to be quite comprehensive but since it was only passed relatively recently, it may be too early to judge implementation.

4. CRIME SITUATION

The magnitude and dimensions of criminality in Bangladesh have been steadily increasing. In 1996, 93,310 cases were recorded by the police, which equal approximately 78 crimes per 100,000 inhabitants. Crimes recorded in the preceding three years show an upward trend: 72,069 in 1993 (60 per 100,000), 75,309 in 1994 (60 per 100,000) and 82,971 in 1995 (65 per 100,000). Thus, crime grew at an average rate of 9.8% between the years 1993 and 1996 against the average growth in population of about 2% per annum. However, it is obvious that these figures understate the real crime rate, as not all crimes are reported or recorded.

Violence against women and children: The most common manifestation of violence against women consists of dowry-related violence, rape, injury or death by corrosive or poisonous substances (i.e. acid throwing), trafficking and prostitution.

Trafficking in human beings: Bangladesh is a source country for women and children being trafficked for the purpose of sexual exploitation, involuntary domestic servitude and debt bondage.

In 1994, it was estimated that 2,000 women were trafficked to six cities in India. In the decade to 2002, it has been estimated by the Coalition Against Trafficking in Women (CATW) that 200,000 women were trafficked out of the country (CATW 2002). The estimated number of women and girls trafficked annually out of the country is 10,000 – 20,000 (TIP 2004). UNICEF reports that 40,000 children from Bangladesh are involved in prostitution in Pakistan (UNICEF 2001). There is also significant internal movement within the country to urban centres for the same purposes.

Arrests for human trafficking

Year	Arrestees	Convictions
2002	60	30
2003	72	17

Source: TIP 2004

Bangladesh possesses laws to prevent trafficking. Some social services are provided for trafficking victims. In early 2004, the Ministry of Women and Children's Affairs attempted to raise awareness on the issue of human trafficking. In 2003, it established 'one-stop' crisis centres in two hospitals for female victims of violence and human trafficking.

Corruption: According to the Transparency International Corruption Perception Index in 2003, Bangladesh scored 1.3 and was ranked 133rd in terms of the level of perceived corruption (TI 2003). This was the lowest rating of any country. In 2004 Bangladesh scored 1.5 and ranked 145 (again the lowest rating of any country despite the slight improvement in score).

In the first comparative study of corruption in South Asia examining what users of key public services actually experience, respondents in Bangladesh considered the police to be the most corrupt public agency, followed by health and land administration (TI 2002).

Public corruption is an acknowledged problem in Bangladesh. In February 2004, the government passed legislation to create an Anti-Corruption Commission.

5. POLICY – DRUGS

5(a) National drug control framework

Convention adherence

Bangladesh is a signatory to all three UN Conventions on drug abuse and trafficking, namely the Single Convention on Narcotic Drugs 1961, the Convention on Psychotropic Substances 1971 and the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988.

Legislation

The Narcotics Control Act of 1990 (Act Number XX of 1990) covers the control of narcotic drugs and psychotropic substances, including provision for the treatment and rehabilitation of drug dependent people. Bangladesh has amended the narcotics act and allows the Director General of the Department of Narcotics Control to send drug addicts for treatment. Drug use is considered a treatable condition rather than a criminal offence.

The Narcotics Control Act was enacted in 1990 and Narcotics Control Rules were framed in 1999 under this Act. The Act was further strengthened through an amendment in 2002. The key features of the amendment are:

- Incorporation of the precursor chemicals in the schedule of drugs.
- Precursors are placed under the purview of the definition of drugs.
- Provisions for warning on labels and packages on drugs and precursors.
- Maintaining correct accounts of drugs and precursors.
- Financial investigation.
- Seizure and forfeiture of assets of illicit traffickers.
- Freezing of bank accounts.
- Application of Controlled Delivery Technique

Institutions and policy

In Bangladesh, the Department of Narcotics Control (DNC) administered by the Ministry of Home Affairs, is responsible for implementing drug law enforcement and drug abuse control

programmes guided by a ministerial level National Narcotics Control Board (NNCB). DNC has an intelligence-gathering and operational role and oversees the implementation of demand reduction initiatives. It is also charged with co-coordinating the efforts of the other Bangladesh enforcement agencies (police, customs, Bangladesh Rifles and coastguard). The DNC does not collate national arrest and seizure statistics, in part because the other agencies are reluctant to disclose the necessary material.

The DNC has recently initiated a community level of coordination to streamline the activities of the non-governmental organizations to strengthen existing and future drug prevention activities in the country. With assistance from UNODC, the process of formation of a national network of GOs and NGOs has been initiated through training for stakeholders held in March 2004 in Dhaka. Four network formation meetings have been held in the divisions of Chittagong, Dhaka, Khulna and Rajshahi.

5(b) Licit control (drugs and precursors)

Bangladesh is a signatory to all the three UN Conventions of 1961, 1971 and 1988 and the SAARC Convention on Narcotic Drugs and Psychotropic Substances, 1990. In view of its obligations under these conventions and the potential for diversion of precursors due to its close proximity to heroin-producing localities in South East Asia, the country has imposed restrictions on the import of precursors.

The 1990 Narcotics Control Act was amended in 2002 and 22 precursor chemicals, as stated in Tables I and II of the 1988 Convention, were included. Sections 19 and 20 of the Act prohibit any kind of illegal operations regarding narcotic drugs, psychotropic substances as well as precursor chemicals. Additionally, rules relating to the licensing of precursor chemicals were framed and adopted.

The Narcotics Control Act prohibits import, export, sale, purchase, manufacture, processing, transport, possession, use or any other kinds of the operations except for medicinal, scientific, or legitimate industrial purposes under license, permit or pass (section 9). The Department of Narcotics Control issues licences, permits or passes. However, they cannot be issued to persons with a criminal record (sections 11& 12). Handling precursors without the requisite licence, permit or pass attracts imprisonment of 2 to 10 years while violation of any condition of the licence attracts imprisonment of up to 5 years and a fine. Importers require an import licence and an import authorisation to import precursors from the Department of Narcotics Control. On arrival of the consignment, DNC verifies the physical stock and use of the precursor. Bangladesh does not export any precursors. Most imports are from India, Malaysia, Singapore, China, Japan, the UK and Italy.

The Ministry of Health and Family Welfare, in consultation with the Drug Administration and the Ministry of Home Affairs, agreed on an arrangement for the control of selected pharmaceutical products at the retailers point that are often subject to illicit use. Under this arrangement, the field force of DNC and the Drug Administration are empowered to carry out a search in any drug store on the sale of some selected products. In this respect, DNC is empowered to lodge cases with the police station if any one is found guilty for not keeping proper records on the sale of higher than the allowable amount of products that are subjected to non-medical illicit use.

5(c) Supply reduction

The supply reduction policy in the country is based on the Narcotics Control Act as amended in 2002. The national development plans in Bangladesh provided explicit strategies on drug abuse control. The Master Plan explicitly defined the long-term objective "to contain and successively reduce the effect on individuals, families, communities and the social fabric of society caused by drug abuse and criminal activities connected with the illicit trafficking of drugs".

5(d) Demand reduction

The Narcotics Control Act of 1990 covers the control of narcotic drugs and psychotropic substances, including provisions for the treatment and rehabilitation of drug dependent people. Bangladesh amended the Narcotics Act in 2002 and this allows the Director General of the Department of Narcotics Control to send drug users for treatment. The demand reduction policy in the country is based on the Narcotics Act (Banglapedia 2002). The Government of Bangladesh recognizes an important complementary role for NGOs in the drug demand reduction sector.

HIV/AIDS: National policy on HIV/AIDS and STD related issues (DGHS 1996) came into effect in 1996. The policy recognises the potential role which IDU can play in the spread of the epidemic. The policy also recognises the limitations of an abstinence-oriented approach as well as the high effectiveness of needle exchange programmes or maintenance programmes although the government has not endorsed them. The policy also recommends that the availability of drug treatment and rehabilitation services should be extended.

A National AIDS Committee was established in 1985 for the prevention and control of HIV/AIDS. Additionally, a task force with technical experts was established supervising aspects of HIV/AIDS and STD prevention and control. The Bangladesh AIDS Prevention and Control Programme is within the Ministry of Health and Family Welfare.

Prisons: In Bangladesh, prisons come under the purview of the Ministry of Home Affairs. They are run by the prison directorate and manned by the Inspector General of Prisons and his staff of 7,620. The prisons are overcrowded by about 290% with 60% of the prison population in remand (ICPS 2004). Conducting treatment programmes among those in remand is the biggest problem. Overcrowding causes many groups of prisoners to be mixed up. This enables prisoners to share their criminal experiences while in prison. Consequently, this undermines the authority of the prisons and escalates violence and other problems among prisoners.

NASROB (see Panda et al 2002) also reported that none of the jails visited had specific programmes for drug users in place. Jail medical officers expressed the need for training that would help them in handling withdrawal symptoms better. They also indicated that regular visits by counsellors to drug users in jail and other innovative service provisions such as voluntary confidential testing and counselling for HIV (VCT) should be organized. NASROB recommended the development of programmes for IDUs in areas where no such interventions exist, scaling-up existing programmes to include all IDUs, and designing targeted interventions for heroin smokers to prevent them from switching to injecting. It also recommended developing appropriate interventions for primary prevention of drug use for in-

and-out-of-school children as well training of police to foster better understanding of an approach to drug users and easier referral to appropriate drug treatment centres.

5(e) Money laundering control measures

Provisions regarding money-laundering offences were included in the revision of the 1990 Narcotics Control Act.

A separate Money Laundering Act was passed in 2002. The Act requires banks, financial institutions and other institutions engaged in financial activities to:

- Establish the identity of their customers;
- Retain correct and full information used to identify their customers and transaction records at least for five years after termination of relationships with the customers;
- Make a report to the Bangladesh Bank where:
    - they suspect that a money laundering offence has been or is being committed and
    - provide customer identification and transaction records to Bangladesh Bank from time to time on demand.

The following are money-laundering offences under the Act:

- Obtaining, retaining, transferring, remitting, concealing or investing in moveable or immovable property acquired directly or indirectly through illegal means.
- Illegally concealing, retaining transfer, remitting, or investing moveable or immoveable property even when it is earned through perfectly legitimate means.
- Providing assistance to a criminal to obtain, retain, transfer, remit, conceal or invest moveable or immovable property if that person knows or suspects that those properties are the proceeds of criminal conduct.
- Banks, financial institutions and other institutions engaged in financial activities not retaining identification and transaction records of their customers.
- Banks, financial institutions and other institutions engaged in financial activities not reporting the knowledge or suspicion of money laundering to Bangladesh Bank as soon as it is reasonably practicable after the information came to light.
- Anyone prejudicing an investigation by informing i.e. tipping off the person who is the subject of a suspicion, or any third party, that a report has been made, or that the authorities are acting, or are proposing to act, in connection with an investigation into money laundering.
- Anyone violating a freezing order issued by the Court on the basis of application made by Bangladesh Bank.
- Anyone expressing unwillingness, without reasonable grounds to assist any enquiry officer in connection with an investigation into money laundering.

5(f) International cooperation

Bangladesh and Myanmar have signed a bilateral agreement in respect of illicit trafficking of narcotic drugs and psychotropic substances including precursors. The DNC maintains contact with the Drug Liaison Officers network based in New Delhi.

The Government is a signatory to the 1990 SAARC Convention on Narcotic Drugs and Psychotropic Substances.

6. POLICY – CRIME

The constitution of Bangladesh provides "to enjoy the protection of the law and to be treated in accordance with law, is an undeniable right of every citizen, wherever he may be, and of every other person for the time being in Bangladesh, and in particular no action detrimental to the life, liberty, body, reputation or property of any person shall be taken except in accordance with law". The constitution further provides that "every person accused of a criminal offence shall have the right to a speedy and public trial by an independent and impartial court or tribunal established by law".

Key laws pertaining to human security are as follows:

The Penal Code, 1960
The Evidence Act, 1872
The Code of Criminal Procedure, 1898
The Child Marriage Restraint Act, 1929
The Muslim Family Law Ordinance, 1961
The Children Act, 1974
The Dowry Prohibition Act, 1980
The Suppression of Violence against Women and Children Act, 2000
The Public Safety (Special Provisions) Act, 2000
Law and Order Disruption Crimes Act, 2002

The Preventive detention law: The Special Powers Act of 1974 authorizes the Government to detain any person in order to prevent them from committing certain prejudicial acts. This is the only article of law that allows the Government to preventively detain anyone. The frequent use of the Special Powers Act has been used as an example of deficiencies in the criminal justice system to deal with alleged criminals.

Crime control institutions: The administration of justice is the responsibility of the judiciary, which comprises the Supreme Court, the Appellate Divisions and the High Court at the higher level, followed by a hierarchy of civil and criminal courts at the district level; and finally, village courts in rural areas and conciliatory courts in municipal areas. The Supreme Court is located in Dhaka. The Courts of District and Sessions Judge, Additional District and Session Judges, Subordinate Judge and Assistant Sessions Judge deal with both civil and criminal cases.

The court of Assistant Judge (formerly *Munsif*) deals only with civil cases. The Courts of District Magistrate, Additional District Magistrate, Magistrate of First, Second and Third Class deal with criminal cases only. The Metropolitan Magistracy, functioning in four major cities of the country, also deals with criminal cases. In most criminal cases in the Courts of Magistrates, and to some extent in the Court of Sessions, some categories of police officials have to play the role of prosecutors. Besides the police officers, the lawyers appointed as public prosecutors and assistant public prosecutors also act as prosecutors in the Court of Sessions.

Ensuring the respect of these laws and ordinances is the primarily responsibility of the police administration, which comprises over 500 police stations. An Inspector General of Police, under the administrative control of the Ministry of Home Affairs, heads the Police

department. In case of violations, the offence is reported to the officer-in-charge of the police station in the form of a first information report (FIR).

Police strategies for keeping pace with the developments in crime have generally taken the form of increasing the police manpower. The Bangladesh Police is a national force. Police stations are the basic units of the police service delivery mechanisms. Approximately 64% of the force is engaged in maintaining public order, with 20% dealing with investigations and inquiries, and about 1% involved in training. Constables comprise 75% of the force. Only 1% of the force is engaged with management and supervision (1997). Following an increase in manpower in 1997, the proportion of management and supervisions fell to 0.74%.

Convention adherence: Bangladesh is not a signatory to the Transnational Organized Crime Convention of 2002, nor any of the three related Protocols on human trafficking, migrants and firearms. It is also not a signatory to the 2003 Corruption Convention.

7. TERRORISM

There are currently two main sources of activity linked to terrorism in Bangladesh. The first relates to the insurgency in the Chittagong Hill Tracts in south-eastern Bangladesh where dissident guerrilla groups remain active (Jane's 2004a). The second relates to the presence of alleged Al Qaeda members operating in conjunction with local groups, some of whom were arrested in 2003.

Convention adherence: Bangladesh is a party to three of the universal instruments related to the prevention and suppression of international terrorism. It is not a party to the 1999 International Convention for the Suppression of the Financing of Terrorism.

BHUTAN

1. EXECUTIVE SUMMARY

- No figures are available on drug abuse in Bhutan, but the government and National Assembly recognize the seriousness of the potential problem.
- Free and unregulated trade with India, open porous borders, and presence of Bhutanese, Indian and Nepalese refugees in each others' countries, make Bhutan vulnerable to drug trafficking.
- Anecdotal evidence indicates rising abuse in the capital Thimpu and in the South, particularly of amphetamines and benzodiazepines smuggled from India.
- Geographical proximity to high-IDU-prevalence areas in Nepal and the northeast states of India, render Bhutan potentially vulnerable to IDU and its consequences. Anecdotal evidence suggests around 5-6 IDU deaths a year attributable to morphine.
- Alcohol abuse ("Ara") is reported in some 80% of domestic violence cases.
- There are no reports of diversion of drugs for abuse.

2. MAJOR CHARACTERISTICS OF THE COUNTRY RELEVANT TO THE DRUG AND CRIME PROBLEM

Nestled in the remote eastern Himalayas, the tiny mountainous Kingdom of Bhutan is flanked by India to the south and the Tibet region of China to the north. Bhutan is a formal Buddhist state where power is shared by the king ("Druk Gyalpo"), Head of the Monastic Body ("Je Khenpo") and the government. Despite its increasing living standards, the country remains largely closed to the outside world.

The government's policy of careful centralized case-by-case visa issue and allowing tourism to expand at only a slow rate is intended to protect the country's values. This point is relevant in the context of a region which claims a strong association between increased tourism and a rise in the drug problem in the 1970s.

The country has made great progress in improving the living standards of its population of 2.1 million since it first started its modernization plan in the early 1960s. Per capita gross domestic product (PPP) is currently estimated at $1,969 (UNDP 2004a). Despite this rapid development, over 80% of its people farm their own land according to subsistence practices and herd livestock. Agriculture itself accounts for 45% of GDP.

Over the past decade social indicators have improved. Infant and maternal mortality, for example, have dropped by almost 50%, and literacy and education enrollment rates have risen. Unlike much of the rest of South Asia, primary school enrollment among girls is higher than boys in many urban areas, and nationwide almost half of primary school students are girls (45% out of an overall enrollment ratio of 71%). Adult workloads are roughly equal,

and both men and women take responsibility for childcare. Property rights are also much more equal than in most of South Asia, with women rather than men inheriting property in some areas.

Neither drugs nor crime appear, at present, to be significant problems facing Bhutan. A systematic assessment of the extent and nature of the situation in the country is, however, hampered by the absence of data in either area.

3. DRUG SITUATION

3(a) Production and cultivation

Cannabis plants grow wild in Bhutan, but as yet no serious cases of abuse have been reported. The trend of abuse is on the rise and the Royal Government has expressed its concern about the problem. There are no reports of cultivation of opium, cannabis or coca, or of the production of drugs. There is some residual traditional use of wild cannabis in pig feed and making hemp fibre products.

3(b) Manufacture

Bhutan is a small country with limited licit drug needs. No drugs other than traditional medicines are manufactured either legally or illegally.

3(c) Trafficking

Free trade with India and open porous borders make Bhutan vulnerable to drug trafficking.

3(d) Diversion of drugs and precursors

Sporadic cases of abuse of cough syrups, sleeping pills and correcting fluids[3] are reported (Bhutan 2003).

Precursors are not manufactured in the country; they are instead imported for use as laboratory chemicals. While precursor manufacture is an offence under the Penal Code of Bhutan, precursor trafficking is not. There is some limited regulation of precursor imports. Apart from an isolated incident of export from Bhutan of a relabelled precursor import from India, there is no history of diversion of precursors.

The Department of Revenue and Customs and the Royal Bhutan Police have limited resources and facilities and cannot easily detect cases of diversion and trafficking. The Drug Regulatory Authority is the single co-ordinating agency for licit drug regulation. The regulatory system and mechanisms for information exchange, both internally and externally are at the developmental stage. The country's vulnerability lies in the possibility of it being used as a site for channelling licit precursors to illicit purposes, as a transit point and a point for document conversion.

[3] Correcting fluid is the whitener used for correction of errors in typewriting. The solvent in the fluid gives a high if the fluid is sniffed.

The proposed Prevention and Control of Drug Abuse Act 2005 and Rules and Regulations made thereunder will bridge the gaps in Bhutan's control mechanisms against licit drug and precursor diversion.

3(e) Drug prices

Not available.

3(f) Demand

No figures are available on drug abuse in Bhutan, but the government has recognized the potential problem. There are initial reports of Bhutanese students in India and individuals engaged in prostitution on the Indo-Bhutanese border experimenting with IDU. The Government plans to conduct drug abuse surveys in 2 to 6 cities, depending on available funding.

Alcohol consumption still poses a problem (WHO SEARO 2002). Alcohol use is extensive in Bhutanese society, and there are indications of the initial availability and use of amphetamines, particularly among the youth. Heroin and injecting drug use in Bhutan is, however, currently minimal, unlike in neighbouring countries (World Bank 2003b). According to official Bhutanese sources, the situation in the country can be summarized as follows (Dorji 2002):

- Substance users are mostly male, students, under the age of 25;
- An increasing percentage of youth are using multiple drugs;
- There is some injecting drug use in Bhutan; and
- Gross under-reporting exists because of the stigma attached to publicly acknowledged addiction. As a result, the full nature of the situation is not known.

Despite limited available data, in June 2005, the National Assembly called for preventive education measures to be taken by the Government, civil society, local communities, schools, and the monastic community, and for effective treatment, rehabilitation and social reintegration when prevention fails. Appropriate legal frameworks for this have been carefully integrated into the proposed Prevention and Control of Drug Abuse Act 2005.

3(g) Costs and consequences

There is very little information on the nature, extent and pattern of drug use in Bhutan, even less so on consequences of drug use. However the geographical proximity of the country to high IDU prevalence areas such as Nepal, and northeast states of India render it potentially vulnerable to IDU and its consequences.

A high percentage of Bhutan's population is adolescents and youth (63% of the population is younger than 24 years), and this percentage is predicted to rise. This will add to the HIV/AIDS risk. The incidence of other STDs is high with annual rates of gonorrhoea standing at 2% and syphilis only slightly lower (UNDP 2003b.)

3(h) Money laundering

Bhutan enacted the Bhutan Penal Code Act in 2004, criminalizing the laundering of the proceeds of crime. Although there are no preventive regulatory provisions yet in Bhutan law, UNODC is currently helping Bhutan to draft these.

4. CRIME SITUATION

Homicide rate per 100,000 citizens (1998)	2.78
Homicide cases convicted (in %)	NA
Number of people incarcerated	70,000
Number of people incarcerated per 100,000 population (2001)	54
UNODC Organized Crime Rate Index Rating	NA
TI Corruption Perception index (2002)	102/102; Score 1.2/10
Human Trafficking	Origin: Yes; Transit: Yes; Destination: NA

Source: CICP Fact Sheet, UNODC 2003.

Bhutan does not publish prison figures. There is little violent crime and levels of theft are low. In Bhutan, trafficking in human beings is prohibited under law.

5. POLICY – DRUGS

5(a) National drug control framework

Convention Adherence

Bhutan is a party to the United Nations Convention against Illicit Traffic in Narcotics Drugs and Psychotropic Substances, 1988. It became party to the 1961 and 1971 Conventions on 24 and 18 August 2005 respectively.

Legislation

Since the devolution of full executive powers by the King in 1998 to a Council of Ministers elected by the National Assembly by secret ballot, a large volume of legislation has been enacted. In the drug control sphere, this includes the Civil and Criminal Procedure Code (2000), the Sales Tax, Customs and Excise Act (2000), the Medicines Act (2003) and the Penal Code of Bhutan (2004).

On 20 June 2005, Bhutan's National Assembly approved accession to the 1961 and 1971 Conventions, and tasked the Ministers of Health and Education with drafting comprehensive new legislation addressing all aspects of drug abuse control. They sought UNODC help to draft this legislation.[4]

Institutions

The nodal agencies dealing with drug control are the Ministry of Health and the Ministry of Education. However, officers of Police, Revenue and Customs and Agriculture are involved

[4] As a result, between 24 August and 2 September 2005, UNODC assisted Bhutan to draft the "Prevention and Control of Drug Abuse Act 2005". It is expected to be adopted by the National Assembly in November 2005. UNODC has been requested to help draft the necessary subordinate Rules and Regulations to give detailed effect to this new Act.

in drug law enforcement in the country. In addition, the Ministry of Home Affairs also deals with drug control activities.

In Bhutan, the competent authority for HIV/AIDS prevention and control is the Director, Department of Public Health, Ministry of Health, and the Programme Manager, National STD/AIDS Control Programme, Public Health Department, Ministry of Health, Royal Government of Bhutan.

There is no specific identification of responsibility for Drug Demand Reduction in Bhutan. However, the IECH Bureau of the Ministry of Health has the primary responsibility to inform, educate and communicate on health and health-related matters. In this Ministry, the Joint Director, Quality Assurance and Standards Department (QASD) is the national focal point. The competent authority in Bhutan for youth affairs is the Director, Department of Youth and Sports, Ministry of Education, Royal Government of Bhutan.

Under the proposed "Prevention and Control of Drug Abuse Act 2005", a high-powered inter-ministerial body, the Narcotics Control Board, will be established. A Narcotics Control Agency will also be established. The Board's powers will include proving and updating Bhutan's National Drug Control Strategy, and designating each agency responsible for administering and enforcing particular provisions of the Act. It will also have power to give guidance to these agencies to ensure proper implementation of the Drug Control Conventions in Bhutan and the National Drug Control Strategy. The Narcotics Control Agency will be the executive arm of the Board.

5(b) Licit control (drugs and precursors)

The Health Ministry authorises the issues of the import licenses by Ministry of Trade and Industry for controlling the import of precursor chemicals. The Health Ministry authorizes the issuance of import licenses and authorisations for licit drugs and to some extent precursors. Bhutan has no pharmaceutical industry. Most of the precursor chemicals are imported from India. At present, Bhutanese authorities tend to rely on Indian authorities to control imports of precursor chemicals from India, however this will change under the proposed new Bhutan legislation.

5(c) Supply reduction

Drug trafficking does not appear to be a major problem in Bhutan at present. The National Drug Strategy to be developed under the new legislation by the Narcotics Control Agency and approved by the Narcotics Control Board will address both drug supply reduction and demand reduction.

5(d) Demand reduction

In April 1999, the Ministry of Health and Education initiated an awareness campaign on substance abuse, including a workshop for teachers.

Prisons: the prisoners are provided with treatment at the Basic Health Unit (BHU) in Bhutan. A Medical Officer, Health Assistant, Assistant Nurse and two non-medical staff man the Unit. Health records of the individual prisoners are maintained and minor ailments of the prisoners are treated at BHU itself. The medical officer visits the BHU once a week for the routine checkups. The prisoners who need further investigation are referred to concerned

medical specialists as and when required. Emergency services are available 24-hours-a-day. Health Education programmes are provided on a regular basis.

5(e) Money laundering control measures

See the section above on money laundering.

5(f) International cooperation

Bhutan is an active participant in regional initiatives to address the drug issue. The Government is a signatory to the 1990 SAARC Convention on Narcotic Drugs and Psychotropic Substances. Bhutan plans to join INTERPOL before December 2005. Bilateral and multilateral Conventions are self-executing under Bhutan's law, but need domestic implementing legislation to be fully effective. Bhutan's Chief Justice has asked UNODC to help draft up-to-date, flexible international cooperation legislation, including 2005 amendments to the draft Evidence Act to enable foreign evidence to be received and used in proceedings before Bhutan's Courts.

6. POLICY – CRIME

Bhutan is not a signatory to the Transnational Organized Crime Convention of 2002 nor any of the three related Protocols on human trafficking, migrants and firearms. It is also not a signatory to the 2003 Corruption Convention.

7. TERRORISM

Insurgent groups maintained a presence in Bhutan after a crackdown by a neighbouring country in the 1990s. In December 2003, a military campaign by the Bhutanese army resulted in the expulsion of the groups from their camps (Jane's 2004a).

Bhutan is a party to six of the 12 universal instruments related to the prevention and suppression of international terrorism, including the 1999 International Convention for the Suppression of the Financing of Terrorism.

INDIA

1. EXECUTIVE SUMMARY

Drug Trafficking: India is wedged between the world's two largest areas of illicit opium production, the Golden Crescent and the Golden Triangle. This proximity has traditionally been viewed as a source of vulnerability, since it has made India both a destination and a transit route for opiates produced in these regions. This fact continues to be important in defining drug trafficking trends in the subcontinent. However, the extent to which heroin seized in the country can be sourced to the diversion of licit opium grown in the country is a matter which continues to be debated.

Drug abuse: In 2004, UNODC and the Ministry of Social Justice and Empowerment, jointly release the National Survey on the Extent, Pattern and Trends of Drug Abuse in India, the first of its kind. It showed that the number of chronic substance-dependent individuals were as follows: 10 million (alcohol), 2.3 million (cannabis) and 0.5 million (opiates). The survey not only points to the problem of India's population having twice the global (and Asian) average prevalence of illicit opiate consumption, but also shows that the treatment resources available are not commensurate with the 'burden of work' (number of dependent drug users) requiring immediate treatment.

Drug-driven HIV/AIDS: India is home to one of the largest HIV/AIDS epidemics in the world. In this context, there is rising concern about the large number of IDUs and the attendant risk of HIV. Sentinel surveillance data from 2003 indicates a rise from 7.4% to 14.4% in HIV prevalence amongst injecting drug users in New Delhi. In 2 of the 6 states now into a 'generalized' epidemic, there is a strong IDU-HIV link. There is also rising concern about the drug abuse/HIV nexus between IDUs, female sex workers, their partners, the non-substance using partners of IDUs and the so-called "general population". The link is strong and is seen as one cause of the 'feminization of the epidemic' in India.

Licit pharmaceutical diversion: In India, currently, injecting drug use is more closely linked to the abuse of licit opiate pharmaceuticals than to illicit drugs. India is a large manufacturer of pharmaceuticals. The law regulates their production and sale, but there is no uniformity in the monitoring of compliance with the law. This contributes to an increase in the abuse of pharmaceutical drugs. The smuggling of pharmaceuticals from India, especially codeine-based cough syrups, dextropropoxyphene and injectable buprenorphine, is a major concern for India's neighbours, particularly Bangladesh, Nepal and Sri Lanka. Other pharmaceuticals that are also commonly diverted for abuse within India as well as for smuggling include diazepam and nitrazepam.

Illicit cultivation: A small amount of illicit opium cultivation takes place in India – primarily in Himachal Pradesh, Kashmir, Uttaranchal and Arunachal Pradesh. Indian authorities discovered new areas under illicit opium poppy cultivation in Karnataka recently (about 40 km from Bangalore) and took prompt action to destroy the illicit crop. It is

extremely difficult to estimate the extent of illicit cultivation. Kashmir and Himachal Pradesh have emerged as sources of cannabis resin or Hashish seized in the country. Hashish is also being smuggled into India from Nepal across the land border in the states of Bihar and Uttar Pradesh, from where it finds its way to Delhi and Mumbai.

Licit cultivation: India is the only country currently producing licit opium gum for domestic medical and scientific purposes as well as for export under the terms of the 1961 Single Convention. However, an unknown portion of India's licit opium crop (1,061mt in 2004) is diverted into illicit channels and then converted into heroin, usually close to source.

Amphetamine-Type Stimulants (ATS): Amphetamines are also a growing concern for Indian authorities, both as trafficked substances and in terms of abuse. India has embarked upon successful control efforts in this regard. In May 2003 Indian authorities (with cooperation from the US and China) dismantled their first clandestine laboratory (in Kolkata) which had been established to manufacture ephedrine. Nationals of China and Myanmar had established the illegal laboratory. In June 2004, officers of the Indian Directorate of Revenue Intelligence identified and seized a clandestine laboratory involved in the illicit manufacture of MDMA, methaqualone powder and a tablet-making unit.

Money Laundering: The Prevention of Money Laundering Act entered into force in 2005. This act strengthens the already-robust provisions of the 1985 NDPS Act in terms of money laundering.

Precursors: India has a well-developed chemical industry, which produces substantial quantities of acetic anhydride, ephedrine, pseudo-ephedrine, potassium permanganate and many other precursor chemicals. In spite of precursor control legislation and procedures being in place, several cases of diversions of significant quantities of precursor chemicals have occurred in recent years. The growing threat of traffickers establishing ATS laboratories in the region, and availability of ephedrine and pseudo-ephedrine in India is of grave concern to Indian law enforcement authorities.

Crime: Crimes against women are a matter of serious concern in India. Women in the country suffer due to a lack of awareness of their rights, illiteracy and oppressive practices and customs. A sizable number of crimes against women go unreported due to the social stigma attached to them.

Human trafficking: The issue of trafficking in human beings – and especially in women and children – is increasingly of concern in India. India serves both as a source and destination country for trafficked persons. It is also a transit country. Many women and girls arriving in India are intended for forced labour and sexual exploitation. The Indian NGO establishment, which is involved in trafficking issues, is extremely energetic and active.

Corruption: According to Transparency International, the corruption perception index (CPI) for India is 2.8, placing it 83rd in the year 2003 in a ranking of 133 countries. In 2004 India scored 2.8 again and ranked 90th among 146 countries. Underground "Hawala" banking is the typically-used alternative remittance system in India. The system is known to also meet a number of crime-related objectives such as bribery and tax evasion.

2. MAJOR CHARACTERISTICS OF THE COUNTRY RELEVANT TO THE DRUG AND CRIME PROBLEM

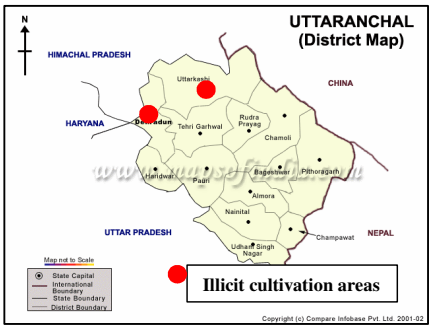
India contains 17% of the world's people, yet it accounts for only 2% of its GDP and 1% of its trade. Poverty remains pervasive – India is still home to 260-290 million poor. Per capita income growth has been slow and there is a great unevenness in the distribution of income. These conditions, together with the geographic location of India between the world's two largest producers of illicit opium, and the breakdown of traditional social capital resulting, in part, from large-scale rural-to-urban migration and its attendant modernization influences, have all contributed to the rise in drug abuse in recent years. Nonetheless, the fact that most (70%) Indians still live in the countryside adds to the importance of recent findings about the extent of substance abuse (including injecting drug use) in the rural areas. The process of industrialisation has itself contributed new and cheaper pharmaceutical drugs widely abused by the poor and unemployed. At the same time, recent rapid economic growth (in the region of 8%) has created pockets of affluence which propel a market for the sorts of "designer drugs" more commonly consumed in western countries. The fact that India is the world's largest producer of licit opium gum opium has, despite strict controls, meant that some portion of this product is liable to diversion by unscrupulous farmers adding to the availability of drugs on the market.

3. DRUG SITUATION

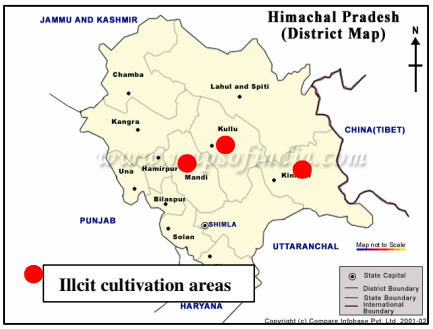
3(a) Production and cultivation

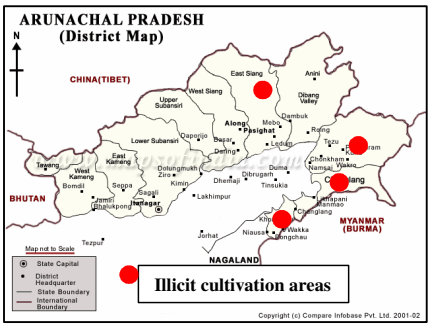
Illicit Cultivation

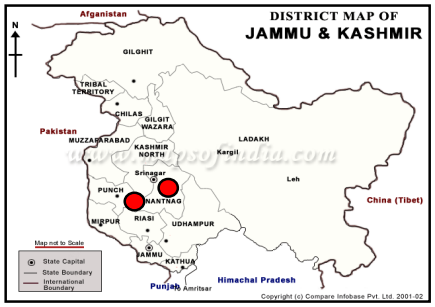
For centuries, opium has been cultivated in the north-eastern states of India for medical use by both people and livestock. It is also used in festivals and celebrations in these areas as well as Rajasthan. Most areas have now curtailed this practice, but it remains prevalent in remote areas, such as in the east of Arunachal Pradesh.



Illicit cultivation of opium poppy still occurs in India. It has been argued that illicit cultivation of opium poppy in the north east became commercial when the tribal population came into contact with timber merchants from the plains in the late 1980s. There is very little economic activity in these districts, and agricultural practices are essentially still subsistence-based. Opium is often the only marketable commodity produced, and it has the added advantage of being collected at the farm gate by traders or wholesalers – an option not normally available for other agricultural products.







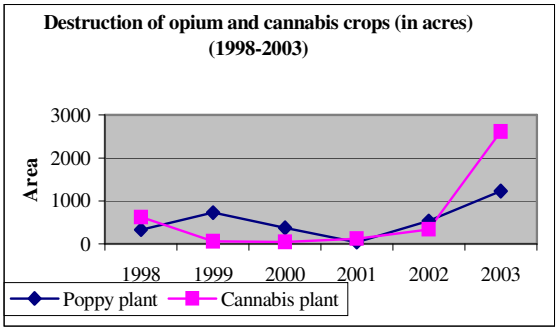
Though it is extremely difficult to estimate the extent of illicit cultivation, according to a UNODC-sponsored study in 2001 which received logistical support from the Central Bureau of Narcotics (CBN), some production of opium was reported in Arunachal Pradesh (in the Upper Siang, Lohit, Changlang districts and Khonsa circle of Tirap district), Uttaranchal (Uttarkashi and Dheradun districts) and in Himachal Pradesh (Kulu, Mandi and Kalpa districts). Certain quantities are reportedly also produced in Jammu & Kashmir, Bihar and West Bengal (NCB 2002). Reports in 2004 cited experimental cultivation in Karnataka.

The market dynamics of illicit opium cultivation have been studied in some depth in Arunachal Pradesh. In order to determine the extent of illicit cultivation of opium poppy, a survey was carried out with logistical support from the CBN in three districts of Arunachal Pradesh. The survey covered 86 villages out of 506 on the three districts Upper Siang, Tirap and Changlang. Out of 86 villages 52 were observed to be growing opium. The main findings of the survey are as follows: (a) the majority of the cultivators had only started opium growing in 1999; (b) the size of the plots varied between 50sq.m and 12ha.; and (c) the average yield is approximately 5-8kg/ha. On this basis, it was estimated that cultivation in Arunachal Pradesh could reach 1,000ha, and that about half of this amount was accounted for in Lohit district. CBN destroyed 248, 153 and 218 hectares of illicit poppy during 1999, 2000 and 2002 respectively in Upper Siang, Lohit, Tirap and Changlang districts of Arunachal Pradesh. It also destroyed 9 hectares of illicit opium in Kullu during 2001 in association with Himachal Pradesh police.

Destruction of narcotic drug yielding plants in India

		1998	1999	2000	2001	2002	2003
Poppy plant	Area (in acres)	333	729	379	45	539	1,234
Cannabis plant	Area (in acres)	627	66	50	1,23	n/a	2,620

Source: NCB 2004.



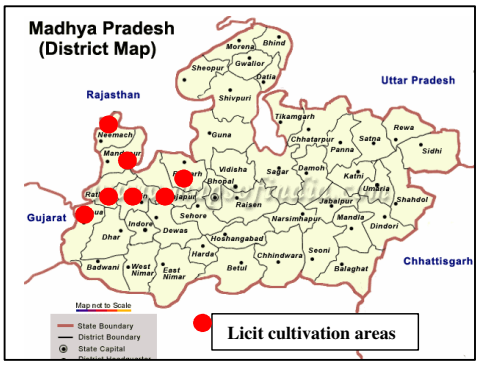
The extent of such cultivation is very limited in comparison with the quantity of licit opium cultivation in India. Nonetheless, in line with its obligations under the international drug control treaties, India has stepped up its efforts to destroy illicit opium (see graph and table on this page).

Cannabis is also illicitly cultivated in the states of Jammu & Kashmir, Himachal Pradesh, Uttar Pradesh, Andhra Pradesh, Tamil Nadu, Kerala and Manipur. Every year, 80 to 100 tonnes of ganja (cannabis herb), both indigenous and smuggled is seized by the

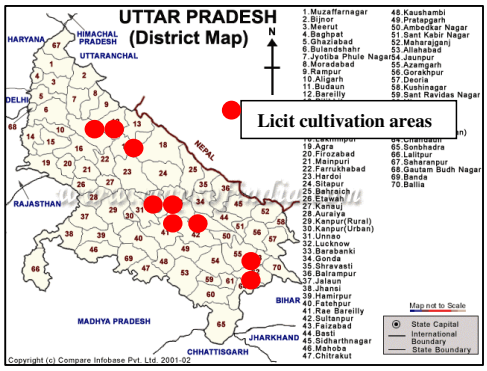
enforcement agencies (NCB 2002). Judged on the basis of seizures, most of the cannabis cultivation in India occurs in the north east (NCB 2004).

Licit Cultivation

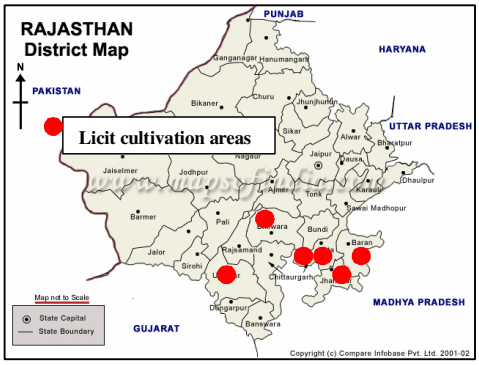
India is the only country currently producing licit opium gum for medical and scientific purposes for domestic needs and for export under the terms of the 1961 Single Convention.[5]



Opium poppy is cultivated in three states of India – Madhya Pradesh, Rajasthan and Uttar Pradesh – in the following 22 districts:
Madhya Pradesh: Mandsaur, Neemuch, Ratlam, Ujjain, Jhabua, Shajapur, and Rajgarh.
Rajasthan: Kota, Baran, Jhalawar, Chittorgarh, Udaipur and Bhilwara.
Uttar Pradesh: Barabanki, Faizabad, Ghazipur, Mau, Lucknow, Raibareilly, Bareilly, Shahjahanpur and Budaun.



The Central Bureau of Narcotics, based in Gwalior, implements a stringent licensing system in India. The crop is generally sown in November and harvested in March-April. Opium is used to extract alkaloids such as morphine, thebaine and codeine. After the extraction of the opium, the pods are crushed and the poppy seeds are extracted and can be used as condiments in Indian cooking.



The sale of poppy seeds forms a significant proportion of the income from the licit opium crop. The crushed pods left after extraction of the seeds are referred to as poppy straw. This poppy straw contains a small concentration of morphine residue. The state governments in India regulate the sale of poppy straw for medical and scientific purposes. Trafficking and abuse of poppy straw is a common problem in some north-western states of India.

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[5] The other countries which authorize licit opium gum production are the Democratic Republic of Korea (only for domestic purposes), and Japan (only in small quantities to maintain the technology). China produced licit opium for medical purposes until the end of 2001. While the country appears to have stopped such production it maintains estimates for opium production. There are 11 other countries that cultivate opium poppy for the extraction of alkaloids. These are: Australia, China, Czech Republic (where poppy-straw as an opiate raw material is only obtained as a by-product), France, Hungary, Slovakia, Spain, the former Yugoslav Republic of Macedonia, Turkey, the United Kingdom and Serbia and Montenegro (where poppy-straw as an opiate raw material is only obtained as a by-product). There are 6 more which cultivate only for horticultural or culinary purposes: Austria, Estonia, Germany, Netherlands, Poland, Ukraine, but they harvest the produce using means which do not involve the process of lancing and obtaining gum, thereby minimizing the risk of having opium diverted into illicit channels.

Raw opium is a viscous product with considerable moisture content. Opium tendered by the farmers at the time of procurement normally comprises of 55-60% solids; the remainder is moisture. For the sake of uniformity, all production figures of opium in India are calculated using a consistency ratio of 70 degrees i.e., comprising 70% solids and 30% moisture).[6] The extent of licit cultivation of opium poppy in recent years is given below.

Licit cultivation (licensed area in hectares)

Year of harvest	1997	1998	1999	2000	2001	2002	2003	2004
Opium poppy	29,799	30,714	33,459	35,270	26,683	22,847	20,410	21,141

Source: CBN 2004, and correspondence with CBN in September 2005.

Licit production (metric tons at 70 degrees consistency)

Year of harvest	1997	1998	1999	2000	2001	2002	2003	2004
Opium produced at 70 degrees consistency	1,271	335	1,382	1,705	995	1,055	684	1,061

Source: CBN 2003, and correspondence with CBN in September 2005.

Number of licensed cultivators for the 2003-2004 growing season

Name of unit	No. of cultivators licensed	No. of cultivators			
		Did not sow	Who actually cultivated	Uprooted	Tendered opium
Madhya Pradesh	48,207	783	47,424	871	46,553
Rajasthan	44,695	2,273	44,422	491	43,931
Uttar Pradesh	10,795	77	10,718	2,647	8,071
Total	105,697	3,133	102,564	4,009	98,555

Source: CBN 2004.

Licensed cultivation/harvested area (in units) for the 2003-2004 growing season

Name of unit	Area licensed in hectares	Area utilized (in hectares)				Quant-ity of opium at 70º consis tency	Average at 70º consist-ency
		Not sown+ unutilized	Measured	Uprooted	Harvested		
Madhya Pradesh	9,642	877	8,765	200	8,565	500	58.39
Rajasthan	9,339	768	8,571	110	8,461	506	59.83
Uttar Pradesh	2,160	22	2,138	573	1,565	55	42.27
Total	21,141	1,667	19,474	883	18,591	1,061	57.07

Source: CBN 2004.

The opium is thereafter dried and, for export, the consistency is increased to 90 degrees, i.e., 90% solids and 10% moisture. Most of the opium produced in India is destined for export. The quantities of opium exported in the recent past are contained in the table below.

[6] Since all opium is first tested at the collection centres, in the case of farmers who produce low-consistency opium (e.g., 50 degrees consistency), a smaller amount would be recorded as their total. As an example, if a farmer produces 14 kg of opium of 50 degrees consistency, it will be reckoned as 10 kg (14 x 50 / 70).

Recent Opium Exports (in metric tons at 90 degrees consistency)

Year	1997-98	1998-99	1999-2000	2000-01	2001-02	2002-03
Opium exported	735	528	650	574	495	495

Source: CBN 2003.

The 2005 crop: According to provisional data from the Central Bureau of Narcotics, the total quantity of opium harvested in 2005 (March – April) declined by more than half to 439 metric tons. This was the result of a conscious decision by the union government to reduce the number of hectares under cultivation. The number of hectares harvested in 2005 was 7,833, down from 21,141 in 2004. The number of cultivators who actually tendered opium was 79,016, down from the 2004 total of 98,555. The average yield declined minimally from 57.07 to 56.04 kgs per hectare at 70 degrees consistency.[7]

Diversion: Although an elaborate system of regulatory and preventive controls has been established to prevent the diversion of opium, certain quantities do flow into illicit channels. This is evidenced by seizures in and near the poppy-cultivating areas[8], although the extent of diversion is almost impossible to determine. One obvious incentive for unscrupulous farmers is the higher price offered by the illicit market (ranging from Rs.5,000 per kg during the crop season in April, to between Rs.15,000 - 20,000 in December/January). This can be compared with the government's official procurement prices, which generally vary from Rs.720 – Rs.2,100 per kg depending on the quantity of opium tendered per hectare.

Market studies also lend indirect support to the notion that the illicit manufacturing of some quantum of heroin within India results from diverted product. For example, a UNODC study of the illicit drug markets of Delhi (UNODC ROSA 2001) estimated, on the basis of respondents, that a significant portion of the heroin available on the city's streets originated from opium poppy cultivated in India. To reduce the risk of diversion, attempts have been made to ensure that the product is not left with the cultivators for a significant amount of time following the conclusion of the lancing and extraction of the opium. In an effort to further reduce the risk, the CBN has also initiated a project to estimate the licit opium poppy cultivation area through satellite imagery.

3(b) Manufacture

Opium / heroin: The number of heroin manufacturing facilities ('labs') detected during the past few years are as follows:

Year	1999	2000	2001	2002	2003
'Labs'	3	5	6	7	3

(Source: National Drug Enforcement Statistics as on 30 Nov 2004 complied by the Narcotics Control Bureau, India)

Methaqualone: Methaqualone is a depressant used in combination with diphenhydramine (or, alternatively, diazepam) in the manufacture of Mandrax®. Methaqualone is not typically abused in India. It is illicitly produced in India and exported for consumption (both oral and smoked in combination with cannabis as 'white pipe') in South Africa, a country with which India has strong, historical, cultural and trading links. The NCB notes that the illicit

[7] Source: correspondence between CBN and UNODC in September 2005.

[8] For example the Annual Report of the Narcotics Control Bureau indicates that during the year 2003 39% of national seizures of opium occurred in the three states licitly cultivating opium (NCB 2004).

manufacturing of this drug, which was limited mainly to Maharashtra and Gujarat, could take place in pharmaceutical establishments in other parts of the country. Illicit manufacturing facilities have, in recent years, been discovered in Hyderabad, South Gujarat, Rajasthan and Eastern Uttar Pradesh. In some cases it was observed that these illicit operations had been financed and controlled by non-residents based outside India. The principal destination for the end product remains South Africa.

Substitute chemicals: One recent trend detected during certain investigations has been the use of acetyl chloride as a substitute chemical for Acetic Anhydride, which is controlled under the NDPS Act. The use of such chemicals will render the location and identification of illicit manufacturers increasingly difficult.

Amphetamine type stimulants: Although India produces many precursors used for illicit manufacture of amphetamines, until recently, illicit ATS factories had not been discovered. The precursors for ATS, especially ephedrine and pseudo-ephedrine, tended to be smuggled out to Myanmar for ATS manufacture there. A change in trend was however observed as a result of the successful dismantlement on 17 May 2003 of an illicit ATS laboratory in Kolkata and the seizure of 24 kg of ephedrine. The facility, involving Myanmarese, Chinese and Indian nationals, had yet to start production. The raid was the result of a successful joint global operation by the Indian Narcotics Control Bureau, and authorities from China and the United States. On 5 June 2004, officers of the Directorate of Revenue Intelligence dismantled another factory in South India, which was manufacturing ecstasy (MDMA – Methylene DioxyMethyl Amphetamine) as well as methaqualone. Methamphetamine was also seized in the operation. Considering the relative ease of availability of ATS precursors in India and the growing demand for ATS in the world, especially SE Asia, the pattern is of concern.

Other Licit Drugs

India is a large manufacturer of pharmaceuticals. Its approximately 25,000 manufacturers account for about 10% of the total quantity of pharmaceuticals produced in the world. While the law requires all drugs with abuse potential to be sold only on prescription, there are reports of significant diversion (INCB 2003). Proxyvon® (a preparation of dextropropoxyphene), buprenorphine, Phensidyl® (a codeine based cough syrup), diazepam, nitrazepam and lorazepam are the most commonly abused pharmaceuticals (NCB 2002). In India, currently, injecting drug use is more closely linked to the abuse of licit opiate pharmaceuticals than to illicit drugs. A related problem is the issue entrance of spurious drugs into the marketplace.

3(c) Trafficking

India is wedged between the world's two largest areas of illicit opium production, the Golden Crescent and the Golden Triangle. This proximity has traditionally been viewed as a source of vulnerability, since it has made India both a destination and a transit route for opiates produced in these regions. However, the question of precisely how much of the heroin consumed in India is attributable to opium diverted from licit production continues to be debated. In addition, Nepal is also a traditional source of cannabis, both herbal (marijuana) and resinous (hashish). As is typical of all countries, an assessment of the work of law enforcement in seizing quantities of drugs and making related arrests provides the basis upon which an analysis of drug trafficking patterns can be made. The table below depicts a series for the past seven and a half years.

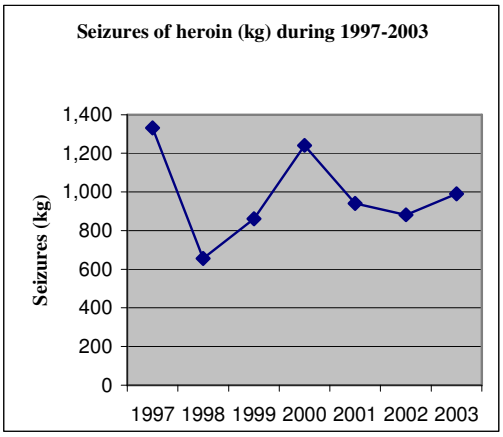
Drug Seizures in India (in kg)

Drugs		1997	1998	1999	2000	2001	2002	2003	2004 (up to October)
Heroin	Seizures	1,332	655	861	1,241	940	881	991	856
	cases	2,990	3,095	2,937	2,845	3,893	4,432	5,578	2087
Cocaine	Seizures	24	1	1	0.35	2	2	3	1
	cases	6	6	4	5	10	5	11	4
Opium	Seizures	3,316	2,031	1,635	2,677	2,533	1,835	1,720	1616
	cases	1,333	954	927	1,255	1,205	1164	905	451
Morphine	Seizures	128	19	36	39	26	66	109	48
	cases	75	56	125	142	146	148	266	137
Cannabis	Seizures	80,866	68,221	40,113	96,218	86,933	88,491	79,483	105,097
	cases	7,062	6,018	6,518	6,071	7,615	4,172	9,389	2004
Cannabis resin/ hashish	Seizures	3,281	10,106	3,391	5,041	5,664	3,010	3,013	4,012
	cases	2,223	2,193	2,500	2,078	2,117	2,038	1,739	883
Methaqualone	Seizures	1,740	2,257	474	1,095	2,024	7,458	345	1614
	cases	207	114	8	31	8	7	6	3
Acetic anhydride (litres)	Seizures	8,311	6,197	2,963	1,337	8,589	3,288	857	2663
	cases	12	9	7	14	8	4	6	7
Ephedrine	Seizures	8,311	1,051	2,134	426	930	126	3,234	1,000
	cases	12	14	51	8	5	4	8	2

Source: National Drug Enforcement Statistics, NCB as well as NCB Annual Reports.

Heroin:

The trafficking of heroin on a commercial scale dates back to the 1970s when the traditional Balkan routes were disturbed by geopolitical developments. Drug traffickers started using India as a transit country for heroin originating in South West Asia. They were assisted in this regard by pre-existing networks of smugglers operating on the Indo-Pakistan border engaged in gold and other commodity smuggling. The opening up of the CIS route for SW Asian heroin rendered India less attractive as a transit route and the annual seizures of heroin during the past few years have declined to hover around one metric tonne.



In relation to global trends, this average annual Indian seizure of one metric tonne is relatively modest when compared with the approximately 50 metric tons seized annually across the world (UNODC 2004). India has nonetheless witnessed a marginal increase in heroin seizures during the year 2003. Seizures increased from 881 kg during 2002 to 991 kg during 2003 (NCB 2004).

Main routes: The data indicates that the areas most vulnerable to drug trafficking are the north western states bordering Pakistan as well as Maharashtra (whose capital is Mumbai), Delhi and the Tamil Nadu coast which constitute the exit routes. A new trend has been detected during the past 18 months that includes the movement of heroin from the northern population belt eastwards and out of South Asia via Bangladesh. It has been suggested that

this movement can be explained by the strengthening of controls imposed upon the export of heroin via the Tamil Nadu route.

It is recognized that unscrupulous farmers divert part of the licitly produced opium and this is converted into heroin. Heroin trafficked in India originates from three main sources: (a) South West Asia, (b) South East Asia and (c) indigenously produced heroin from diverted opium. South West Asia, which has traditionally been the primary source, accounting for 37% of the total heroin seizures during 1998. The share of SW Asian heroin in total Indian seizures has been gradually declining and accounted for a mere 4% of the total heroin seized during 2003 (NCB 2003). South East Asian heroin always accounted for only around 1% of the total seizures (NCB Annual Reports, various years).

The absence of a heroin signature programme in India causes difficulty in ascertaining with absolute certainty the provenance of much of the heroin seized. In cases where specific packaging, marks and numbers are still present it is possible to identify provenance. However, once the product passes through several hands, these identifying marks may be lost because of possible substitution and adulteration of the original seized drug.

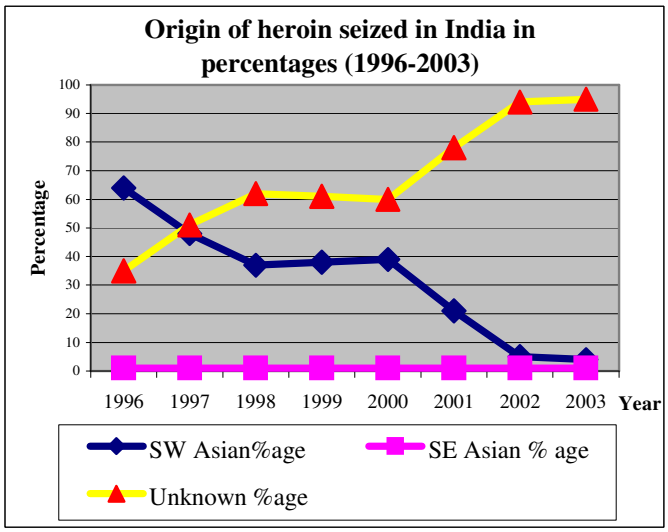
Year	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
Total heroin seized (kg)	1,257	1,332	655	861	1,241	940	881	991
SW Asian %age	64	48	37	38	39	20	5	4
SE Asian % age	1	1	1	1	1	1	1	1
Unknown %age	35	51	62	61	60	79	94	95
Total quantity (kg)	1,257	1,332	655	861	1,241	940	881	991
SW Asian qty. (kg)	802	640	240	326	483	185	45	39

Source: NCB Annual Reports, various.

South West Asia: South West Asia has traditionally been considered the main source of heroin in India but its quantum has fluctuated significantly in response to the level of tension associated with activities on the Indo-Pakistan border. For example, during 1998, 1999 and 2000 over 35% of the heroin seized in India was deemed to have originated in South West Asia (NCB 2002). This figure declined to 20% in 2001 and to 4% during 2003 (NCB 2003). Security concerns between India and Pakistan and consequent military build-up appear to have been the cause of the reduced trafficking. The net effect was a significant fall during these years both in the total quantity of seizures and the proportion of South West Asian heroin involved in total seizures. Most of the seizures of South West Asian heroin have taken place in states close to the border – namely Rajasthan, Punjab and Jammu & Kashmir.

South East Asia: Total heroin seizures in the north-eastern states totalled only 8 kg in 2002 (or 1%) compared with 12kg in 2001. Trafficking volumes of heroin entering India mainly from the Myanmar border are significantly lower than the volumes of product that enter the country from Pakistan. Moreover, while heroin from Afghanistan and Pakistan is reported to mainly transit India to overseas destinations, there are no reports that the heroin trafficked into north east India is either to other parts of the country or smuggled abroad. Such product tends to be consumed mainly in the north-eastern states themselves. The purity of heroin trafficked in from Myanmar tends to be high (heroin number 4). The NCB reports that the problems of interdiction in the north-east relate to "the existence of traditional cross-border ethnic links, lack of restrictions on movement, inhospitable terrain and the problem of insurgency". (NCB 2002)

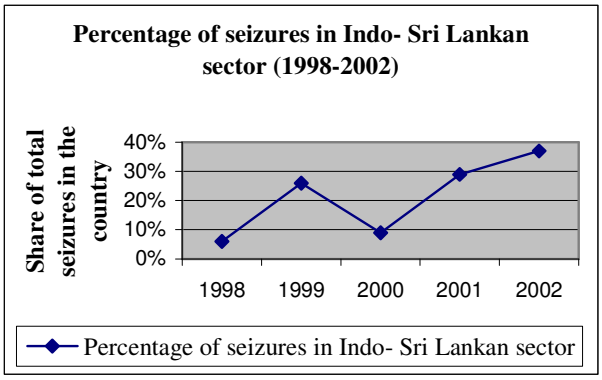
Locally manufactured heroin:



Notwithstanding the caveat above regarding the absence of a signature programme and in spite of the strict controls exercised by the CBN, an unknown quantity of opium is believed to be diverted into illicit channels. According to NCB figures, approximately 4% of the heroin seized during 2003 was sourced in South West Asia and 1% in South East Asia. The origin of the remaining heroin seized could not be determined with complete accuracy.

Nonetheless, according to the NCB, while "a major percentage of [...] diverted opium is intended for local consumption of [opium] addicts in the country [...] some of it also appears to get processed into heroin in makeshift clandestine laboratories" (NCB 2002). An analysis of the seizures on a state-by-state basis shows that the three opium-cultivating states – Rajasthan, Madhya Pradesh and Uttar Pradesh – accounted for nearly 50% of total seizures. Most of the heroin laboratories dismantled in India are also located near to the opium cultivating areas.

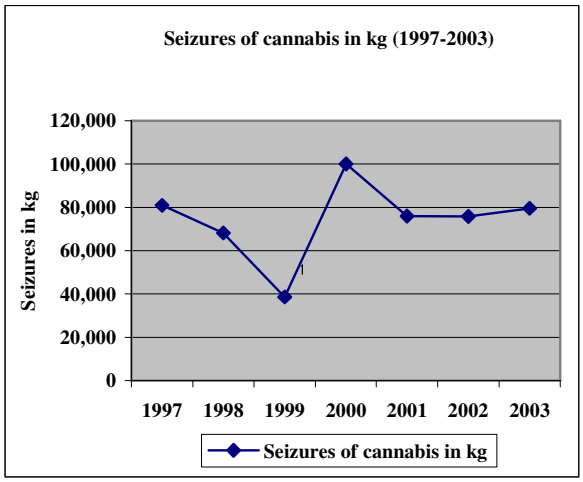
Indo-Sri Lankan sector: Seizure statistics as well as information from other sources have demonstrated the rapid increase in the use of the Tamil Nadu coastline around Tuticorin as a staging point for heroin shipments to Sri Lanka. The Tamil Nadu route has become the most significant drug trafficking route out of India in recent years. According to the NCB, "geographical proximity and ethnic links contribute to smuggling between coastal southern India, especially the southern Coromandel coast and the north western coast of Sri Lanka by sea, mainly by small craft" (NCB 2002). Of the total seizures of heroin, only 6% was seized in the Indo-Sri Lankan sector during 1998. This figure increased to 29% during 2001, and 37% during 2002.



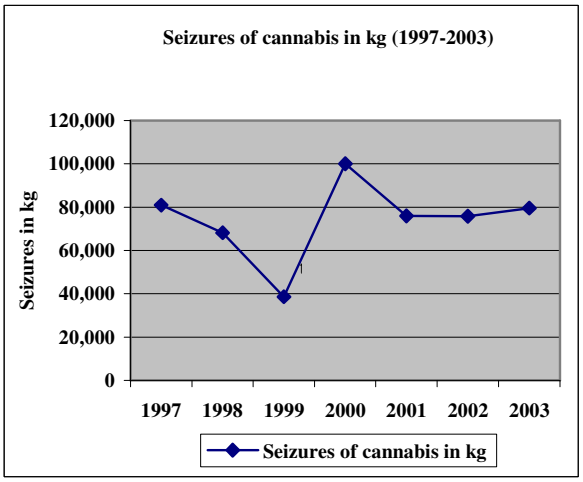
Heroin has traditionally been smuggled out to destinations in the west primarily through Mumbai and Delhi. The two new routes developed over the past few years, viz., the Indo-Sri Lankan sector and Indo-Bangladesh sector especially the former continues to grow in significance. In September 2005, New Delhi witnessed its largest seizure (18kg) of a combination of heroin and cocaine smuggled in by West African nationals from Kabul en via New Delhi en route to Addis Ababa.

Cannabis:

On average, Indian law enforcement agencies seize between 80-100 mt of cannabis each year. In 2003, the figure was 79 metric tons of hashish (*charas*) and herbal cannabis (ganja) compared with 88 metric tons in 2002 and 87 metric tons in 2001. In India, herbal cannabis constitutes the majority of seizures of illicit drugs in volume terms. In 2003, the north-east as a whole accounted for 34% of all cannabis seized throughout the country (NCB 2004).



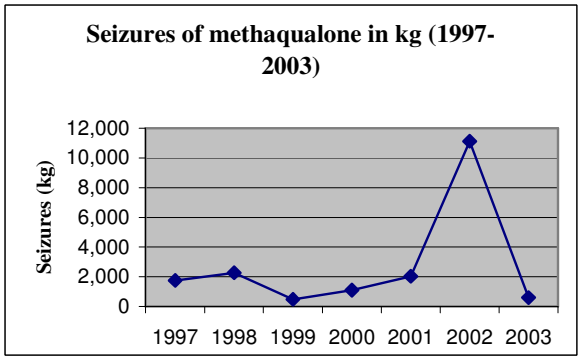
Cannabis is widely cultivated along the states of Manipur and Meghalaya. It is reported that the militant organizations in the region have developed a form of patronage with the narcotic smuggling groups in exchange for money.



Hashish is produced indigenously and both herbal cannabis and hashish are also smuggled in from Nepal by trucks and passenger vehicles. Nepalese hashish is reported to constitute approximately 40% of the total seizures (NCB 2002). Movement across the Indo-Nepalese border tends to be relatively free without any passport or visa restrictions. Among the Indian states, while Gujarat and Maharashtra remain the key transit states, Kashmir has emerged as a significant source of hashish. In the very recent past, some seizures of cannabis have been sourced to Bhutan.

Methaqualone: Seizures of methaqualone declined considerably during 2003 to 593 kg. During the previous two years, 2002 (11,130 kg) and 2001 (1,984 kg) seizures of methaqualone had increased sharply over the quantity seized in 2000 (1,095 kg). Although seizures were made in all parts of the country, most were concentrated in Mumbai.

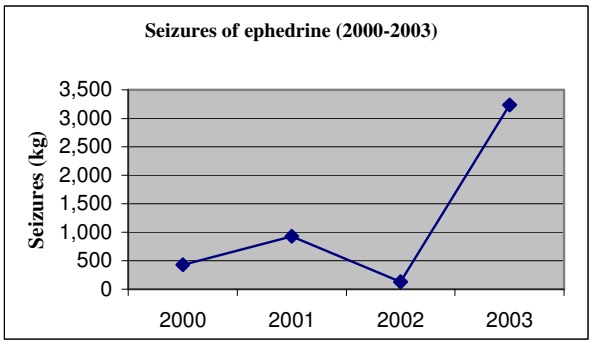
The pattern of seizures during the last three years, as well as information on organized criminal groups involved in its production, suggests that there is a need to review earlier assessments that the illicit production of methaqualone in India has been eliminated. There are clear indications of a revival of illicit production particularly in the vicinity of Mumbai. An important factor in the



clandestine manufacture of methaqualone in the Mumbai area is the closure of a number of small-scale pharmaceutical units. Some former employees of these units who possess the necessary expertise have reportedly been lending their technical skills to illicit methaqualone manufacturers. In some cases it was found that these illicit operations were financed and controlled by non-residents based outside India, particularly the United Arab Emirates. Illicit facilities have been detected and shut down in Uttar Pradesh, Rajasthan, Gujarat and Andhra Pradesh.

The principal destination for the end product remains South Africa. Another feature, which has been reported through some investigations, is the use of acetyl chloride as a substitute chemical for acetic anhydride which is controlled under the NDPS Act. The use of such chemicals will render the location and identification of illicit manufacturers increasingly difficult. Authorities in India are cooperating with the International Narcotics Control Board in this regard.

Amphetamine Type Stimulants (ATS):



The volume of trafficking of ATS and the quantum of abuse has increased in India in recent years. Since 2000, small consignments have been entering India principally from across the Indo-Myanmar border. For example, during the year 2000, 0.09 kg and 2,839 tablets of amphetamines were seized. The quantity increased to 9,336 tablets in 2001 and 9,926 tablets during 2002. While ATS are smuggled from Myanmar into north-eastern states of India, ephedrine and pseudo-ephedrine – the precursors for their manufacture – are smuggled from India to Myanmar. It has not been established whether this process is part of a barter arrangement.

In December 1999, India imposed controls on ephedrine and pseudo-ephedrine under the NDPS Act. It is interesting to note that seizures of ephedrine in India after a significant fall in 2000 to 426 kg rose again to 930 kg in 2001, fell to 126 kg in 2002, and again increased to 3,234 kg in 2003. The overall trend appears to be one of increased trafficking and consumption.

During 2003, authorities of Narcotics Control Bureau – in coordination with Chinese and US authorities – foiled an attempt to establish an ATS manufacturing facility in Kolkata. During 2004, officers of DGRI dismantled an ecstasy manufacturing facility and another facility for tabletting the drug in South India. Thus, attempts to manufacture ATS within India appear to have surfaced. This is a matter of concern because India is a major producer of the ATS precursors ephedrine and pseudo-ephedrine.

Cocaine: Seizures of cocaine have remained steady – but not statistically significant – at about 2kg during 2001, 2002 and 2003 (National Drug Enforcement Statistics compiled by NCB). Cocaine appears to be smuggled in primarily to meet the demand of the more affluent drug users in India's metropolitan areas. There are increasing press reports of cocaine as a drug of choice among this group. Cocaine users are the third most common users of treatment services in Maharashtra (UNODC ROSA and MSJE 2002).

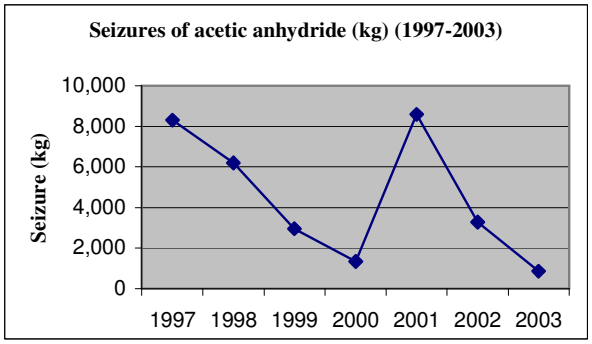
Pharmaceutical preparations: The illicit trafficking of pharmaceuticals both within and outside the country takes place on a large scale, mainly to Bangladesh, Myanmar, Nepal, Pakistan (via Dubai) and CIS countries (NCB 2002). Authorities in Bangladesh report concern over the volume of pharmaceutical preparations like cough syrups and painkillers, which are smuggled into that country from India. For example, during 2002, law enforcement authorities on the Indian side of the border seized 300,000 bottles of Phensidyl® (NCB 2002). A similar problem is being observed, though not on the same scale, regarding the smuggling of painkillers and cough syrups into Nepal.

Drug trafficking in the north-east of India: Most of the problem substance abuse in the north-eastern states of India relates to alcohol, cannabis (commonly referred to as 'ganja'), heroin Number 4 and Spasmoproxyvon®.[9] The latter two are of particular concern, as they both tend to involve the practice of injecting. Heroin Number 4 enters the country across the border from Myanmar. While there are joint cross-border meetings with Myanmar aimed at improving cross-border cooperation, these are not held regularly in all states. The heroin commonly referred to as 'brown sugar' enters the north-east states from their respective borders with other Indian states. There have been no large seizures of heroin in the north-east of India. Some opium is seized (usually it is wet opium imported from Myanmar). Most of the bulk seizures are accounted for by cannabis. Some states in the northeast impose tight controls on the availability of SP. Ephedrine, a precursor for the manufacture of ATS also moves move into Myanmar from India.

3(d) Diversion of drugs and precursors

The diversion of precursor chemicals from licit channels takes place in spite of strict controls exercised by law enforcement agencies.

Acetic anhydride (AA): Acetic Anhydride is a precursor to the production of heroin and methaqualone. India produces approximately 45,000 mt of acetic anhydride each year for use in its pharmaceutical and dye industries. Strict controls have been imposed on this chemical under the NDPS Act, Export Import Policy as well as the Customs Act.

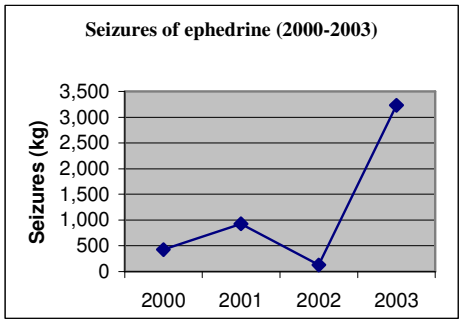


There are 11 manufacturers of acetic anhydride in India with an annual output of 30,000 to 40,000 tons for various industrial and pharmaceutical uses. Acetic anhydride is subject to a special customs regime, according to which its storage and transportation within 100 km of the Indo-Myanmar border and 50 km of the Indo-Pakistan border are subject to special controls. Traffickers have tried alternative methods such as exporting acetic anhydride in misdeclared sea cargo consignments using Dubai as a transshipment point. Acetic anhydride has continued to be seized by local law enforcement authorities. The acetic anhydride seized had been intended for use mainly in the illicit manufacture of low-grade heroin in India (INCB 2004).

[9] Spasmoproxyvon is an analgesic containing dextropropoxyphene, a narcotic drug regulated under the 1961 UN Convention - more generally referred to as 'SP'.

Seizures of acetic anhydride during the past few years are depicted in the graph on this page. There has been a decline in seizures between 1997 and 2000. However, in 2001 the seizures jumped up to 8,589 kg to come down again to 3,288 kg in 2002 and down further to 857 kg during 2003.

There has been a decline in the smuggling of acetic anhydride across the Indo-Pakistan border, the traditional favourite route. Neither India nor Pakistan has reported seizures of acetic anhydride along the border in recent times. Most of the diverted acetic anhydride appears destined to manufacture either methaqualone or heroin within the country. There have been attempts, some successful, to export acetic anhydride clandestinely from India in maritime cargo consignments (NCB 2000). However, the most common method of diversion is pilferage by drivers of tankers carrying acetic anhydride. This acetic anhydride is further accumulated by illicit traders and supplied to illicit drug manufacturers.



Ephedrine: Ephedrine is a precursor to the production of amphetamine-type stimulants (ATS). India produces over 500 mt of ephedrine and pseudo-ephedrine annually. The seizures of ephedrine during the past few years are as follows:

Year	2000	2001	2002	2003
Seizures (kg)	426	930	126	3,234

Source: National Drug Enforcement Statistics compiled by NCB India.

These figures indicate a gradual increase in the seizures of ephedrine in the long-term. Both substances have been declared controlled substances under the NDPS Act in December 1999. Consequently, all manufacturers, traders and consumers of these chemicals are required to maintain records and comply with other restrictions under the NDPS Act. Despite these controls, diversion and trafficking appears to be on the increase.

Anthranilic acid: Anthranilic acid is the precursor used for illicit manufacture of methaqualone. It has been brought under control under the NDPS Act. In almost all illicit methaqualone facilities within the country, anthranilic acid is used.

3(e) Drug prices

As per reports available, the approximate prices of various narcotics drugs in the illicit Indian market are given below. All prices are as per NCB Annual Report 2002.

Pharmaceutical preparations

Pharmaceutical preparations containing narcotic drugs and psychotropic substances are often diverted for abuse; these tend to fetch a price of 400% to 500% in excess of their licit market price. A strip (8 capsules) of Spasmoproxyvon costs Rs.50 (US$1.04) while its licit price is Rs.11 (US$0.22) (average daily dose = 20 capsules). Benzodiazapines such as Nitrazepam and Diazepam are also diverted for abuse. A strip of these costs Rs.70-80 (US$1.45-1.66) while their licit price is Rs.12 (US$0.25)

Heroin

The illicit market price of heroin in India varies with the region, the level of purity and the stage in the marketing chain. On average, wholesale heroin prices in India are reported to be in the region of Rs. 200,000 per kg (US$4,500). Street prices in north east India are as follows: half a gram of heroin number 4 costs Rs.600-800 (US$12.50-16.66); half a gram of brown sugar costs Rs. 250-350 (US$5.20-7.29). By comparison with prices in other countries, the wholesale price of heroin can start from US$25,000 per kg.

Hashish

The wholesale price of hashish in India is approximately Rs.13,500 (US$300 per kg) on average, although the price varies significantly throughout the country. The price at street level can reach Rs.35,000 (US$729). In the US, the price can fetch US$2,500 per kg.

Herbal cannabis (ganja)

Wholesale price of herbal cannabis can be as low as Rs.400 ($9) per kg near to source areas. Nearer the main consumption centres it can fetch prices between Rs. 2,000-3,000 ($44-66). In some cities, street prices up to Rs. 4,000- 6,000 (US$83-125) per kg. Internationally, wholesale prices for herbal cannabis tend to range around $2,300 per kg.

Precursors

The licit price of acetic anhydride in India is about Rs.50 (US$1) per litre. The illicit price varies depending on the stage in the chain of illicit supply. Illicit drug manufacturers may pay up to Rs.1,000 (US$20) per litre.

3(f) Demand

Although many studies examining the issue of substance use in India have been published in the scientific literature, few published studies have addressed the issue of the epidemiology of substance use disorders in the country. While some treatment-setting-based studies have been published, there is a relative dearth of studies from the community setting. The latest information on drug demand in India comes from the national survey of drug abuse in India released under the title of "The Extent, Pattern and Trends of drug abuse in India" (UNODC ROSA and MSJE 2004).

Summary findings of the National Survey released in 2004

This survey, jointly released in June 2004 by the Ministry of Social Justice and Empowerment and UNODC, contains a multi-modality approach whose main advantage is to ensure crosschecking, triangulation and multiple indicators in order to provide the most accurate picture of drug abuse trends. The National Survey has four major components.

- National Household Survey of Drug and Alcohol Abuse (NHS)
- Drug Abuse Monitoring System (DAMS)
- Rapid Assessment Survey of Drug Abuse (RAS), and
- Focused Thematic Studies:
    - Drug Abuse among Women
    - Burden on Women due to Drug Abuse by Family Members
    - Drug Abuse among Rural Population
    - Availability and Consumption of Drugs in Border Areas

- Drug Abuse among Prison Population

The **NHS** was carried out between March 2000 and November 2001 on a randomly selected nationally representative sample (males only, 12 to 60 years) across the country. Altogether, 40,697 males were interviewed and data on various socio-demographic and drug use parameters was collected. Alcohol, cannabis and opiates were found to be the three most common drugs of use. The prevalence of current use (i.e., use within the preceding month) was as follows:

- Alcohol - 21.4%
- Cannabis - 3.0%
- Opiates - 0.7%
- Any illicit drug - 3.6%
- IDU - 0.1%

Based on the above data, it can be projected that currently in India, there are approximately:

- 62.5 million alcohol users
- 8.7 million cannabis users
- 2 million opiate users

It was observed that that among current alcohol users, 17% were dependent users. Correspondingly, 26% of current cannabis users and 22% of current opiate users were dependent users. These figures translate to 10 million alcohol-dependent individuals, 2.3 million cannabis-dependent and 0.5 million opiate-dependent individuals. This can be considered as the 'volume of work' for India in terms of providing treatment services.

In the **DAMS** component (UNODC ROSA and MSJE 2002), data was obtained from patients seeking help in various drug abuse treatment centres. A total of 203 centres participated. The four most commonly abused substances were alcohol, cannabis, heroin, and opium. Alcohol was reported by 43.9% of treatment seekers. This was followed by opiates as a group (26.0%) and cannabis (11.6%). About 14% of individuals reported injecting drug use (IDU).

In the **RAS** component (UNODC ROSA and MSJE 2002a), information was collected from drug users on the streets of 14 cities in the country.[10] Some Key Informants (KIs) were also interviewed. Out of 4,648 drug users interviewed, 371 (8%) were women. Opiates (heroin, buprenorphine and propoxyphene) and cannabis were the major drugs abused. The highest proportion (35.6%) of subjects was currently (i.e., within the last one month) using heroin followed by other opiates (propoxyphene, opium, buprenorphine, and pentazocine) at 28.6%. About 22% were using cannabis, about 5% were alcohol users and 3.7% had used sedatives and hypnotics. Nearly half had injected drugs at some time in their life (43%).

Through **Focussed Thematic Studies**, it was found that drug abuse does exist among women in India and women also bear significant burden due to drug abuse by their family members. Drug abuse was also reported in rural areas, border areas and prisons.

[10] In the five cities - Chennai, Delhi, Imphal, Kolkata and Mumbai- another RSA was also conducted prior to the national survey and has been reported in Dorabjee and Samson (2000).

The nature of drug use in India

- *Rural versus urban background*: In this NHS, 51.6% of the subjects came from a rural background and the remaining 48.4% were from urban India. They resembled each other on most of the parameters. The monthly income was slightly higher among the subjects from an urban background. People from an urban background more often reported heroin abuse, injecting drug use (IDU) and needle sharing. In contrast, users of other opiates and cannabis were generally from a rural background. A marginally higher percentage of urban users had been introduced to drug use earlier, i.e. before the age of 20 years (42% versus 34%).

- '*Ever use' versus 'current use*:' It was observed that many 'ever users' were 'current users'. The proportion of 'current users' as part of 'ever users' was around 80% for alcohol, 70% for cannabis and 65% for opiates. Thus, drug use, once initiated, appears to continue in a majority of cases.

- *Youth (DAMS):* Among treatment seekers (the DAMS component), there were several young subjects. Overall, about 5% of total treatment seekers in various states were below 20 years of age. It was noted that young people reporting for treatment were more often users of propoxyphene, heroin and cannabis.

- *Youth (RAS):* A total of 368 out of 2,831 subjects were below the age of 20 years. In addition it was seen that the mean age of initiation to drug use was around 19 years. The data from Chennai described drug abuse by street children, who used a variety of substance including inhalants, cannabis, alcohol and heroin. Some of these children were involved in drug dealing.

- *Reasons for drug use*: Common reasons given for drug use were curiosity, experimentation, being in the company of drug users and to experience the effects. By and large, the reasons were similar regardless of the substance being used.

- *Treatment-seeking (DAMS)*: Very few current users of these drugs contemplated treatment for drug use. Only a small minority did actually seek help. Among alcohol users, only 2% actually sought help. Four percent of cannabis users and about 18% of opiate users reported that they had visited treatment centres to quit drug taking, although there were significant regional variations within the country. However, a large number of IDUs (73%) had reported for treatment.

- *Treatment-seeking (RAS)*: Overall, about one-third had attempted to reduce drug consumption in the preceding six months. However, only a minority (27%) had ever reported to any organisation for help and an even smaller percentage (12%) was currently receiving treatment. Some were not even aware of the availability of treatment facilities. Some others reported that they faced difficulty in obtaining help for treatment from the established treatment centres. Amongst those who reported for treatment, the level of satisfaction was not high. The available responses suggested that certain factors – lack of infrastructure, cost of treatment, lack of facilities and indifferent attitude of staff – which discouraged them from undergoing treatment.

- *Implications*: The data shows that a large number of current users require help to prevent them from progressing towards regular or dependent use, and as a result, interventions

should be planned for these subjects. However, the dependent users (addicts), varying between 17% and 26% of current users would need treatment most urgently. This number (0.5-10.6 million, of alcohol, cannabis, opiate and sedative/hypnotic users) might constitute the estimated caseload burden for India at present.

Injecting Drug Use (IDU)

The most significant recent shift in drug use patterns in India is the move from smoking or chasing to IDU. Heroin, buprenorphine (Tidigesic® / Tamgesic®) and dextropropoxyphene (Spasmoproxyvon®) are the drugs that are commonly injected in India. HIV prevalence among drug users in India demonstrates considerable heterogeneity. There are high levels in some areas particularly in certain parts of North East India (e.g., the state of Manipur with a reported HIV prevalence of up to 60% in some districts). High prevalence also occurs in many cities with a concentrated IDU population (e.g. Chennai and New Delhi). Low prevalence is observed in other urban areas such as Mumbai and Calcutta.

Information on IDU is available from several components of the survey. These include the National Household Survey (NHS), the Drug Abuse Monitoring System (DAMS), the Rapid Assessment Survey (RAS), and four of the Focused Thematic Studies, namely: Drug abuse among Women, Drug abuse among Rural Population, Availability and Consumption of drugs in the Border Areas and Drug abuse among Prison Population.

- *Proportion of IDUs*: The proportion of IDUs varied between 0.1% (in NHS) and 43% (in RAS). In the RAS, the highest prevalence of IDU was reported from Imphal (80%) followed by Chennai (43%) and Kolkata (38%). In the RAS, the age of IDU initiation varied between 15 and 28 years. There was a gap of 2-10 years before shifting to injecting practices. In the DAMS component, 14.3% reported 'ever' using drugs through the injecting route and 9.4% could be called 'current' IDUs.

- *Profile of IDUs*: IDUs were present among all sections of the population. However, the prevalence was higher depending upon the setting and population sub-group. It was definitely higher in the urban sample and more so among those recruited from the street (non-seekers of treatment). Finally, even among the rural sample, though prevalence was low, IDUs were detected. IDUs among women, though rare, were also reported.

- *Drugs being injected*: The common drugs of abuse by means of injecting were propoxyphene, heroin and buprenorphine. IDUs were often poly drug users and the abuse of pharmaceutical products was popular with them.

- *Reasons for injecting*: Common reasons cited for injecting drugs were 'non-availability of heroin (brown sugar)', 'injections are less expensive', 'better and quicker high' and 'peer-influence'. The data also suggested that non-availability of heroin and easy over-the-counter availability of injectable pharmaceutical products such as pentazocine and buprenorphine led to a transition towards injecting. This should be seen in the context of a lack of availability of traditional drugs of abuse.

- *'Reverse switch'*: Although it was observed that most IDUs had shifted from non-injecting to an injecting route, some others had also reported a 'reverse switch' i.e.

shifting to a non-injecting route from injecting practices. Many drug users reverted to smoking because of blocked veins, health hazards, increased awareness, availability of "good-quality" heroin and treatment.

Multiple adverse consequences and risk behaviours related to IDU were also found. These are described under 'Costs and Consequences'.

Substance use in prisons

In India, 70% of prison inmates are 'under trials' (in remand), moving in and out of the prison settings until they are convicted or discharged. Although India has a low prison population (29 prisoners per 100, 000 inhabitants), it suffers from prison overcrowding: prisons are generally 30% overfilled (ICPS 2004). This may facilitate the spread of diseases, including HIV/AIDS. Drug dependent individuals comprise about 8% of admissions in Tihar Jail, New Delhi, one of Asia's largest jails. The majority of these are primarily heroin users who inhale, although IDUs have also been reported in sizeable numbers (UNODC ROSA and MSJE 2002b). Most are long-duration drug users (more than five years) and some have histories of multiple arrests. Since the universal mandate of prisons is rehabilitation of convicts and safe custody of remand prisoners, the prison staff is more interested in the safe custody of the latter. The long judicial process increases the exposure of prisoners in remand to the risk of drug abuse.

Drug addiction treatment and rehabilitation are carried out in Delhi Prisons. With an increase in the number of medical officers at present, Delhi Prison was able to take over the detoxification of drug users from an NGO working since 1989. Currently, there are 3 detoxification centres with 72 detoxification beds, 60 for adult males and 12 for adolescents. Following detoxification, the adult males are rehabilitated in therapeutic communities run by AASRA, an NGO that houses about 800 drug dependent prisoners. The end results of the programme are still evolving. The prison environment has become conducive to rehabilitation and it is now possible to conduct rehabilitation programmes with wide range of disciplines. Gradually, a positive change in the mindset of the prison staff has occurred for the treatment and rehabilitation of drug dependents in the prison environment since 1993.

Various studies have shown that the severity of drug use and the vulnerability to consequences of drug use increase among inmates especially if no services address the needs of this group.

Substance use among street children

Street children are those for whom "the street" has become the home rather than "the family". In such situations, there is no protection, supervision or direction from responsible adults (HRW 1996). According to some estimates, India has the largest number of working children in the world (Simmhan 2004), as well as the largest number of street children in the world (HRW 1996). According to one dated estimate, at least 18 million children lived or worked on the streets of urban India in 1996 (HRW 1996). The recent estimate is that about 47.2 million homeless and runaway adolescents are roaming on the streets of India (Khurana et al 2004). Street children are a group known to be generally vulnerable to drug abuse. A review of drug abuse among children in India (Tripathi and Lal 1999) stated that common drugs of abuse among children and adolescents in India were tobacco and alcohol, while the use of illicit drugs like cannabis and heroin were also reported. Of concern was the finding, in the

same study, of a high prevalence of drug use and even IDU among street children and working children. Street children have been found to be involved in crime, prostitution, gang-related violence and drug trafficking (Das 2003).

A study examining high-risk behaviours among street children in Bangalore reported that 50% of street children who abused drugs also practiced unsafe sex (BOSCO 1999). In another study from the same city (Ramkrishna et al 2003), 121 street boys were interviewed. The median age was 16 years. Drug and alcohol use was common. Half the boys inhaled "solution" (typewriter correcting fluid), and nearly half (46%) consumed alcohol. About 61% boys were sexually active. Anal sex, which is usually a boy-to-boy activity, was the most commonly reported sexual behaviour, followed by vaginal sex. A commonly observed feature of substance abuse by children and adolescents in India is the abuse of inhalants (Waraich et al 2003, Basu et al 2004). In a recently published study (Pagare et al 2004) 115 male street children aged 6 to 16 years were interviewed in New Delhi. More than half (57.4%) of the subjects had indulged in substance use before coming to the observation home. The agents consumed were nicotine (44.5%), inhalants (24.3%), alcohol (21.8%) and cannabis (26.4%). Substance use was found to be significantly associated with domestic violence, maltreatment of the child, nuclear families, running away from home, and the working status of the child.

Recent findings on drug consumption from small-scale studies

Since the research was done for the National Survey during 2000-2001, a number of smaller studies have been undertaken most of whose findings essentially serve to confirm the overall trends depicted in the National Survey. A synopsis of this work is given below.

Kumar and Basu (2000) reviewed the prevalence of substance abuse among medical students and doctors in India and reported that the frequent use of alcohol/drugs among medical students was up to 56% while 'ever' use was up to 81%. Common drugs abused were alcohol, tranquillizers and opioids. Reasons cited for drug use included, "to relieve stress", "to feel good" and "heightened sexual experience" (particularly for opium).

A cross-sectional survey was carried out at two points of time with an interval of one year in a representative sample of the general population in Delhi (Mohan et al 2002). Matched data for two points of time was available for 5,414 males and 4,898 females. In the total sample, the annual incidence rates (per 100 persons) among males for any drug use, alcohol, tobacco, cannabis and opiate were 5.9, 4.2, 4.9, 0.02 and 0.04 respectively. This was one of the rare studies, which examined incidence (proportion of new cases) as opposed to other such studies, which tend to examine only prevalence (proportion of all cases).

Another study (Mohan et al 2003) examined a methodological issue related to substance use epidemiology. A survey of 500 households in a New Delhi urban slum compared reports of substance use in the family as provided by an informant who was the head of the household with reports provided by the individuals themselves. Information from the two sources was compared for 1,132 people above the age of 15 years. The agreement regarding the presence of symptoms and classification of dependence for the use of alcohol, tobacco and opiates ranged from good to excellent. The authors concluded that interviewing the head of the household provided useful estimates of drug use and dependence for substances associated with observable physiologic withdrawal syndromes. This method was described as less costly and quicker to perform than traditional self-report methodologies.

The same group of researchers (Mohan et al 2001), reporting a survey of 72 colonies in five types of housing clusters in Delhi, obtained drug use information from 6,004 heads of households. The prevalence of tobacco, alcohol, cannabis and opiate use among males was 27.6%, 12.6%, 0.3% and 0.4% respectively. De et al (2003) attempted to apply age-at-onset typology in a sample comprising 80 people seeking treatment for opium addiction. The early onset group (the mean age at onset was 21 years) was characterized by a significantly younger current age, more urban and unemployed subjects, younger ages at the onset of opiate use and dependence, a higher severity of opiate use, a higher lifetime use of sedatives and tobacco, younger ages at the onset of dependence on alcohol and cannabis, higher sensation seeking, and higher global psychopathology in terms of MPQ (Multidimensional Personality Questionnaire)[11]. The late onset group (mean age at onset 27 years) was distinctively different within these parameters. The authors concluded that the age at onset typology in opiate dependence appeared to be feasible and to have some similarities to age at onset typology in alcoholism.

Recent findings in North East India

According to sources used for the National Survey, (UNODC ROSA and MSJE 2002, UNODC ROSA and MSJE 2002a and UNODC ROSA and MSJE 2004), alcohol is the drug most commonly used in all the states except Mizoram. However, alcohol users are those who most commonly present for treatment at the treatment services in Assam and Meghalaya. Moreover, although alcohol is not readily available in Manipur, Mizoram and Nagaland[12], alcohol users are the second highest users of services in these states. In Manipur, Mizoram and Nagaland, opiate users are the most common users of services. Significantly, users of propoxyphene (a drug not available in the injectable form) are the highest users of services in Mizoram and Nagaland (although these two states are not contiguous). Use of propoxyphene (diluted to inject) is associated with a higher risk of abscesses, increasing the morbidity of drug users. Users of inhalants in Manipur and users of codeine-based cough syrups in Mizoram are the third most significant users of services. Cannabis users are the second largest users of services in Assam and Meghalaya.

Chaturvedi et al (2003) interviewed a sample of 1,831 people (age 10 years and above) about their drug use habits, if any, and types of substance used, in Meghalaya and upper Assam. The prevalence of substance use was 29.4% tobacco, 12.5% alcohol, and 4.9% opium. Opium and cannabis users were mainly confined in Assam close to the Arunachal Pradesh border, indicating a regional influence. Mean ages for substance use initiation were: 18.5 years for tobacco, 21.8 years for alcohol, and 25.8 years for opium.

North East India HIV/AIDS Network reported a profile of drug users from selected areas[13] of North East India (NEIHAN 2003). Using the stratified random sampling method, a set of 865 respondents were identified and interviewed. The data was reported separately for all states.

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[11] Multidimensional Personality Questionnaire: An instrument routinely used by psychologists to make personality assessment.

[12] Due to the restricted alcohol licencing system in these traditionally conservative Christian dominated states.

[13] The states in which the study was conducted were: Meghalaya, Assam, Nagaland, Manipur and Mizoram. In all, data was collected from 10 sites, spread over these five states.

From Meghalaya, out of 258 respondents only one-third were married, and just over half were unemployed. A large majority had witnessed the onset of drug use below 20 years. About 40% were IDUs. The rest were heroin smokers or alcohol, cannabis and pharmaceutical tablet users. From Assam, out of 125 respondents 29% were married. The majority (73%) had started drug use below the age of 16 years. About two-thirds were IDUs. From Nagaland, out of 191 respondents, just less than a quarter were married. About 55% were unemployed, and a large majority (82%) started below the age of 20 years. All were IDUs, most (about 90%) of them injected Spasmoproxyvon. From Manipur, out of 205 respondents, about one-third were married and about one-third were unemployed. About 41% had started using drugs below 18 years of age. An overwhelming majority (90%) were IDUs, most of whom injected heroin. From Mizoram, of the 86 respondents, 94% were IDUs.

An epidemiological study was carried out to assess the prevalence and pattern of use of various substances in Arunachal Pradesh, India (Chaturvedi and Mahanta 2004). A representative sample of 5,135 people aged 10 years or older was interviewed. Overall, the prevalence of substance use was about 31% tobacco, 30% alcohol and 4.8% opium, which varied across location, gender, race, age, education, and occupation. Poly-drug abuse and high opium use prevalence was described as alarming by the authors. In recent times, attempts have been made to conduct localized RSAs in India as well.

From the state of Assam, (again, in the North East India) Sarin (2004) reported a qualitative assessment of IDU. This RSA involved KIs with law enforcement officials, service providers as well as in depth interviews with IDUs. Spasmoproxyvon, heroin and Fortwin® were the drugs most commonly injected. While injectable heroin is reportedly being smuggled from Manipur and Nagaland, the pharmaceuticals are purchased locally in the black market, often at higher prices. Chasing heroin was described as almost always a precursor to IDU. A general impression, reported from KIs as well as discussion with IDUs was that, IDU prevalence had peaked in mid-1990s and is now decreasing.

3(g) Costs and consequences

Drug abuse has been found to be associated with significant adverse consequences to the individual, his/her family and by extension, to the whole society. In the National Survey, current drug users reported several hazards. Commonest among these were generalised weakness of the body, followed by the inability to visit friends / relatives and the inability to perform as husband or father. Additionally, some complained of depression, anxiety, memory loss, coughs and difficulty in breathing and poor sexual performance. Other adverse consequences related to drug use in the survey include the fact that between 6% and 49% of users report reported drug-related arrest and between 24% and 66% reported drug-related violence. Unprotected sex practices with partners other than spouses were quite common including sex with sex workers, which varied between 4% and 24%.

<u>Injecting Drug Users</u>

- *High-risk behaviour*: The IDUs were engaged in several high-risk behaviours. Needle sharing was common among them as was indirect sharing (e.g., sharing of cotton swab, filter and spoons etc.). Most did not clean the needles and syringes. Many used only water to clean.
- *Sexual behaviour*: In addition to injecting drug use and sharing of needles, high-risk behaviours also included unsafe sex. Among IDUs there was an increased reporting

of sex with sex workers (40%-66%). A few subjects in Chennai, Imphal, Amritsar and Hyderabad had been tested for HIV and the proportion varied between 7% (Chennai) and 47% (Hyderabad). An even smaller proportion was aware of their HIV test report. The risk perception regarding acquiring HIV/AIDS was low among IDUs.

- *Consequences*: In addition to the common domestic, social, economic, legal and health consequences of drug abuse, IDUs suffered from many health consequences such as abscesses in superficial veins, subcutaneous tissues and muscles, septicaemia, HIV infection and Hepatitis B and Hepatitis C infections.

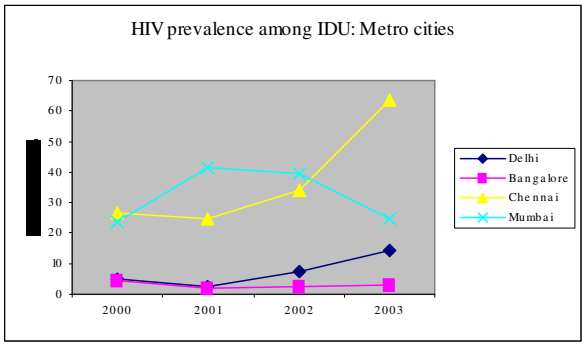
The burden on women by drug abusing male family members

The sample in one of the Focused Thematic Studies was based on interviews of subjects who were living with an affected close family member who was a current regular (daily or near daily) user of drug(s) other than exclusive alcohol and / or tobacco. The women themselves were not regular users of any dependence producing substances. The subjects were recruited from eight urban centres namely Bangalore, Chandigarh, Chennai, Delhi, Imphal, Pune, Solan & Shimla and Thiruvananthapuram, as well as from various settings such as treatment centres, the community or the workplace. The data was obtained from 179 women having affected family members from eight sites and 143 key informants from these sites.

- *Drugs abused by the male family members*: About 41% were current users of heroin and about 52% reported abuse of psychotropic drugs (buprenorphine, propoxyphene, barbiturates, minor tranquillizers, other sedatives and cough syrups). Many were poly-drug users. A large proportion of them (67%) had been using these intoxicants for more than five years and about 41% were currently undergoing treatment for drug abuse.

- *Burden on women*: The study found that across all sites, drug use was considered a predominantly male phenomenon and the impact of male drug abuse on women was generally economic, followed by stigmatisation, emotional and a whole range of relationship difficulties and neglect of children who were in turn more prone to child labour or delinquency. Domestic violence, crime and increased trafficking were recognised as possible outcomes of individual drug use. The family burden, especially on the woman, of caring for drug users was also substantial. Besides the economic burden, women were seen as making adjustments at the cost of their own welfare, growth and development. The lack of social support systems served to aggravate their economic, social and emotional burden.

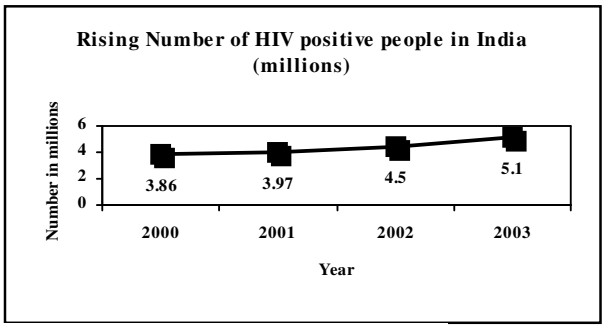
- One of the major burdens the women faced was that of stigma – blame for the drug use of the family member, blame for hiding the issue from others and blame for not getting timely treatment. The woman thus became the victim of not only the drug user but also the society at large.



- Women continued to look after the drug using family member despite continued addiction and

in the process suffered from constant worry and depression. These women were often subjected to violence and lived in a hostile environment. Most domestic violence reported in the study was directed at women and took place in the context of demands for money to sustain the habit. To prevent further violence, the woman usually conceded and provided the money, creating a vicious cycle of violence as an effective mode of extracting money.

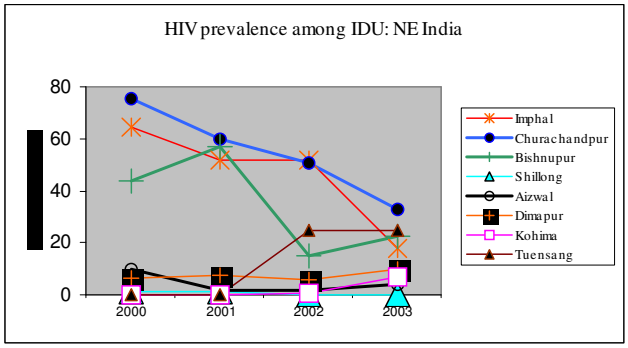
HIV/AIDS



Source: NACO 2004a

Although India continues to be a low prevalence country with an overall prevalence rate of less than 1% among the adult population, the absolute number of people affected is high. It is estimated by the National AIDS Control Organisation (NACO) that there were 5.1 million HIV-infected persons in India as of October 2003 compared with 4.5 million in 2002, 3.97 million by the end of 2001 and 3.86 million in 2000, indicating a steadily increasing rate of infection (NACO 2004a). Antenatal data (which is used as a proxy for HIV prevalence among the general population[14]) from states such as Maharashtra, Tamil Nadu, Andhra Pradesh, Karnataka, Manipur and Nagaland indicate above 1% prevalence, while in states such as Gujarat and Goa, prevalence figures have crossed 5% in the high-risk group (though less than 1% among pregnant women). This data supports the notion that HIV infection is spreading from high-risk groups to low-risk groups in the population.

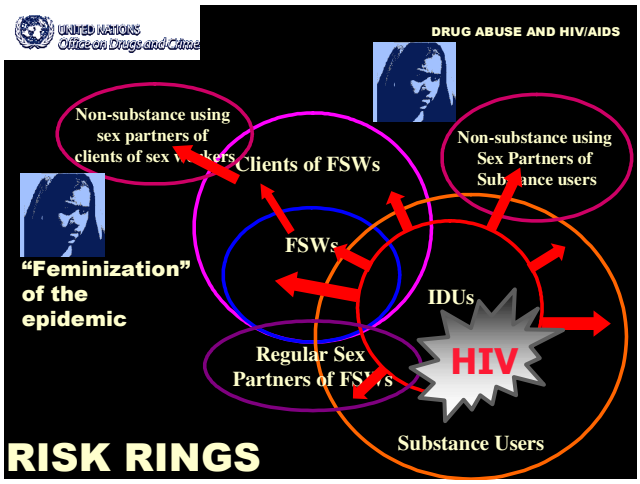
Wide differences in HIV prevalence rates have been observed in the IDU community in the country (Dorabjee and Samson 2000). NACO has been periodically collecting data on HIV seroprevalence among high-risk groups, which include IDUs in various sites across the country. The last two figures on this page show the trend of HIV prevalence among IDUs at 12 sites in India over a period of last four years (NACO 2004c).



As depicted in these diagrams, while in the rest of the country the HIV prevalence among IDUs shows a steady increase, in the north-east, a gradual reduction can be seen over the past four years, although at sites such as Imphal, Bishnupur and Tuensang, in the northeast it is still high. In many cities with concentrated populations of IDUs, the HIV prevalence is above the critical level of 5%, causing great public health concerns.

[14] Classification of HIV/AIDS epidemic: **'Low level'**— HIV prevalence less than 5% in any (high-risk) sub-population, **'Concentrated'** – more than 5% prevalence in any (high-risk) sub-population but less than 1% among pregnant women and **'Generalised'** – prevalence of more than 1% among pregnant women. (Source: UNAIDS/WHO 2004)

NACO has been conducting sentinel surveillance annually at these specific sites. Interestingly, the National Survey also found IDU at sites where it was not expected. In the RAS component of the national survey, for example, 67% and 87% of the sample was comprised of IDUs in Trivandrum and Jamshedpur, respectively – two places where earlier IDU was not known to be a major pattern of drug use. Other components of the National Survey also reported that IDU is now spreading into smaller towns and rural areas.



Thus, there is a large body of evidence suggesting that not only is the prevalence of risk-behaviours high among drug users, but the prevalence of HIV/AIDS itself has also been found to be variable.

It should be pointed out, however, that it is risky to try to derive national estimates of IDU using the national household survey as a basis. This is because household surveys, in general, tend not to access marginalized populations. Since IDUs are more likely to belong to such groups they are not necessarily captured through such a methodology. As a result, estimates of IDUs based on household surveys tend to produce an underestimation. Thus, although the National Household Survey (NHS) did suggest a lifetime prevalence of IDU among adult males at around 0.1%, it would be inappropriate to use this figure for projecting the absolute numbers of IDUs for the country as a whole. Furthermore, the only data on HIV seropositivity among IDUs comes from sentinel surveillance and certain ethnographic studies and can not therefore be extrapolated on a national basis.

Some information on IDU directly contributing to the development of AIDS cases is available, but it cannot be extrapolated for HIV infection as a whole.

The nature of IDU and the manner in which it can serve as the epicentre for the origin and spread of HIV into the general population has been described in various bodies of research (MAP 2001). The figure entitled 'Risk Rings' reviews the overlapping series of risk rings related to IDU (Hersey 2004). Although precise figures are not easily obtainable, it can nonetheless be concluded that the indirect impact of IDU on the spread of the HIV epidemic is considerable.

Drug - HIV Situation in north-east

Ever since an explosive HIV epidemic was reported among injecting heroin users in certain parts of northeast India in late 1980s, the phenomenon of drug use in this sector has attracted much attention. Although traditionally betel nut, tobacco, cannabis, country liquor and opium were the common drugs of abuse, a shift from traditional usage to non-traditional forms of drug use such as heroin smoking, heroin injecting and injecting dextropropoxyphene (available in capsule form, the powder of which is dissolved in water and injected after filtering it through a cotton wad) took place during the early 1970s to early 1980s. Subsequently it was observed that a considerable proportion of the local youths in northeast India started injecting drugs straight away rather than gradually switching from cannabis abuse to sleeping pills or codeine containing cough syrup to injecting drug use (UNODC ROSA and MSJE 2004b).

In the late 1980s, HIV made inroads among injecting drug users in Manipur, Mizoram and Nagaland – three of the four northeastern states having a common international border with Myanmar. Within the next decade, Manipur and Nagaland moved into a generalized epidemic situation.

Panda et al (2001) examined the interface between drug use and sex work in Imphal, the capital of Manipur. They interviewed 69 women drug users through street-based outreach workers. Thirty-eight women (55%) were injecting drug users. Eighty per cent of the respondents reported having sex with non-regular partners; two-thirds reported sex in exchange for money or drugs. HIV and HBsAg testing, offered to all the study participants, generated data on HIV/AIDS and HBsAg infection. The prevalence of HIV infection in injecting drug users was significantly high (57% compared with 20% among non-injecting drug users), although the prevalence of HBsAg was similar in the two groups (48% versus 56%). The authors recommended an innovative outreach strategy for effective implementation of interventions among women injecting drug users and non-injecting drug users who operate from the streets as sex workers to support their drug habit as well as their livelihood.

Saha et al (2000) evaluated the Hepatitis C virus (HCV) and Hepatitis B virus (HBV) infections among 77 Manipuri couples, among whom all the husbands were both IDUs and HIV positive. This study showed for the first time a high prevalence of HCV (92%) and HBV (100%) infection amongst the HIV positive IDUs in Manipur.

There is increasing evidence that the non-injecting sexual partners of injecting drug users are becoming infected in places like Manipur. In another study (Panda et al 2000) 161 HIV-infected IDUs and their wives were recruited. The HIV status of wives was determined by enzyme-linked immunosorbent assay (ELISA) plus Western blot. Seventy-two wives (45%) were found to be HIV-positive. The following elements were associated with HIV infection of the wife: (a) a sexually transmitted disease (STD) in either member, (b) an estimated duration of HIV in the husband for greater than 8 years, and (c) a history of blood transfusions. Improved control of STDs, condom promotion, and improved blood screening in Manipur were recommended.

3(h) Money laundering

Scope of problem in India

Illicit cultivation, illicit manufacture of drugs, diversion of licit opium, precursors and pharmaceuticals as well as trafficking of the drugs is prevalent in India. All of these activities generate illicit drug money. There appears to be no estimates on the extent of drug money generated in India. Possible illicit uses of this drug money include: (a) own use by traffickers, (b) the financing of terrorism; (c) the buying of political influence.

Sources of drug money in India

a) In Uttar Pradesh, Madhya Pradesh and Rajasthan unscrupulous farmers divert licitly produced opium.
b) From precursor trafficking (one litre of acetic anhydride costs about Rs. 50/- in licit market while it fetches up to Rs. 1,000/- in illicit market).
c) Illicit cultivators of opium and cannabis in Jammu and Kashmir, Himachal Pradesh, Uttaranchal, the north eastern states, Orissa, Andhra Pradesh and Tamil Nadu.

d) Illicit manufacturers of heroin (primarily in opium growing regions of Uttar Pradesh, Madhya Pradesh and Rajasthan), methaqualone (primarily in and around Mumbai, Hyderabad and Gujarat).
e) Drug traffickers who smuggle drugs through Mumbai, Delhi, Kolkata and now increasingly through Tuticorin (to Sri Lanka).
f) Small-scale drug peddlers and the chain of drug traders within the country.

Other sources of "black money" in India:

a) Evasion of income tax: High rates can encourage income tax evasion resulting in accumulation of black money. Similarly, black money is generated through evasion of other taxes also.
b) Real estate transactions: The tax on registration of property is called 'stamp duty', which is very high in many states in India. This may encourage buyers to show the value of the property as less than its true value. Over a period of time, the under-valuation of properties in the account books can become the norm. In this way, each transaction becomes both a source of black money for the seller and a means of concealing black money to the seller.
c) Corruption among public servants and politicians as well as in private firms.
d) Smuggling: Restrictions on imports and high rates of tariffs rendered smuggling very profitable.

Techniques of laundering in India

Aside from the traditional approaches which are employed in India (using businesses with a high cash-transaction rate, over- or under-invoicing of imports, remittances from abroad, etc.) the following techniques are of interest in the Indian context.

a) Hawala: These are illegal foreign exchange transactions. Any person wanting to convert rupees into foreign exchange or vice versa is legally obliged to go through official banking channels. This exposes the transaction to possible investigation by authorities. Hawala is an illegal foreign exchange transaction that operates on the basis of trust. Once the transaction is completed, accounts pertaining to that transaction are destroyed leaving little trace for the investigator.
b) Casinos of Nepal: The casinos in Nepal operate only in Indian Rupees. Many casinos issue a fake certificate indicating that the patron has earned an amount of money in the casino in exchange for an underhand fee. The patron simply returns to India and provides the false documentation to the tax authorities. The black money becomes white.
c) *Benami* accounts: Money is deposited in fictitious *Benami* accounts and through a series of transfers the money is transferred to the laundered account.

The number of seizures of drugs during the years 1998-2002 and the number of cases where properties have been frozen are as follows:

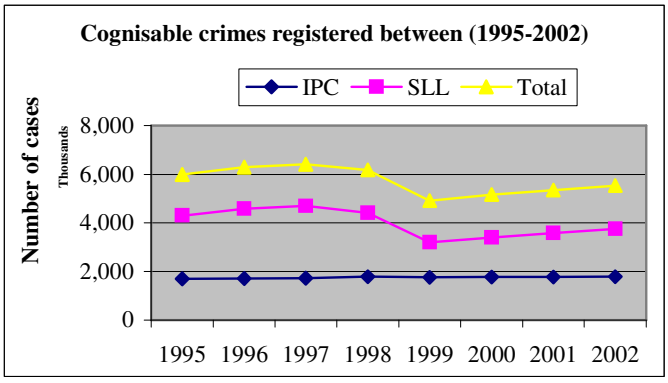
Year	**1998**	**1999**	**2000**	**2001**	**2002**
No. of seizures	12,446	13,029	12,460	15,005	11,472
No. of cases where property has been frozen	36	7	4	2	41
Percentage	0.29	0.05	0.03	0.01	0.36

Source: NCB 2002.

Even considering that the majority of seizures tend to be for small quantities of drugs where no financial investigation and asset forfeiture is possible, the number of financial investigations remains limited. This may be explained by the fact that (a) many cases are booked by police who may not be trained in financial investigations and hence there is hesitation in initiating the process and (b) many enforcement officers are not even aware of the provisions for financial investigation and asset forfeiture under the NDPS Act. As noted in Section 5 below, the law is weighted heavily in favour of the investigators and the necessary quasi-judicial procedures in India remain relatively simple.

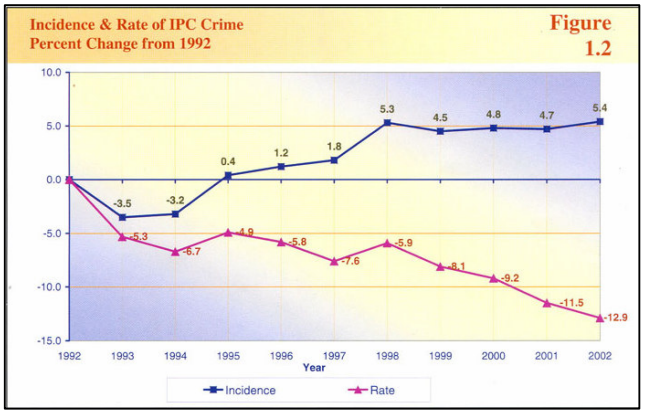
4. CRIME SITUATION

4(a) Main characteristics



According to the National Crime Records Bureau the total cognisable crime[15] in the country has been steadily increasing. It is noted that this is however keeping pace with the increase in population though at a varying rate over the past 50 years. A review of the available data suggests that organized criminal activities, trafficking in human beings, underground banking and corruption are of particular significance.

According to the report entitled *Crime In India 2002* issued by the National Crime Records Bureau under the Ministry of Home Affairs, a total of 5,531,172 crimes were registered in the year 2002 in India. These comprised 1,780,330cases under the Indian Penal Code (IPC) and 3,750,842 under Special and Local Laws (SLL). Violent Crimes (221,810 cases) constituted 12.45 percent of the total IPC crimes reported in 2002. Of these, 44.2% of the crimes were violent crimes affecting life (97,966 cases); violent crimes affecting property were 12% (26,706); violent crimes affecting public safety were 36.4% (80,765); and violent crimes against women (rape) were 7.4% (16,373 cases).



A total number of 370,629 property crimes constituting 20.8% of the total cognizable crime under the IPC were reported during the year. As compared with the previous year, this form of crime recorded a decrease of 2.9 percent. The share of these crimes has also been steadily

[15] Cognizable offences are defined as offences which are more serious by nature for which a police officer may arrest a person without a warrant or authorisation from the Court. Non-cognisable offences, by contrast, are simple offences for which the police may not arrest persons unless courts issue arrest warrants.

decreasing during the past four decades, from 67.1% in 1953 to 20.6% in 2000. Over 61,820 economic crimes, constituting 3.47% of the total cognizable crimes under the IPC, were reported in the country in 2002.

The National Capital Territory (NCT), New Delhi reported the highest IPC crime rate[16] at 349.6 in the country as compared with the national average of 169.5. Among the other states, the crime rate was highest in Kerala (322.9), a state in the southern part of India. The total number of cases registered during the period, as can be seen is more or less constant during the period. The National Crime Records Bureau also studied the percent change in the incidence and rate of IPC crime during the decade 1992-2002. The adjacent diagram shows that while the absolute number of cases increased 5.4% during the decade, the incidence declined by 12.9%.

Limitations of the statistics: Crimes may not always be reported and hence statistics do not always depict the full picture. The accessibility, credibility and perceived friendliness of the police as well as the educational levels and awareness of the people determine whether the victim of a crime actually makes the effort to file a complaint with the police. Wherever there are low trust levels of the police, victims either suffer in silence or take direct vigilante action (e.g., retaliation). Either way, the crime does not get recorded. For instance, one of the states best known for high crime rates in India is Bihar. As per the statistics (see table below), it is ranked 26th in criminality while Pondicherry, generally considered to be safe, is ranked number one in terms criminality.

Incidence and rate of Total Cognizable Crimes (IPC) during 2002

Sl. No.	**State/UT**	Incidence of Total Cognizable Crimes	Percentage Contribution to All-India Total	Estimated mid-Year Population (In Lakhs)	Rate of Total Cognizable Crimes	Rank of Criminality
(1)	(2)	(3)	(4)	(5)	(6)	(7)
STATES:						
1	ANDHRA PRADESH	143,610	8.1	769.15	186.7	14
2	ARUNACHAL PRADESH	2,228	0.1	11.15	199.8	11
3	ASSAM	36,346	2.0	272.47	133.4	22
4	BIHAR	94,040	5.3	851.71	110.4	26
5	CHHATTISGARH	37,950	2.1	213.03	178.1	16
6	GOA	2,440	0.1	13.88	175.8	17
7	GUJARAT	106,675	6.0	517.89	206.0	10
8	HARYANA	40,152	2.3	216.44	185.5	15
9	HIMACHAL PRADESH	12,243	0.7	61.78	198.2	12
10	JAMMU & KASHMIR	19,967	1.1	104.40	191.3	13

[16] The crime rate is the number of crimes committed per 100,000 of the population and is a measure for comparing the crime situation in different regions and countries. The referenced statement indicates that 169.5 crimes are committed per 100,000 population in India while the number is much higher (349.6) in the NCT of New Delhi. It should be noted that the crime rate depicts only cases which are booked by the police. Thus, a state such as Kerala and a Union Territory (Union Territories are regions which are administered directly by the Central Government) such as Pondicherry have very high crime rates while states such as Bihar, where questions of control arise, have much lower rates of crime on paper.

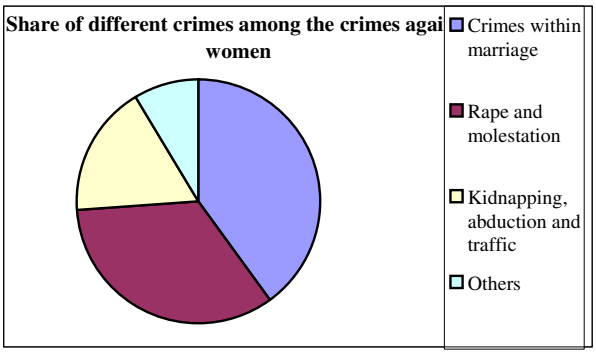
11	JHARKHAND	31,439	1.8	275.43	114.1	25
12	KARNATAKA	113,699	6.4	536.81	211.8	9
13	KERALA	104,200	5.9	322.70	322.9	4
14	MADHYA PRADESH	191,799	10.8	620.72	309.0	6
15	MAHARASHTRA	165,462	9.3	988.26	167.4	18
16	MANIPUR	2,584	0.1	24.43	105.8	27
17	MEGHALAYA	1,664	0.1	23.58	70.6	34
18	MIZORAM	2,820	0.2	9.10	309.9	5
19	NAGALAND	1,114	0.1	20.47	54.4	35
20	ORISSA	47,728	2.7	373.43	127.8	23
21	PUNJAB	28,794	1.6	247.71	116.2	24
22	RAJASTHAN	151,248	8.5	581.25	260.2	8
23	SIKKIM	485	0.0	5.53	87.7	30
24	TAMIL NADU	166,942	9.4	629.43	265.2	7
25	TRIPURA	3,075	0.2	32.47	94.7	28
26	UTTAR PRADESH	146,037	8.2	1708.10	85.5	31
27	UTTARANCHAL	7,976	0.4	86.76	91.9	29
28	WEST BENGAL	58,962	3.3	817.07	72.2	33
	TOTAL (STATES)	1,721,679	96.7	10335.15	166.6	
UNION TERRITORIES						
29	A & N ISLANDS	608	0.0	3.65	166.6	19
30	CHANDIGARH	3,806	0.2	9.32	408.4	2
31	D & N HAVELI	349	0.0	2.28	153.1	21
32	DAMAN & DIU	261	0.0	1.64	159.1	20
33	DELHI	49,137	2.8	143.83	341.6	3
34	LAKSHADWEEP	53	0.0	0.62	85.5	32
35	PONDICHERRY	4,437	0.2	9.91	447.7	1
	TOTAL (UTs)	58,651	3.3	171.25	342.5	
	TOTAL (ALL-INDIA)	1,780,330	100.0	10506.40	169.5	

4(b) Trends

Crimes against women: Crimes against women are a matter of serious concern in India. Women in the country suffer due to a lack of awareness of their rights, illiteracy and oppressive practices and customs. The resultant consequences are many: a consistent imbalance in the sex ratio (in favour of men), high rate of female infanticide, a low literacy rate among girls and women, a high drop out rate of girls from education, relatively lower wage rates. As is evident from the graph shown above, while all crimes have been either decreasing or are more or less constant since 1995, crimes against women have been steadily rising. This could be due to either an absolute increase in the number of crimes against women, or the fact that women are becoming more vocal. Either way, the rising rate of crimes against women is a matter of serious concern. Various kinds of crimes against women during 2002 are as follows:

Type of offence	Cases	% of total crimes against women
Rape	16,373	11.09
Kidnapping and abduction	14,506	9.82
Dowry deaths	6,822	4.62
Cruelty by husbands and relatives	49,237	33.34
Molestation	33,943	22.98
Eve teasing (sexual harassment)	10,155	6.88
Importation of girls	76	0.05
Sati prevention Act	0	0.00
Immoral Traffic Prevention Act	11,242	7.61
Indecent Representation of women (prevention) Act	2,508	1.70
Dowry prohibition Act	2,816	1.91
Total no. of crimes against women	147,678	100

The above crimes can be categorised into the groups depicted as per the pie diagram below. The diagram shows that almost 40% of the reported crimes against women are committed within the family setting (noting that it is also often the case that rape occurs within the family, see below), which adds a social dimension to the problem. The culture of South Asia places great emphasis on the institution of family. It is also an economic entity by itself where the men are often the sole or main breadwinners. Hence, it is important for a woman to ensure that the marriage does not break both for social and economic reasons. If a woman reports to the police against a husband or in-laws she places her marriage at risk. Women suffering domestic abuse face difficulties when going through the legal system. This often compels them to avoid seeking redress from the police. The number of cases of dowry deaths[17] and cases brought under the Dowry Prohibition Act bear testimony to this social pressure on women.[18] Culturally appropriate solutions – which address crimes against women within the marriage, while not destroying the marriage – need



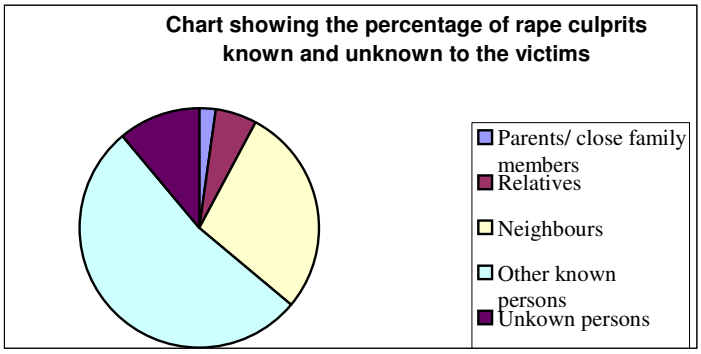
[17] Dowry is an amount, which, traditionally was paid by the bride's parents to the groom at the time of marriage. Since it is considered an inappropriate and exploitative tradition, dowry is prohibited in India. However, the practice of dowry continues in many families and at times it turns exploitative with the husband and in-laws abusing the woman for more dowry sometimes leading to the death of woman including by suicides. Dowry Prohibition Act is heavily loaded against the accused and in favour of the women who complain against harassment for dowry.

[18] The crime figures for 2002 above show that cases booked under the Dowry Prohibition Act were about 2% of the total cases while dowry deaths were double that figure. At first sight it may seem paradoxical that there are more cases brought for dowry deaths than under the Dowry Prohibition Act for harassment. However, this can be explained by the fact that women being harassed for dowry tend to tolerate their treatment to the point of death with very few actually going to the police about it. Hence there are more deaths than cases under the Act.

to be found. These could include counselling by police (following the Delhi police experiment) and family courts, which deal with the problem in-camera, expeditiously, and as far as possible, amicably.

Rape: Of the 16,373 cases of rape booked during 2002, the victims knew the culprits in 14,537 (over 88%). The culprits were close family members, neighbours, relatives or other known persons.

Culprit	Parents/ close family members	Relatives	Neighbours	Other known persons	Unknown persons	**Total**
Cases	369	924	4,600	8,644	1,836	16,373
Percentage	2.25	5.64	28.10	52.79	11.21	100.00



Underground banking: Underground banking is an important element of local economies. The alternative remittance system through non-official banking systems is called "Hawala". Such secret funds are useful in order to meet a number of objectives such as bribery and tax evasion. It is reported that most cases of money laundering in India relate to an attempt mainly by commercial entities to evade taxes, rather than being related to illicit drug trafficking. It is believed that this underground banking system developed in the 1940s from networks related to people who emigrated from India to Hong Kong, Britain, Canada and the United States. Today, it is estimated that a fee of 15-30% is demanded for the illegal transfer of money across international borders.

4(c) Issues of specific concern

Organized Crime: Organized crime in India is present in large cities and especially in Mumbai which is generally considered the commercial capital and where it is believed that organized criminal groups began to establish themselves from the early 1960s onwards. Its organised criminal gangs are involved in the following kinds of business. While most gangs indulge in many of these activities, they do specialize in certain areas:

a) **Settlement of business disputes and recovery of dues:** In any business culture where there is a propensity to evade taxes a significant part of all business transactions are usually done in cash. Debtors in such transactions who do not pay their dues cannot be taken to court for obvious reasons. Such disputes tend to be settled and dues recovered by organized criminal gangs through threats backed by credible display of force. Once debt recovery is effected, the criminal gang takes a certain agreed upon percentage of the recovered sum. Even where the business transactions are accounted for and legal, the recovery of dues through the normal judicial process is often slow. In such cases, some businessmen prefer to settle disputes through the use of organized criminal gangs.

b) **Contract killings:** Contract killings are another important aspect of the business of organized criminal gangs. Colloquially, hiring someone as a contract killer is referred

to giving him 'supari'. The value of the 'supari' depends on the importance of the person to be killed and the difficulty involved in killing. Killing a person who has private guards, for instance, would command a higher amount of 'supari' than one without and similarly, the richer the man, the higher the amount of supari. However, the average cost of a contract killing is too high for the common man on the street to be threatened. Hence, Mumbai is considered quite safe for the ordinary citizens despite the existence of a large network of organized criminal gangs.

c) **Smuggling:** Smuggling has been a very profitable venture in the underworld thanks to the high rates of customs duties in India. With a view to saving the scarce foreign exchange for essential needs, the Government of India banned import of gold for many years resulting in a significant difference in the national and international prices of this commodity. Gold smuggling, therefore, has become an attractive business. In recent years, the Government of India permitted the import of gold and reduced import tariffs on most commodities. Further, the government has also been encouraging multinational companies to establish their manufacturing facilities in India with the result that electronic goods and other consumer durables are now available in the local market. Smuggling has thus been rendered less and less profitable in recent years and hence organized criminal gangs are gradually shifting to smuggling of drugs both into the country and out of it.

d) **Extortion:** Extortion from businessmen and industrialists is another regular source of income for organized criminal gangs. Since the entire business community can be terrorized into submission, few will oppose making the regular payment or 'hafta' to the gangs. In return for the hafta, the organized criminal gang provides 'protection' from other criminal gangs. The city of Mumbai is thus divided into territories among different organized criminal gangs. Gang warfare among these groups is common.

e) **Drug trafficking:** India is one of the few countries of the world where drugs are manufactured, smuggled into and out of the country, sold in the large domestic market and precursors are manufactured and diverted both for use within the illicit drug industry within the country as well as for smuggling out of the country. These patterns provide considerable business opportunities for the underworld. According to information available to UNODC, most gangs have a specialised department dealing with drug manufacture and trafficking.

f) **Human trafficking and prostitution:** Human trafficking including running brothels is another important business for organized criminal gangs. This subject is dealt with in detail below.

g) **Hawala and money-laundering:** As explained above, Hawala is an informal method of transfer of money both within the country and to other countries. Hawala operators also convert the money into other forms of currency and move the money through different countries and banks to conceal traces of the money. Ill-gotten money earned through bribes, smuggling, drug trafficking and other crimes is transferred through hawala. Additionally, a significant percentage of legitimate business activities are unaccounted for mainly to evade tax. In some businesses, unaccounted for cash transactions have become the market norm. Money in such cases cannot obviously be transferred through banks and hence it is transferred through hawala operators. Hawala is thus a thriving profitable business.

h) **Financing of Bollywood movies:** Until recently, Bollywood movie producers did not have access to credit from banks due to certain regulations. Organised criminal gangs find an excellent opportunity to invest their money in these projects and, although no statistics are available on the matter, it is reported that the Bollywood movie industry is financed to a significant extent by money from the underworld. The

government is currently considering regulatory changes which would give film producers access to bank credit thus reducing their dependence on the underworld.

i) **Financing of real estate:** The cost of registering the real estate (commonly called "stamp duty") is approximately 15% of the transaction value of the property in most states in India. Individuals thus tend to declare a much lower value on the property in the documents than the authentic transaction value. The result is that the average documented price of property in specific given areas is much lower than the market value. The remaining amount is transacted in cash. Thus, persons with illegal money can invest their money by buying real estate. Organised criminal gangs invest in real estate as it is not only an excellent place to deposit funds but also to earn money through businesses. Often properties are purchased in *benami* (pseudonymous) deeds to circumvent the regulations of land ceiling.

Most state governments in India do not have a law to deal with organized crime. In recent years, Maharashtra, whose state capital is Mumbai, enacted a law to deal with organized crime. The traditional judicial system has had difficulty addressing the problem of organized criminal groups. As per the Indian Evidence Act, confessions made to a police officer or to anyone else (except a magistrate) while in the custody of a police officer are inadmissible as evidence in the court of law. Most victims and witnesses of organized crime are too afraid to give evidence in the court of law against a criminal gang. Hence, the judicial process is stymied.

Corruption: According to the Transparency International Corruption Perception Index in 2003, India scored 2.8 and was ranked 83rd in terms of level of perceived corruption (TI 2003) (in 2004, score 2.8 and rank 90). In the first comparative study of corruption in South Asia examining what users of key public services actually experience, respondents in India considered the police to be the most corrupt public agency, followed by the health and power sectors (TI 2002).

According to a Price Waterhouse Coopers economic crime survey conducted in 2003, the admitted experience of economic crime in India is lower than in the Asia-Pacific region[19] as well as globally, and was contrary to the general perception of the relative incidence of economic crime in India (PWC 2003). About 53 % of the respondents perceived corruption and bribery as the most prevalent economic crime in India. The perceived prevalence of corruption and bribery was significantly higher in India compared with the Asia-Pacific region or globally. Surprisingly, on being asked which type of economic crime their organization had suffered in the previous two years, only 11% of the respondents reported suffering corruption and bribery. This highlights that while people carry a perception about widespread existence of corruption and bribery, there is either a marked reluctance to admit that they have suffered from it, or it exists to a degree less than is perceived. Looking ahead over the next five years, 70% of the respondents from India believe that the risk from economic crime would be the same or higher. Thus, despite improved controls, there appeared to be a concern that the chances of being subject to economic crime in the future continue to be high.

[19] For the purpose of the survey, this region included Australia, Hong Kong (SAR), India, Indonesia, Japan and Singapore.

Trafficking in Human Beings:
India is a country of origin, transit and destination for trafficked persons. Most of the trafficking, however, takes place within India itself. The problem of bonded labour[20] and indentured servitude is also significant. Indian women and children are trafficked to the Middle East and the West for purposes of forced labour and sexual exploitation. However, India remains – above all – a destination for trafficked women and girls (both internally and externally) because of the demands of the local sex industry, estimated to be worth 400,000 million Rupees annually. Many women and girls arriving in India are intended for forced labour and sexual exploitation. Concentrated evidence of this is available in Mumbai (which contains one of the largest red light districts in the world) and Kolkata. Some local culturally-sanctioned practices (e.g., the *Devadasi* system) also expose women and girls to sexual exploitation and trafficking (DWCD 2004). One worrisome recent trend is that India is now also a destination country for sex tourists from the Middle East and the West.

Nature: In India, most trafficking takes place for the following purposes: sex work, drug peddling, organ trading, child labour, camel jockeys and domestic work. Traffickers pay Rs. 2,000 – 5,000 for each child in the village. This price may rise to as high as 60,000 by the time the child reaches the city (STOP 2002). The demand for younger children is increasing because of paedophilia, and myths of sex with a virgin increasing potency and getting rid of HIV/AIDS and STIs (STOP 2002). According to one study, 15 per cent of commercial sex workers are under 15 years of age, while another 25 per cent are between 15-18 years old (Mukherjee and Das 1996). Another study estimates that there are between 300,000-500,000 children in prostitution in India (UNICEF 2001a).

Magnitude: In India, current calculations about the number of people trafficked are obscured by the fact that no clear dividing line is made between trafficking and commercial sexual exploitation. The clandestine nature of operations and the stigma associated with trafficking make it difficult to obtain accurate figures. The number of women and children involved in sex work is variously estimated to be in the vicinity of one million (NHRC 2004). Another stud suggests that approximately 2 million women are involved in sex work in India, 25-30 per cent of whom are minors (CATW 2002). The same study estimates that there are more than 1,000 'red light' areas all over the country. At any given time in India, 20,000 girls are being transported from one part of the country to another (NHRC 2004).

The main states providing the trafficked people are Andhra Pradesh, Maharashtra, Karnataka, Tamil Nadu, Bihar, West Bengal and Uttar Pradesh. The main countries of origin for foreign trafficked sex workers in India are Bangladesh and Nepal where, according to one source, it is estimated that 300,000 and 200,000 women respectively have been trafficked into India (ADB 2002). A decade ago, it was reported that slightly over 50 per cent of female child prostitutes in India came from Nepal or Bangladesh (ADB 2004). Nepalese women and girls are currently working in situations of prostitution in several Indian cities. It is estimated that 5,000-12,000 of them are trafficked to India every year (ADB 2002). The traffickers deceive their victims with fraudulent promises of jobs or marriage and take advantage of the lack of sufficient cross-border cooperation between Nepalese and Indian authorities in respect of

[20] If a labourer is in dire need of money and has no means of raising a loan, he or she pledges their future labour as well as the labour of spouses and children and borrows the money. Thereafter, the labourer is expected to repay the debt by working for the person who lent the money. The labourers are usually illiterate and the person lending the money often manipulates the calculations to ensure that the debt is never completely repaid. Thus, the labourer and their offspring keep perpetually working free for the creditor/owner.

human trafficking. No passports are required at the Nepalese-Indian border, across which free movement is permitted for both Indian and Nepalese citizens.

Consequences: Indignity, social stigma and debt bondage are among the commonest consequences for the individual trafficked. Another result of the illegal trade in trafficked women and girls is the spread of HIV/AIDS. Most of the trafficked girls die very young (the average life span is estimated to be only 30 years) mainly from HIV/AIDS, but also from malnutrition, abuse, neglect and sexually transmitted diseases. It is already clear that the HIV/AIDS situation in Nepal is strongly linked to the question of trafficking in Nepalese women and girls into India.

Rescue and rehabilitation: The Indian NGO establishment that is involved in trafficking issues is widely regarded as being extremely energetic. They have taken the lead in requesting (and often providing) anti-trafficking training for state and federal police officials. They are also visible in awareness campaigns and protection for the victims of trafficking. The Department of Women and Child Development has established a network of over 350 short stay homes for the protection and rehabilitation of victims (TIP 2004). The central government has in the past two years opened 80 protective homes.

Enforcement: At present, human trafficking is not treated as an "organized crime" at the federal level, even though many states have already enacted special laws on organized crimes. Trafficking has not been declared a federal offence and the Central Bureau of Investigation (CBI) has no *suo moto* authority to intervene unless specifically asked by a state government. By the same token, the CBI is unable to take on even international trafficking crimes without federal clearance. A study undertaken by the National Human Rights Commission (NHRC 2004) has recommended that trafficking in women and children should be made a federal crime with the CBI given powers to investigate cases on its own. The report of the study, which covered 13 states and union territories, expressed concern over current restrictions on the Central Bureau of Investigation which prevent it from probing such cases unless specifically asked to do so by a state government or Delhi. The report has also suggested the establishment of a special cell in the CBI to deal with trafficking. The CBI director should be left to pick cases for investigation, keeping in view their "multi-state or international ramifications". The CBI should be given "contiguous powers" of investigation of cases involving states, it recommended.

Number of cases booked under the Immoral Trafficking (Prevention) Act

Act	**1998**	**1999**	**2000**	**2001**	**2002**
Immoral Traffic (P) Act	8,695	9,363	9,515	8,796	11,242

Source: National Crime Records Bureau, *Crime in India* 2002, (July 2004)

The all-India reporting of crimes under the ITPA shows a continuous increase year after year, except in 2001. This reflects a combination of increased trafficking and increased awareness among law enforcement of the issue. However, the vast majority (87 per cent) of the arrests made spanning the period 1997-2001 were against the actual victims of trafficking under Section 8 of the ITPA (soliciting) and not against the brothel owners or traffickers (NHRC 2004).

Under orders from the Supreme Court, the Department of Women and Child Development established a committee in 1998 which found that "in spite of many interventions for prevention, law enforcement, rescue and rehabilitation, there does not appear to have been

much impact on the prevalence of commercial sexual exploitation of women and child" (DWCD 1998). The following reasons were adduced:

- Lack of seriousness among law enforcement machinery and administration[21];
- Risks faced by social workers, NGOs, and government officials working in red-light areas and among victims;
- Insufficient awareness about the prevalence of child trafficking;
- The lure of a comfortable lifestyle, which made it more difficult to "rehabilitate" some victims;
- Social stigma and family problems facing victims;
- Difficulties in estimating the age of child victims;
- Inadequate institutions for care and rehabilitation of rescued victims;
- Lack of coordination between border police of neighboring countries to stop cross-border trafficking; and
- Lack of support lines and drop-in centers for women in need

The Committee also found that quite often it is the prostitutes rather than those who traffic them who are arrested and prosecuted, thus re-victimising the victims[22]. In order to reduce such a possibility, the committee recommended:

- Modification of criminal procedures to make them more gender-sensitive and child-friendly;
- More provision for NGO participation in criminal proceedings on behalf of victims;
- Provision for confiscation of assets and income of exploiters;
- Better enforcement of the Bonded Labour System (Abolition) Act;
- Setting up of exclusive anti-trafficking and prevention cells, including women police officers, in major cities and high-impact areas;
- Provision of counseling and free legal advice to women in custody;
- Establishment of task forces in major cities to coordinate activities of government agencies, NGOs, and others;
- Review of laws relating to elimination of child pornography; and
- Continuation of police raids on brothels as permitted under the ITPA.

[21] For example, one study (NHRC 2004) interviewed 852 police official, and found that 80 percent admitted that trafficking received "no priority or low priority".

[22] It has been found, for example, that instead of prosecuting the traffickers under sections, 3, 4, 5 and 6 of the Immoral Trafficking (Prevention) Act, most prosecutions take place under section 8. Section 8 prosecutions are undertaken against the trafficked persons and result in further victimization of the victims and trafficked person (Prayas 2004).

5. POLICY – DRUGS

5(a) National drug control framework

Convention adherence

India is a signatory to all three UN drug control conventions, namely, the Single Convention on Narcotic Drugs 1961 (as amended by the 1972 Protocol), the Convention on Psychotropic Substances 1971 and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

Legislation

The broad legislative policy on narcotic drugs and psychotropic substances is contained in the three Central Acts. These are:

- Drugs and Cosmetics Act, 1940,
- The Narcotics Drugs and Psychotropic Substances Act, 1985 (NDPS Act, 1985), and
- The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988.

Amendment to the NDPS Act:
The NDPS Act 1985 was amended with effect from 2nd October 2001. The amendments now incorporated in the Act have brought about significant changes in the penal structure under the NDPS Act 1985 as they have made financial investigations and the forfeiture of illegally acquired property more purposeful. In addition, provisions have been included for new investigative techniques and for removing certain practical difficulties faced by the investigating officers. The amendments are:

a) **Graded punishments:** The amended Act grades punishment into three categories depending on the quantity of drugs seized and also provides for judicial discretion as far as the severity of punishment is concerned. Violations relating to small quantities now attract imprisonment of up to six months or fine or both. Violations in respect of commercial quantities continue to attract a minimum prison sentence of 10 years, which may extend to 20 years and shall also involve a fine of not less than Rs. 100,000 (approx. US$2,100) that may extend to Rs. 200,000 (approximately US$4,200). Any violations involving quantities of drugs more than prescribed the small quantities but less than commercial quantities shall be punishable with rigorous imprisonment for a term, which may extend to 10 years and with fine.
b) **Financial investigations made easier:** The property of a drug offender can, after the amendments be frozen as soon as he is arrested, without waiting for conviction or completion of full period of preventive detention.
c) **Money laundering becomes an offence:** The laundering of illegally acquired property has been made an offence under the Narcotics Act.
d) **Removal of difficulties in compliance with Section 50:** The provisions of Section 50 of the NDPS Act, non compliance of which has resulted in a large number of acquittals, have been made more flexible to cater to the real life situations where it is not practicable to take the person to be searched to the nearest Gazetted Officer or Magistrate without the possibilities of the suspect parting with the drugs.

e) **Controlled deliveries:** Further to facilitate complete investigations and to neutralize the entire syndicate involved in drug trafficking, a provision has been made for the movement of seized drugs from one place to another within and outside the country under controlled conditions.
f) **Ambit of Sections 41 & 42 enlarged to include Controlled Substances and Financial Investigations**: The provisions of search, seizure etc. under sections 41 & 42 shall now be applicable for cases relating to financial investigations and controlled substance as well.

The NDPS (Regulation of Controlled Substances) Order, 1993
While the NDPS Act 1985 contains provisions for the control of precursor chemicals, in 1993, the government of India promulgated the NDPS (Regulation of Controlled Substances) Order, which sets out the detailed rules and procedures governing the manufacture, distribution, trade, import, extort, etc. of specified 'controlled substances'. Presently five substances namely, acetic anhydride, anthranilic acid, N-acetylanthranilic acid, ephedrine and pseudo-ephedrine have been notified for controls under this order. In addition controls are also exercised on imports / exports of a few other chemicals.

Together, the 2001 amendments and the 1993 order constitute substantive compliance with the asset forfeiture and precursor control provisions of the 1988 Convention.

The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act is a preventive detention law. Persons who indulge in drug trafficking can be detained through an executive order passed by designated authorities. The Joint Secretary (Revenue) in the central government is empowered to issue such detention orders. Similarly, relevant authorities are also designated to act in this capacity by the state governments.

Institutions

The Department of Revenue in the Ministry of Finance has the nodal co-ordination role as administrators of the NDPS Act, 1985 and the Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988. The Ministry of Social Justice and Empowerment is responsible for implementing the drug demand reduction programme in the country, mainly through support to NGOs.

The nodal agency dealing with drug trafficking is the Narcotics Control Bureau (NCB) located in the Ministry of Home Affairs. However, officers of the Central Bureau of Narcotics, the Directorate of Revenue Intelligence, Customs, Central Excise, Border Security Force, the Coast Guard and the Police authorities of State governments are also empowered to take action against drug trafficking under the provisions of the NDPS Act, 1985.

The nodal agency for drug demand reduction is the Ministry for Social Justice and Empowerment (MSJE) that implements its programmes mainly by supporting NGOs all over the country. The health, treatment and hospitalisation facilities are the responsibility of the Ministry of Health and the Health Departments of the States and Union Territories.

National Policy

National policy on Narcotic Drugs and Psychotropic Substances is based on Article 47 of the Directive Principles of State Policy, Constitution of India, where the 'Duty of the State [is] to

raise the level of nutrition and the standard of living and to improve public health'. It directs, *inter alia*, that the "…the State shall endeavour to bring about prohibition of the consumption, except for medicinal purposes, of intoxicating drinks and of drugs which are injurious to health". The government's policy on the subject which flows from the above said constitutional provision is also guided by the international conventions on the subject, mentioned under 'Conventions adherence' (Para. 7.1.1) above. However, India does not have a national drug control policy or an apex organization in respect of drug control.

The NDPS Act, 1985 lays down the focus and direction of drug control strategy in the country. This Act made an express provision for constituting a Central Authority for the purpose of exercising the powers and functions of the central government under the Act. In exercise of the powers, the "Narcotics Control Bureau (NCB)" was constituted with Headquarters in Delhi on 17th March 1986.

Though the master plan has not been formally adopted, many of its provisions have been absorbed into subsequent National Five-Year Plans.

5(b) Licit control (drugs and precursors)

Licit control: Licit opium cultivation in India is supervised by the CBN headed by the Narcotics Commissioner. An elaborate control system has been designed to ensure that all opium produced in India is duly accounted for and to prevent its diversion to illicit channels. The main elements of the system are licensing control, with the prescription of Minimum Qualifying Yields (MQY), and government monopoly of purchasing. Strict monitoring measures, including stepping-up test measurements and checking of Preliminary Weighment Registers, have been introduced. The entire licensed harvested crop is procured by CBN, and is processed in its two opium and alkaloid factories at Neemuch and Ghazipur.

Precursors: India has an advanced and large chemical industry which manufactures and uses a wide range of chemicals for legitimate purposes. Some of these chemicals are also precursors or essential chemicals frequently used by the illicit drug industry and are, therefore, susceptible to diversion. India produces 15 precursor chemicals, including acetic anhydride, ephedrine, pseudo-ephedrine, anthranilic acid and N-acetylanthranilic acid. The chemical and pharmaceutical industry manufactures, uses and exports many of the precursors listed in Tables I and II of the 1988 UN Convention. India is a signatory to all the three UN Conventions. It exercises control over precursors under three different laws as follows:

Controls under the NDPS (Regulation of Controlled Substances) Order, 1993: This order issued under Section 9A of the NDPS Act, 1985 requires the manufacturers, distributors, sellers, importers, exporters and consumers of controlled substances to maintain records and file quarterly returns with the Narcotics Control Bureau. It also requires any loss or disappearance of the controlled substance to be reported to the Director General, NCB. **Precursors covered:** Acetic anhydride, Anthranilic acid, N-acetyl anthranilic acid, Ephedrine and Pseudoephedrine. **Enforcement agency:** Narcotics Control Bureau for scrutinizing returns. For violations, any officer empowered under NDPS Act can take action.

Controls imposed under the EXIM policy: The EXIM policy (export-import policy) framed under the Foreign Trade (Development and Regulation) Act, 1992 imposes restrictions on the import and export of goods. Export of seven precursors is subject to a No Objection Certificate and import of three precursors is restricted. **Precursors covered:**

Export of Acetic anhydride, Ephedrine, Pseudoephedrine, Methyl-ethyl-Ketone, Phenyl-2-Propanone,3,4 methylenedioxyphenyl-2-propanone and Potassium permanganate requires a No Objection Certificate from the Narcotics Commissioner. The import of acetic anhydride, ephedrine and pseudoephedrine is restricted in India. **Enforcement agency:** Narcotics Commissioner issues NOC for exports and licences for import of precursors whose import is restricted by the Director General of Foreign Trade.

Controls under Section 11 of the Customs Act 1962: The goods specified under this section are subject to intensive checks in the specified areas by the customs officers. The Government of India has notified acetic anhydride as a specified substance under this section within an area of 100 km. along the Indo –Myanmar border and 50 km. along the Indo Pak border. Broadly, the special measures under this section require all persons who own, possess or control the specified substance to maintain records and notify the Customs officers of the details of quantities held and transported. **Enforcement agency:** Customs.

5(c) Supply reduction

An effective statutory and administrative framework has been set up in India to combat drug trafficking. India complies with the regulations under the various United Nations Conventions and co-operates with countries in the region in supply reduction and law enforcement efforts. India is also signatory to the SAARC Convention on Narcotic Drugs and Psychotropic Substances. The detection and eradication of illicit drug crops is a law enforcement priority.

At the operational level, India's drug law enforcement strategy is coordinated by the NCB and is focused upon: (a) combating trafficking through appropriate intelligence, interdiction and investigative initiatives; (b) eradicating illicit drug crops; (c) preventing leakage from licit opium crop; (d) implementing a regime of domestic and international trade controls over select precursor chemicals; and (e) increasingly targeting assets derived from drug trafficking for confiscation and forfeiture.

5(d) Demand reduction

The Ministry of Social Justice and Empowerment has developed a strategy for Drug Demand Reduction in India. The strategy is based on the conviction that a co-ordinated response of government and non-government organisations is more effective for drug abuse prevention. This is being achieved through the Scheme for Prohibition and Drug Abuse Prevention wherein funds are released to voluntary organisations for setting up/maintenance of counselling and awareness centres. The Ministry is supporting 369 NGOs running 459 (counselling, awareness and de-addiction cum rehabilitation centres). Every year on average in excess of 300,000 addicts register at these centres.

The health, treatment and hospitalisation facilities are the responsibility of the Ministry of Health of the States/Union Territories.

MSJE has drawn up a three-pronged demand-reduction strategy (MSJE 2003) based on the approach that drug abuse is a psycho-socio-medical problem that can be handled through community-based interventions. The three components are:

a) Building awareness and educating people about ill effects of drug abuse.

b) Dealing with addicts through a programme of motivation, counselling, treatment, follow-up and social reintegration.
c) Imparting drug abuse prevention rehabilitation training to volunteers having in view to build up and educated a cadre of drug abuse control operators.

The strategy involves the training of volunteers in drug abuse prevention and rehabilitation and is based on the conviction that a coordinated response of government and non-government organisations is more effective for drug abuse prevention.

This is achieved through the Scheme for Prohibition and Drug Abuse Prevention wherein funds are released to voluntary organisations for setting up/maintenance of counselling and awareness centres, deaddiction-cum-rehabilitation centres, de-addiction camps and for preventive awareness programmes, workplace prevention programme and training of service providers.

The national demand reduction strategy formulated by MSJE is complementary to the national master plan drawn up in 1994. In order to counteract the demand for dependence-producing drugs, the **Scheme for Prohibition and Drug Abuse Prevention**, being launched since the Seventh Five Year Plan as a Central plan Scheme, has been reviewed, restructured and titled "Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse". The revised Scheme was implemented from 1st April 1999 in the light of the approach and objectives envisaged for Ninth Five Year Plan. The Scheme is implemented through registered Societies / Trusts / Companies or the Organisations/Institutions by providing financial assistance to the extent of 90% of the total approved expenditure and in case of the north eastern states, Sikkim, Jammu and Kashmir it is 95%. These organizations are financially assisted for setting up and maintaining counselling and awareness centres and treatment-cum-rehabilitation centres and for organizing de-addiction camps, Awareness programmes and manpower development.

The Ministry of Social Justice and Empowerment is also in the process of drafting its National policy and study for Drug Demand Reduction in India.

The National Youth Policy 2003 (MOYAS 2003) recognizes the vulnerability of young people to substance abuse, STDs and HIV / AIDS and considers these issues as a priority. The Policy, therefore, advocates a two-pronged approach of education and awareness for prevention and proper treatment and counselling for cure and rehabilitation. It further enjoins that information in respect of the reproductive health system should form part of the educational curriculum. The Policy also stresses the need for establishment of adolescent clinics in large hospitals and similar projects in rural areas to address the health needs of young adults. The department of Youth Affairs and Sports, through the National Service Scheme, (NSS) and the NYKs through their volunteers, carry out awareness generation on drug abuse and AIDS. NSS volunteers, (Urban Student Youth), concentrate on the integrated development of adopted villages and slums, and NYK carry out their activities in rural India. No specific policy on drug abuse control has been drawn up as yet in the Health Ministry.

The National Health Policy 2002 (MOHFW 2002) does not specifically mention drug use as a component or concern.

The programme of the National AIDS Control Organisation (NACO), Ministry of Health and Family Welfare recognises that injecting drug use is also one of the major causes for the spread of HIV/AIDS in the country. The NACO's policy document (NACO 2003)

recognises harm minimization measures such as exchange of syringes and needles, peer education, community outreach, access to health services and oral drug substitution, as the appropriate strategy to prevent HIV among injecting drug users, although the policy further recognises that in India the harm-reduction approach is yet to find wider acceptability because of ethical and moral considerations.

An analysis of national policies pertaining to drug use and HIV/AIDS (UNAIDS and UNODC 2000) found that there was no signal from government that HIV/AIDS prevention will be established as a central element of all drug treatment programmes. Although it had become a part of the draft National AIDS Prevention and Control Policy by then, harm minimisation was (and still is) not a part of national drug control policy and strategy. Many drug treatment agencies did not consider HIV intervention as an urgent issue. Several key informants expressed the view that the injecting epidemic that arose in Manipur was substantially influenced by the adoption of harsh anti-drug policies at that time – the so-called "police model." Instances were cited where severe law enforcement resulted in an acute shortage of heroin, prompting many heroin users to shift to injectable buprenorphine, (which, being licit, is relatively easily accessible).

The same analysis also noted that there was also no clear policy on opioid substitution treatment in India. Many government officers were reported to believe incorrectly that UNDCP (now UNODC) was non-supportive of substitution treatment and several NGO representatives expressed the view that this policy stance was hindering progressive policy reform in India.

5(e) Money laundering control measures

The Narcotic Drugs and Psychotropic Substances Act, 1985 contains provisions for tracing, freezing and forfeiting the properties of drug traffickers, their relatives and associates. It provides for tracing, identifying, freezing, seizing and forfeiting of illicitly acquired properties of drug traffickers, their relatives and associates. The definition of "relatives" is quite comprehensive and thus includes all the relatives in whose names traffickers might place drug money. The offence of acquiring properties illicitly under the provision of this act is punishable with imprisonment of 10 – 15 years or more. A quasi-judicial authority entitled the 'Competent Authority' who also decides on whether the frozen properties should be forfeited must confirm the freezing order. While freezing and seizing are techniques of temporary restraint, the process of forfeiture is a process that transfers the title of ownership to the government. The properties can be forfeited only after the person is either convicted or has been detained under PITNDPS Act. One interesting aspect of the law is that the burden of proving that the property is not illegally acquired rests on the charged person. Only properties earned during the previous six years can be frozen and forfeited under this law.

The President of India has signed the Prevention of Money Laundering Act 2002. The Act has ten Chapters. In Chapter II money laundering is defined as an offence punishable with imprisonment for a term which shall not be less than three years but which may be extended to seven years. Chapter III Attachment, Adjudication and Confiscation refers to the attachment of property involved in money laundering, Adjudicating Authorities and the Management of Properties confiscated. Chapter IV spells out the obligations of banking companies, financial institutions and intermediaries. Chapter V explains summonses, searches and seizures. Chapter VI through to Chapter X goes into administrative details regarding the appellate Tribunal, special courts, authorities, reciprocal arrangements for

assistance in certain matters and procedure for attachment and confiscation of property and Miscellaneous.

Other laws: In addition, certain other laws namely (1) the Benami Transactions (Prohibition) Act 1988, (2) the Income Tax Act 1961, (3) the Foreign Exchange Regulation Act (FERA) 1973 and (4) the Smugglers and Foreign Exchange Manipulators (Forfeiture of Property) Act, 1976, also contain provisions for countering money laundering to some extent. The current legislation provides for a holistic approach to matters that perpetuate or result in money laundering. The Foreign Exchange Regulations Act, 1973 (FERA) has been repealed and is replaced by Foreign Exchange Management Act (FEMA). The Directorate of Enforcement is the enforcement authority for the control of crimes relating to money laundering.

5(f) International cooperation

India has hosted an international, regional and bilateral exchange programme under the aegis of UNODC, SAARC, system, ICPO-INTERPOL and Colombo Plan Bureau. Particularly noteworthy are India's contributions in the fields of precursor control and demand reduction. India has entered into bilateral agreements with a number of countries on matters relating to combating trafficking in narcotic drugs, psychotropic substances and precursor chemicals. To date, India has entered into bilateral agreements with several countries including USA, Mauritius, Afghanistan, Russia, Myanmar, Zambia, the UAE, Bulgaria, Egypt, China, Italy, Turkey. These agreements relate to: a) exchange of information/experience of operational, technical and general nature; b) assistance in joint investigations, identification and destruction of illegal drug processing sites/laboratories; c) control over precursor chemicals; d) prevention of money laundering; e) training and measures to reduce demand through prevention; and f) treatment and public awareness activities.

The Government is a signatory to the 1990 SAARC Convention on Narcotic Drugs and Psychotropic Substances.

The UNODC Regional Office for South Asia is located in New Delhi.

6. POLICY – CRIME

Criminal Justice System: The criminal justice system is derived from the British model. Established procedures for the protection of defendants, except in the case of strife-torn areas, are routinely observed. The penal philosophy embraces the ideals of preventing crime and rehabilitating criminals. Courts of law try cases under procedures that resemble the Anglo-American pattern. The machinery for prevention and punishment through the criminal court system rests on the Code of Criminal Procedure of 1973, which came into force on April 1, 1974, replacing a code dating from 1898. The code includes provisions to expedite the judicial process, increase efficiency, prevent abuses, and provide legal relief to the poor. The basic framework of the criminal justice system, however, was left unchanged.

Constitutional guarantees protect the accused, as do various provisions embodied in the 1973 code. Treatment of those arrested under special security legislation can depart from these norms, however. In addition, for all practical purposes, the implementation of these norms varies widely based on the class and social background of the accused. In most cases, police officers have to secure a warrant from a magistrate before instituting searches and seizing

evidence. Individuals taken into custody have to be advised of the charges brought against them, have the right to seek counsel, and have to appear before a magistrate within 24 hours of arrest. The magistrate has the option to release the accused on bail. During trial a defendant is protected against self-incrimination, and only confessions given before a magistrate are legally valid. Criminal cases usually take place in open trial, although in limited circumstances closed trials occur. Procedures exist for appeal to higher courts.

India has an integrated and relatively independent court system. At the apex is the Supreme Court, which has original, appellate, and advisory jurisdiction. Below it are 18 high courts that preside over the states and union territories. The high courts have supervisory authority over all subordinate courts within their jurisdictions. In general, these include several district courts headed by district magistrates, who, in turn, have several subordinate magistrates under their supervision. The Code of Criminal Procedure established three sets of magistrates for the subordinate criminal courts. The first consists of executive magistrates, whose duties include issuing warrants, advising the police, and determining proper procedures to deal with public violence. The second consists of judicial magistrates, who are essentially trial judges. Petty criminal cases are sometimes settled in *panchayat* courts.

Legislation: Under the constitution, criminal jurisdiction belongs concurrently to the central government and the states. The prevailing law on crime prevention and punishment is embodied in two principal statutes: (a) the Indian Penal Code and (b) the Code of Criminal Procedure of 1973. These laws take precedence over any state legislation, and the states cannot alter or amend them. Separate legislation enacted by both the states and the central government also has established criminal liability for acts such as smuggling, illegal use of arms and ammunition, and corruption. As such several Special Laws (applicable to particular subjects[23]) and Local Laws (applicable to particular parts of India) have been enacted from time to time to meet the growing crime prevention needs. All legislation, however, remains subordinate to the constitution.

Human trafficking: In addition to the Indian constitution, which establishes a right against exploitation by "traffic in human beings" (Article 23), the laws which bear relevance to human trafficking are as follows:

1. Indian Penal Code, 1860 – deals with kidnapping or abduction for various purposes including selling and buying and slavery.
2. Child Marriage Restraint Act, 1929 – prohibits marriages of females below 18 years and males below 21 years of age.
3. Child Labour (Prohibition and Regulation) Act, 1986 – sets hours and conditions of work for children under 14 years.
4. Bonded Labour System (Abolition) Act, 1976 – formally frees all bonded labourers, cancels their outstanding debts and prohibits the creation of new bonded labour arrangements.
5. Immoral Traffic (Prevention) Act, 1956 – deals with various aspects related to prostitution.

[23] For example, the Arms Act, the Narcotics Drugs and Psychotropic Substances Act, the Immoral Traffic (Prevention) Act, the Foreign Exchange Maintenance Act and the Prevention of Money Laundering Act. At the same time, several committees have been formed, in order to help in fighting public sector corruption.

6. Juvenile Justice (Care and Protection of Children) Act, 2000 – is invoked to provide care, protection, treatment and rehabilitation to children in need of care and protection as well as those who come into conflict with the law.

Crime control institutions: The constitution assigns responsibility for maintaining law and order to the states and territories, and almost all-routine policing – including the apprehending of criminals – is carried out by state-level police forces. The constitution also permits the central government to participate in police operations and organization by authorizing the maintenance of the Indian Police Service. The Union Public Service Commission through a competitive nationwide examination recruits police officers.

The constitution also authorizes the central government to maintain whatever forces are necessary to safeguard national security. Under the terms of the constitution, paramilitary forces can be legally detailed to assist the states but only if so requested by the state governments. In practice, the central government has largely observed these limits. In isolated instances, the central government has deployed its paramilitary units to protect central government institutions over the protest of a state government.

The principal national-level organization concerned with law enforcement is the Ministry of Home Affairs, which supervises a large number of government functions and agencies operated and administered by the central government. The ministry is concerned with all matters pertaining to the maintenance of public peace and order, the staffing and administration of the public services, the delineation of internal boundaries, and the administration of union territories.

In addition to managing the Indian Police Service, the Ministry of Home Affairs maintains several agencies and organizations dealing with police and security. Police in the union territories are the responsibility of the Police Division, which also runs the National Police Academy and the Institute of Criminology and Forensic Science. The Central Bureau of Investigation investigates crimes that might involve public officials or have ramifications for several states. The ministry also is the parent organization of the Border Security Force.

In most states and territories, police forces are functionally divided into civil (unarmed) police and armed[24] contingents. The former staff police stations, conduct investigations, answer routine complaints, perform traffic duties, and patrol the streets. Since the late 1980s, women[25] have entered in larger numbers into the higher echelons of the Indian police, mostly through the Indian Police Service system.

There are a few Central Law Enforcing Agencies characterized as "Special Investigation Agencies" which also register cognisable crimes, investigate and place results to "normal" or

[24] Contingents of armed police are divided into two groups, the district armed police and the Provincial Armed Constabulary. The district-armed police are organized along the lines of an army infantry battalion. They are assigned to police stations and perform guard and escort duties. Those states that maintain distinct armed contingents employ them as a reserve strike force for emergencies. Such units are organized either as a mobile armed force under direct state control or in the case of district armed police (who are not as well equipped) as a force directed by district superintendents and generally used for riot-control duty.

[25] Women police officers were first used in 1972, and a number of women hold key positions in various state police organizations. However, their absolute numbers, regardless of rank, are small. Uniformed and undercover women police officers have been deployed in New Delhi as the Anti-Eve Teasing Squad, which combats sexual harassment against women ("Eves"). Several women-only police stations have also been established in Tamil Nadu to handle sex crimes against women.

"special" courts for trial. The agencies include the Central Bureau of Investigation, the Directorate of Enforcement, the Central Board of Direct Taxes, the Directorate of Revenue Intelligence, the Directorate of Preventive Operations, the Narcotics Control Bureau, and the Directorate of Income Tax.

Convention adherence

India is a signatory to the Transnational Organized Crime Convention of 2002 as well as the three related Protocols on human trafficking, migrants and firearms. It is also a signatory to the 2003 Corruption Convention.

7. TERRORISM

There are currently a number of sources of activity linked to terrorism in India. These include primarily conflicts between the government of India and groups which have either limited or expansive secessionist aims in some states which border other countries. India has emphasized that terrorist violence being inflicted in many parts of the world emanates from the same extremist sources such as the Al Qaeda network and its range of ideological affiliates which threaten parts of India. The country's problems are compounded by insurgencies and ethnic violence in the Northeast, as well as left-wing extremist (Naxalite) movements in parts of Andhra Pradesh, Jharkhand, Bihar, Chhattisgarh, Madhya Pradesh, Maharashtra, Orissa West Bengal and Uttar Pradesh.

In March 2002, parliament passed the Prevention of Terrorism Act. The two other main pieces of legislation dealing with terrorism are: (a) The Unlawful Activities (Prevention) Amendment Ordinance, 2004; and (b) The Prevention of Terrorism (Repeal) Ordinance, 2004.

Convention adherence

India is a party to all 12 of the universal anti-terrorism instruments related to the prevention and suppression of international terrorism, including the 1999 International Convention for the Suppression of the Financing of Terrorism.

MALDIVES

1. EXECUTIVE SUMARY

- Findings from a rapid assessment in 2003 confirm that opiates (mainly heroin) and cannabinoids (mainly hashish) are the most frequently used drugs. About 8% reported IDU and half of these had started injecting before the age of 17 years. About half reported sharing of syringes 'ever'. A variety of sexual risk behaviours were reported.
- The country is aware of the various factors which may threaten a drug-driven HIV epidemic (sexually active young population, the importance of blood transfusions in public health) and has taken countermeasures.
- Seizures of heroin by Indian and Sri Lankan authorities destined for the Maldives appear eight times the average annual seizures within in the country itself by the Maldivian authorities. Considering the small size of the country, this trend is a matter of great concern.
- The Maldives is very well connected with the outside world through its international airport and sea ports. It is potentially vulnerable as a point for the illegal shipment of precursor chemicals or large quantities of drugs destined for other countries.

2. MAJOR CHARACTERISTICS OF THE COUNTRY RELEVANT TO THE DRUG AND CRIME PROBLEM

In the Maldives, drug trafficking and drug abuse appear to be by-products of the country's recent increased exposure to the outside world. Drug abuse was reportedly not a problem before the mid-1970s. The appearance of drug abuse in its present form seems to have coincided with the development of tourism in early 1970s. This period also witnessed increased overseas travel by Maldivians.

The Maldives is an Islamic society. Legislation pertaining to drug-related crimes is strict. Yet, at the same time, the traditionalism of its value system is under pressure from many sources. First, tourism is at the heart of the modern Maldivian economy, bringing with it a source of new ideas and customs into the archipelago. Second, the country's high birth rate has produced a generally young population – with 40% of people aged below 15 years.[26] Women play a major role in society and hold strong positions in government and business. A large percent of government employees are women. The male-to-female ratio of enrolment and completion of secondary education remains equivalent. Thus, along with a relatively high human development index ranking (currently the highest among the SAARC countries) have appeared a number of social challenges.

[26] Source: *Maldives - Country Health Profile, 2000* accessed at http://w3.whosea.org/

The population of 309,000 is dispersed across an archipelago of 26 atolls with approximately 1,190 small coral islands, 202 of which are inhabited with 87 exclusive resort islands. Thus, despite the high literacy rate, this degree of population dispersal, combined with the high internal migration among the islands, imposes difficulties in communicating health-related messages relating to drugs and, importantly, to HIV/AIDS.

Although the prevalence of HIV is currently deemed low in the islands, there are several forms of social intercourse which may be regarded as risk-related. First, due to the need to move from island to island, many husbands are staying away from families.[27] In addition, despite being an Islamic society, the rate of divorce and remarriage is high with serial monogamy representing an established cultural pattern.[28] The level of sexual awareness among youth in Maldives is also high. Finally, one additional HIV-related concern is the fact that the Maldives is endemic for the disease Thelassemia. As a result of this, patients require frequent blood transfusion raising the issue of HIV/AIDS blood safety. Public health officials are concerned at the potential implications should IDU take hold in the country.

3. DRUG SITUATION

3(a) Production and cultivation

Maldives is not a drug cultivating or producing country. All abused drugs are imported via neighbouring countries by air and sea.

3(b) Manufacture

The Maldives does not manufacture any drugs either legally or illicitly. Its legal requirements are met through imports. As per Section 2 of the Maldives Law on Narcotics, planting, production, import, export, selling, buying, giving, possession, with the intention to sell and being an accomplice in any such activity involving illegal drugs is a crime and attracts life imprisonment.

3(c) Trafficking

In 1993 the first case of heroin was detected. With the introduction of heroin, drug abuse among the young age group escalated dramatically. The first major seizure of cocaine was made in September 1993 at Malé International Airport when 8 kilograms of cocaine was found concealed in the false bottom of suitcases in the possession of a foreign national. In 1997, three Maldivians were discovered to have orchestrated an attempt to smuggle in 1,372 grams of hashish oil in seven professionally packed cans of corned beef while they were about to board a flight to Malé from Trivandrum Airport. In 1998, over 450 arrests were made for drug abuse and related offences. For a small country like the Maldives, these were alarming trends. Despite stringent drug laws, and intensive efforts to prevent drug entry by several agencies, there has been growing concern about the problem of drug abuse.

[27] Source: Maldives AIDS Brief http://www.worldbank.org/mv

[28] See www.health.gov.mv and Jenkins 2000. There is some indication that, as a result of recent legislation imposing more formal requirements on couples intending to divorce, the divorce rate has declined.

Maldives – seizures (in grams)

Drugs	1997	1998	1999	2000	2001	2002
Heroin	461	1,142	360	586	171.32	40.8
Cocaine	-	-	0.3	-	-	-
Cannabis- resin/ hashish oil	1,750	86.81	1.74	621	-	0.8
Cannabis						71.61

Source: MDV Police 2002.

As can be seen from the above statistics of seizures made within the Maldives, the absolute volumes involved are small. Despite this, even in 2002 the Maldivian authorities reported that, "The problem of drug-related offences have now become the most frequent one faced by the Maldivian criminal courts, showing a 200 % increase in recent years. The rapid increase in drug abuse is of great concern to health and law enforcement authorities as the majority of the drug abusers in Maldives are young people between 16 and 30 years. For a small developing country like Maldives where more than 50% of the population is below 16 years of age, this indeed, is an alarming trend" (MDV 2001). Since this report was issued, the perception behind it continues to be a focus of government attention.

It is suspected that a considerable quantity of drugs is smuggled into or through the country via port calls of ocean-going vessels. However, random rummaging of such vessels has resulted in a few seizures. There have been a number of seizures of heroin in India and Sri Lanka which were destined for the Maldives during 2003 and 2004. These are listed below:

Seizures of heroin in Indo-Maldivian sector

Sl. No.	Date of Seizure	Qty. Seized (kg)	No. of Persons arrested	Nationality of arrestee	Agency effecting the seizure
2003					
1	26.04.2003	0.295	2	Indians	NCB, RIU, Trivandrum
2	30.06.2003	0.350	2	Indians	NCB, RIU, Trivandrum
3	23.07.2003	0.440	1	Indian	PNB, Colombo
4	25.07.2003	0.283	1	Indian	NCB, Chennai
5	30.09.2003	0.130	1	Indian	Customs, Trivandrum
6	07.10.2003	0.408	1	Indian	Customs, Trivandrum
7	12.12.2003	0.500	1	Indian	NCB, Chennai
8	13.12.2003	0.750	1	Indian	DRI, Chennai
9	14.12.2003	0785	1	Indian	NCB. Chennai
10	26.12.2003	0.274	1	Indian	Customs, Sri Lanka
2004					
11	23.02.2004	0.160	1	Indian	NCB,RIU, Trivandrum
12	08.04.2004	0.270	2	Indians	NCB,RIU, Trivandrum
13	7.7.2004	1.035	2 1	Indians Sri Lankan	NCB, Chennai
14	14.7.2004	0.111	3	Indians	AIU, Trivandrum

The above seizures amount to 4.215 kg of heroin during 2003 and 1.576 kg during 2004 (to July). During 2003, seizures of heroin by Indian and Sri Lankan authorities destined for the Maldives appear eight times the average annual seizures amount seized in the country itself by the Maldivian authorities (approximately 500 gms). This trend is a matter of great concern especially considering the small size of the islands' population.

Although there is no hard evidence at this time suggesting that the Maldives is a transhipment point for narcotics, international observers and some government officials remain wary about the country's potential to become a transhipment point for smugglers. As the country has a large amount of commerce and traffic via the sea, the customs service and police find it difficult to search all ships.

3(d) Diversion of drugs and precursors

The Maldives is not a producer or exporter of precursor chemicals. Further, given the absence of chemical industries on the islands, the regulation of the importation and use of precursor chemicals is relatively simple. There appears to be no immediate threat of any smuggling of these chemicals for the manufacturing of illicit drugs. Nevertheless, the geographical location and the formation of the country makes the Maldives a potential location as a diversion point for illegal shipments of precursor chemicals or large quantities of drugs intended for another country. The difficulty in policing these areas makes the country even more vulnerable. Under the existing rules prior import authorization must be obtained before such chemicals can be brought into the country. Under the existing control regime, the Ministry of Health receives Pre Export Notifications from various countries and it then notifies the Ministry of Defence and National Security which is responsible for issuing security clearance to the Maldives Customs authorities.

The table below shows a list of precursors imported into the country for licit use during the year 2002.

Substance	Quantity
Acetone	24,751 kg
Hydrochloric acid	7,670 kg
Methyl ethyl ketone	585 kg
Potassium permanganate	233 kg
Safrole	0.03 kg
Sulphuric acid	41,768 litres
Toluene	77 litres

Source: MDV 2002.

3(e) Drug prices

In the Maldives the most commonly abused illicit drug is heroin and the street value of it is Mrf. 100 equivalent to US$ 7.78.

3(f) Demand

The main drugs of abuse in the Maldives are heroin, including the crude form of heroin known as “brown sugar”, and cannabis and its derivatives. Rare cases of cocaine abuse and the use of MDMA or Ecstasy pills have also been reported. Injecting drug use is uncommon.

Based on reports by the Police Headquarters and information from the health care sector, the prevalence of heroin injecting is estimated to be 1% of the drug abusing population.

Rapid Situation Assessment findings: The most recent information on drug abuse in the Maldives is contained from a Rapid Situation Assessment[29] which was conducted by FASHAN (a local NGO) and the National Narcotic Control Bureau (NNCB) in 2003 (FASHAN and NCB 2003). 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.

Two hundred and sixty four drug users, above the age of 16 years and reporting drug use in the previous six months, were interviewed according to a structured interview schedule. Key informants (KIs) and focus group discussions were also held. Most KIs as well as focus group respondents felt that drug abuse was increasing in the Maldives. The mean age of respondents was about 21 years while the mean age of onset of drug abuse was about 17 years. Almost half were below the age of 20 years. About one-third held a job at the time of the interview. About 71% lived in their own house or family home. Most of the respondents (81%) were unmarried. Opiates (mainly heroin) were the drug of initiation for 43% of respondents, followed by cannabis by 34%. Commonly abused drugs (currently) were opiates and cannabis. The use of alcohol, cola water (eau de cologne), inhalants / solvents, and sedatives / hypnotics was also reported. About 8% reported IDU and half of them had started injecting before the age of 17 years. A further 33% had witnessed injecting. About half reported the sharing of syringes 'ever' (i.e., at some point during the drug-using career). A variety of sexual risk behaviours were reported (see details below). Opiates (mainly heroin) and cannabinoids (mainly hashish) are the most frequently used drugs. The most common reason for initiation was peer pressure (38%), followed by a desire to experiment (26%). The findings of RSA highlight the urgent need for the development of multi-pronged strategies in the prevention and treatment of drugs users and better liaison and networking between different agencies.

Prisons: One-third of the respondents in the RSA who had experience of prison reported that they could get drugs within the prison. The report suggests that there are more than 800 drug users currently in prison. A lack of any therapeutic intervention means that very little is done to motivate drug users to quit their habit. The banishment of drug users to different islands was felt to be counter-productive by many key informants since this only displaced the problem from one region to another. There is an expressed need for a model for therapeutic intervention in prisons.

3(g) Costs and consequences

The Maldives government conducted a large-scale situation assessment on HIV/AIDS fairly early in the epidemic, one of the findings of which was drug abuse related sex-behaviour. As

[29] In order to prepare a National Master Plan for Drug Abuse Control in the country, the government sought UNODC assistance in preparing a detailed assessment of the drug scenario in the country. A preparatory mission visited the Maldives in 1999 to prepare guidelines for a Rapid Situation Assessment. UNDP Maldives funded the RSA and the report was formally released in 2003.

a result of this finding, the government conducted a Rapid Situation Assessment on drug abuse and is now in the process of developing a master plan to address the problem.[30]

Adverse consequences of drug use also were reported in the Rapid Situation Assessment cited above, which revealed that 94% of the respondents had reported problems with the law after drug use: 55% of the respondents had been under police lock-up in the previous year, 38% had been jailed and 17% has been jailed in the previous one year.

The Maldives has, to date, enjoyed relative freedom from the HIV epidemic. The majority of HIV cases reported to date have been expatriates, or Maldivians with a history of travel abroad, such as sailors. A recent situation assessment of HIV/AIDS (Jenkins 2000) carried out by the UN theme group on HIV/AIDS in the Maldives points to drug abuse associated sexual behaviours among youth as the single most obvious potential risk factors for HIV. Causes of this link are reported to be the sale of sex for drug money or the exchange of sex for drugs. Under either scenario, the result is frequent partner change and the potential for exposure to HIV infection. The emergence of a drug sub-culture has also been demonstrably marked by language, clothing style and music preferences.

In the RSA (FASHAN and NCB 2003), a majority of the unmarried respondents (75%) reported a sexual experience, and 68% of the married respondents reported an extramarital sexual experience. The age at first sexual experience ranged from 7-24 years, with one-third having been exposed to a sexual experience by 15 years of age and 92% having had a sexual experience during their teenage years. More than one in four respondents reported having had sex with a commercial sex worker. The experience of group sex was reported by 43% of respondents. 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%) of respondents reported consistent condom use.

Thalassemia: The Maldives has the highest incidence of Thalassemia in the world with a carrier rate of 18% of the population. Although the National Thalassemia Centre screens for carrier status among all persons seeking to marry and offers medical termination of pregnancy to couples who are both carriers of this trait, the fact remains that the illness is still prevalent today, though declining. This illness requires frequent blood transfusion services by those affected. The population below 35 years[31] would be that segment of society significantly involved in either the receipt or provision of transfusion services. The existence of IDU (as reported in the RSA) coupled with a high prevalence of Thalassemia calls for assured safe blood transfusion in order to prevent the transmission of HIV. Blood safety cannot be assured as HIV also has a window period and all blood transfused cannot undergo a PCR trace lab investigation. Therefore, it is essential to incorporate this concern and aggressively address drug use, injecting drug use issues and concerns in the country as a shared needle used by a group of drug users may transmit HIV.

[30] The country even made 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 take place for the purpose of research (FASHAN and NCB 2003).

[31] In the Maldives, 48.73% of the population is aged 17 and under. A further 27.52% of the population is aged between 18 to 35.

3(h) Money laundering

The Maldives is not considered an important regional financial centre. The financial sector of the Maldives is very narrowly spread across five commercial banks[32], two insurance companies, a finance leasing company, a housing finance company, two small money transfer services, capital market (Securities Trading floor) and a government provident fund. There are no offshore banks. The Maldives Monetary Authority (MMA) is the regulatory agency for the financial sector. The MMA has the authority to supervise the banking system through the Maldives Monetary Authority Act. These laws and regulations provide the MMA access to records of financial institutions and allow it to take actions against suspected criminal activities. Banks are required to report any unusual movement of funds through the banking system on a daily basis (INCSR 2003). The Maldives is in the process of establishing a Financial Intelligence Unit and to develop legislation on anti-money-laundering and combating the financing of terrorism.

4. CRIME SITUATION

4(a) Main characteristics

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
No. of cases dealt with by courts										
In Male' Courts	4,123	4,039	5,303	5,698	5,583	4,674	4,624	5,053	4,867	5,430
In Island Courts	8,597	8,099	7,651	8,224	9,557	7,974	6,343	6,254	6,686	6,960
Total	12,720	12,138	12,954	13,922	15,140	12,648	10,967	11,307	11,553	12,390
% of cases in Male' courts	32	33	41	41	37	37	42	45	42	44
Cases handled by the High Court										
Cases filed	89	168	175	164	170	212	222	213	197	194
Cases dealt	108	119	156	117	204	203	225	254	205	213
Cases awaiting trial	47	96	116	162	129	138	79	95	87	68
Persons sentenced										
Both Sexes	1,042	1,044	1,171	1,098	1,278	1,745	1,661	2,187	1,898	1,737
Male	569	656	796	806	359	1,396	1,342	1,820	1,579	1,461
Female	473	388	375	292	919	349	319	367	319	276
% of male convicts to total	55	63	68	73	28	80	81	83	83	84

Source: MDV 2003

4(b) Trends

Total crime: The total number of crime cases remained more or less constant at around 4,900 since 1995. However, considering the small population of about 309,000, the crime rate works out to 1,445 per hundred thousand population which is significantly higher than other larger countries in the region (e.g., India, where it is 169 per hundred thousand population). The number of cases in the high courts has also been rising. The average number of cases in the High Court between 1998-2002 was 35% higher than the average number of cases during 1993-1997 which can perhaps be attributed to the easier access to the High Court as the

[32] One international bank, three branches of foreign banks from neighbouring countries and the public owned bank.

population migrates to the capital, Male, from other islands. Maldives belong to the countries with rather high prison population: 414 per 100,000 inhabitants, with a relatively high percentage of female prisoners (ICPS 2004).

Total crime versus drug offences: However, the number of drug offences appears to have grown by at least a factor of two in recent years (MDV 2001). The Maldives is a country where a significant proportion of the population is young and hence the growing share of drug offences is a matter of concern.

Growing crime in Male': The share of Male courts in the total cases has been rising from 32% in 1993 to 44% in 2002. The primary source of employment in the Maldives is tourism, which attracts people from islands to the capital Male, and perhaps also accounts for the emergence of Male as the primary centre of crime in the country.

Gender analysis: The share of males in the total persons convicted has also been steadily rising and increased from 55% (1993) to 84% (2002). The average number of persons convicted has risen by 63% between 1998-2002 compared to the previous five years. Conviction of males increased by 138% while conviction of females declined by 33%.

Type of crime: Crime involving bodily harm such as murder and assault declined by 30% between 1997 and 2002 and crime involving bribery and fraud also declined by 33% during the same period. Maldives, as an Islamic state, prohibits consumption of alcoholic liquor. Offences involving alcohol also declined by 52% between 1997 and 2002. However, offences involving illicit sexual relationships and 'misbehaviour' increased by 43% between 1997 and 2002 while offences involving theft and robbery also increased by about 30% during the same period.

Conclusions: Considering the small population of the country, the Maldives has a high rate of crime and the crime is shifting to the capital, which now accounts for under half of all the crimes committed in the country. Offences involving drugs, illicit sexual relationships, 'misbehaviour', theft and robbery have been rising while other offences have been declining. While the total number of offences has been more or less constant between 1993 and 2002, convictions have risen by 63%. Increasingly more males are being convicted.

5. POLICY – DRUGS

5(a) National drug control framework

Convention Adherence

The Government of the Republic of Maldives has ratified all the three UN conventions related to narcotic drugs, namely, the Single Convention on Narcotics Drugs, 1961 (as amended by the 1972 Protocol), the United Nations Convention on Psychotropic Substances, 1971 and the United Nations Convention against Illicit Traffic in Narcotics Drugs and Psychotropic Substances, 1988.

Legislation

Official recognition of the drug problem came in 1977 when a person was arrested with 350 grams of hashish. As a result, the first principal legislative act of the Maldives dealing with

narcotic drugs and psychotropic substances (Law No 17/77 - The Law on Drugs) was passed the same year in order to help the legal system deal with it, and to act as a deterrent. The Law on Narcotics Drugs (Law No. 17/77) is the principal Legislative Act of the Maldives dealing with narcotics drugs and psychotropic substances. Since the adoption of the Law on Narcotics Drugs, the many social and economic changes brought in the country have resulted in the increase of the magnitude and nature of the problem. Hence, the Government in 1995 introduced substantial amendments to Law No. 17/77.

The First Amendment to Law No. 17/77 (Law on Narcotics Drugs) of 1995 also contains two tables; one is a list of illegal drugs and the other is a list of controlled substances. Both of these tables have been drawn up according to the schedules of the Single Convention on Narcotic Drugs of 1961 (as amended by the 1972 Protocol) and United Nations Convention on Psychotropic Substances, 1971. The First Amendment to Law No. 17/77 makes a significant distinction between users and suppliers. While drug suppliers have been prescribed harsher punishment (provision for prescribing life imprisonment sentences for the manufacture, importation, exportation, sale and possession for sale of narcotic drugs), the amendment looks at users less harshly. They are generally given opportunities to reform and become useful members of the society. Thus they receive suspended sentences and may enter a Drug Rehabilitation Centre. After rehabilitation, they are released on parole for a prescribed period after which the sentence is annulled. The amendment also provides legal immunity for those who opt for voluntary rehabilitation.

Institutions

The establishment of the National Narcotics Control Bureau (NNCB) through a Presidential Decree on the 16th November 1997 has further strengthened the efforts aimed at addressing the issues of drug control. The National Narcotics Control Board is primarily responsible for the co-ordination of demand reduction and awareness building programmes, maintaining communication with international drug control agencies and management of rehabilitation programmes. Further, amendments to the law in 1995 brought the management of the Drug Rehabilitation Centre (DRC), previously under the Ministry of Health, directly under the NNCB.

The primary functions of the NNCB are drug demand reduction, awareness building, management of rehabilitation programmes and maintaining communication with international drug control agencies.

The Drug Control Bureau of the Police Headquarters and Maldives Customs Service together are responsible for illicit drug seizures in the country.

The Ministry of Health plays an important role in demand reduction issues. The main policy making body for the AIDS control programme is the National AIDS Council, a multi-sectoral body of government institutions and NGOs.

National Policy

In the Maldives, where there is no manufacturing, cultivation or production of illicit drugs, the government's anti-drug policy aims at stopping narcotic drugs, psychotropic substances and precursor chemicals from entering the country.

The Government has stated its determination to bring about a reduction in the demand for and the supply of illicit drugs. This was reinforced with the establishment on the 16th November 1997 of the NNCB which is responsible for coordinating demand reduction efforts, management of rehabilitation programmes, and maintaining communication with national and international drug control and law enforcement agencies.

5(b) Licit control (drugs and precursors)

With the absence of chemicals and related industries, the regulation of the importation and use of precursors is not complex. The drug problem in the Maldives is presently restricted to the smuggling of regionally-available opiate and cannabis derivatives and the increasing abuse of the same.

The principal legislative acts that deal with drugs and precursor-related chemicals are Law No. 17/77 (The Law on Drugs) and Law No. 4/75 (The Law on Items Prohibited in the Maldives). Article 2 and Article 3 of the Law on Drugs prohibit the manufacture, in any form of prohibited drugs in the Maldives.[33] It also prohibits the manufacture of controlled substances in violation of the law. These provisions make the importation, supply, possession and sale of chemicals for the manufacture of narcotic drugs and controlled substances, punishable on the same basis as the offence of trafficking.

These laws prescribe heavy sentences for drug offenders, but currently do not cover, to the requisite degree, the trafficking of precursor chemicals.[34] Draft precursor control legislation has now been presented to the Office of the Attorney-General, which, once enacted, will regulate and reinforce the import and distribution of pharmaceuticals including chemicals.

Law No. 4/75H, (The Law on Prohibited Items in the Maldives), already provides in Article 5 that all dangerous chemicals can only be brought into or used in the Maldives with the prior approval of and in the manner prescribed by the Ministry of Defence and National Security. The Ministry has not yet – using the authority under Law No. 4/75H – promulgated regulations to include precursor chemicals in the list of dangerous chemicals falling under the Ministry's special regime.

There has been no known case of illegal importation of precursors used for illicit manufacture of narcotic drugs or psychotropic substances into the country.

5(c) Supply reduction

The control of supply through various enforcement agencies like customs and police has been upgraded and assigned a high priority (MDV Paper 2004).

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[33] As per Section 3 of the Law on Narcotics, the import, export, manufacture and sale of drugs for medical uses requires permission from the Ministry of Health. Violation of this attracts imprisonment ranging from 10 to 15 years.

[34] To address this issue, the government sought technical assistance from UNODC. A senior legal expert who visited the Maldives in 2003 had extensive consultations with government ministries and other concerned departments. The UNODC Precursor Control Project arranged a high level government mission to visit India in 2003 on a study mission to observe current precursor control mechanisms in India.

5(d) Demand reduction

Given the current situation as reflected in the RSA, the Government of the Maldives has stated its determination to take action to protect the youth. Responsibility for drug demand reduction falls under the responsibility of the National Narcotics Control Bureau (NNCB). In the area of primary prevention, the Government has undertaken initiatives to amend the law (cited above) and has instituted an awareness programmes (MDV Paper 2004).

Through the 1995 amendments to Law No. 17/77, which makes a significant distinction between users and suppliers, drug suppliers have been prescribed harsher punishment but the simple users are given opportunities to reform in the Drug Rehabilitation Centre after which they are released on parole for a prescribed period following which the sentences get annulled. The amendment also provides legal immunity for those who opt for voluntary rehabilitation.

The Government of the Maldives has stated that it considers that the enjoyment of the highest attainable level of health is a basic right of every citizen. The National Health Policy of Maldives (MDV 2004) recognises drug abuse as a challenge faced by the country among others such as social stress, environmental health problems and age related problems. The policy envisages addressing these issues appropriately.

A number of Drug Awareness Programmes – aimed at various sectors within the community – are either conducted or organized by the NNCB. An awareness programme is conducted annually for all parents of school children of below Grade 7 in the schools of Malé and other atolls. Life skills and drug awareness classes for students above grade 8 are conducted annually. The Atoll Awareness Programme aims to cover the entire Maldives within the next three years, with programmes conducted in every inhabited island in the country. These awareness programmes target atoll and island chiefs, healthcare workers, teachers and island committee chairpersons. Eleven atolls have to date been covered under this programme. A prevention programme is being planned to run for all Atoll Chiefs and Island Chiefs in Male. The development of youth counsellors for the atolls is also a major concern. Television and radio advertisements about the dangers of drug abuse are routinely shown to the public. Workshops and training programmes are organised to ensure that necessary skills are given to officials of law enforcement authorities, counsellors and staff of NGOs. In the area of secondary prevention, the NCB is providing treatment facilities to drug users. It has recently started the medical detoxification services at its rehabilitation centre at Himmafushi Island. In the area of tertiary prevention, the NCB is rehabilitating the affected individuals. There is a plan to upgrade the facilities at its halfway house. The NCB has also started a training course for counsellors to overcome the shortage of manpower in this area.

Recently the Government has formed a National Task Force in the area of substance use to coordinate and plan various activities (MDV Paper 2004).

The Drug Rehabilitation Centre[35] was officially opened in 1997. A detoxification centre was opened in February 2004. So far it has accommodated 135 clients who are following a prescribed community form of treatment. The government is in the process of expanding the services to include more clients. Throughout the islands, there are currently 161 clients (78 residential; 76 community-based and 7 at the detoxification unit) undergoing treatment for

[35] The Drug Rehabilitation Centre is located on an inhabited island, about 10 kilometres from the capital, Male and can currently accommodate about 120 clients (104 Males, 16 Females).

drug dependence. The clients were mostly referred from the court system but the number of voluntary clients has also increased. To date, a total of 578 clients (471 after completing residential and community-based treatment and 127 following detoxification) have been released.[36] The clients are given a comprehensive treatment programme based on therapeutic community and psychotherapeutic intervention during rehabilitation at the drug rehabilitation clinic. All clients follow the community treatment program. Cognitive behavioural therapy is employed in assisting the clients. Some of the therapeutic programmes included in the daily programmes are anger management, drug education, and problem solving skills and overcoming depression. In addition, a structured daily physical exercise programme is implemented, and various educational and skills workshops are held regularly (MDV Paper 2004). In community rehabilitation, the focus is on relapse prevention, looking at resolving the problems clients face when they return to the community. Community rehabilitation is structured in various stages, allowing the clients to become gradually stabilized and self-reliant (MDV Paper 2004).

The Director-General of Prisons is exploring the possibility of developing a Maldives Model for management of drug dependent prisoners, based on the Therapeutic Community Model of rehabilitation followed in Maldives.

A National AIDS Council and a National AIDS Control Program (Shihab 2001) was established during 1987, with the aim of facilitating full commitment in preventing and controlling the disease. The National Aids Council together with the National AIDS Control Program creates awareness of HIV/AIDS amongst the general population of the country. Steps being taken include: awareness programs conducted for health workers to prepare and enable them to generate accurate and adequate information concerning HIV/AIDS; training of peer educators at schools; conducting group educational activities and information education communication programmes, mostly utilizing the mass media. In addition, sentinel surveillance sites are being set up where laboratory facilities are available. Distribution and availability of condoms at all health facilities and pharmacy outlets are also carried out as a major preventive measure.

5(e) Money laundering control measures

The Law on the prevention and Punishment of Corruption (Law no.2/2000) prohibits corrupt acts and practices by public officials and employees of private companies and prescribes preventive measures for such acts and practices. Section 24 of the said law provides for the forfeiture of proceeds of acts prohibited under the said law and section 25 and 26 of the law empower the investigating authorities and judicial authorities to obtain information relating to accounts of suspected persons and to freeze such accounts through the Maldives Monetary Authority, pending a court decision.

As per section 6 of the Law on Narcotics, acceptance, possession or the use of any money or property which is known to have been obtained through a crime mentioned in the law or which is suspected to have been achieved through the same is a crime. Further, taking any action to conceal the source of income of drug money, for the purpose of hiding the source or to lighten the sentence of a convict is a crime as is being an accomplice in such an activity. These offences are punishable with imprisonment of 10-15 years.

[36] Direct report to UNODC from 2004 NCB database.

5(f) International cooperation

Many workshops and training programmes have been carried out recently with the cooperation of various international agencies to increase awareness among government officials. Customs officials and operational staff from regional airports / seaports met in May 1999 to exchange information on trends of drug smuggling within the region.

In September 2000, the Government of Maldives and UNDP (Maldives) signed a three-year project funded by the Government of Italy to strengthen the drug control programmes in the Maldives. The broad development objective is to protect the youth from drug abuse through drug preventive measures and to provide them skills for productive employment.

The National Narcotics Control Board and relevant law enforcement agencies and NGOs involved in drug prevention, participated in various international forums since 1997 to date.

The Government of the Maldives contributes fully to international initiatives in drug control regarding both control of supply and drug demand reduction.

The Government is a signatory to the 1990 SAARC Convention on Narcotic Drugs and Psychotropic Substances.

6. POLICY – CRIME

The Government of Maldives have concluded extradition agreements with the following countries: the Islamic Republic of Pakistan, the Democratic Socialist republic of Sri Lanka and Federal Republic of Germany.

Convention adherence: India is not a signatory to the Transnational Organized Crime Convention of 2002 nor any of the three related Protocols on human trafficking, migrants and firearms. It is also not a signatory to the 2003 Corruption Convention.

7. TERRORISM

Section 2 of the law on the Prevention of Terrorism in the Maldives (10/90) defines terrorist offences and acts of terrorism. As per the said law, terrorist offences and acts of terrorism include causing and attempting to cause death and bodily harm; instilling fear into a person or the public; kidnapping, hostage taking, hijacking and attempts thereof; the importation, manufacture, possession, use, attempted use, sale or distribution of firearms, ammunition or any type of bombs or explosives without the express permission of the government; and dealing in firearms and related items; and setting on fire or causing damage to any property. According to Section 3 of the said law, provision of funds or material or any form of assistance towards the commissioning or planning of any of the activities specified in the said law are regarded as acts of terrorism.

Convention adherence: Maldives is a signatory to eight of the 12 international terrorism conventions. It has signed the 1999 Convention for the Suppression of Financing of Terrorism.

NEPAL

1. EXECUTIVE SUMMARY

- Nepal is one of the poorest countries in the world. It shares porous borders with India and the resulting free flow of goods and people is used to conceal trafficking in drugs and human beings.
- There are multiple reports of high drug-related HIV sero-prevalence especially among IDUs in the Kathmandu valley (70%).
- Considering the extent of the drug-abuse-driven nature of the HIV epidemic in Nepal, there is a paucity of responses to drug demand reduction. The impact of current harm-reduction initiatives has not been assessed.
- Nepal is a significant source country for women and girls who are trafficked into India for work in brothels and as domestic labour. Some of these women are trafficked onwards to Gulf countries or SE Asia.
- HIV prevalence is high among Nepali sex workers who return to the country from India.
- All the above should be considered in the context of the ongoing political instability. The country is currently trapped in a complex triangular political crisis and protracted civil war involving the monarchy, the political parties and the Maoist rebels with the potential for the Royal Nepalese Army to emerge as a political force.
- The armed Maoist insurgency began in 1996 as a low intensity and mainly rural campaign to replace the present polity with a "people's republic." The conflict has accelerated to a degree where it now affects all parts of the country. This has rendered difficult (and at times, impossible) the work of international aid agencies. This includes operations aiming at limiting the spread of drug-related HIV. The insurgency also has had the effect of limiting the countermeasures required against drug trafficking and the cultivation of illicit crops.
- The armed conflict has caused a deterioration in the trafficking situation. In many cases, women and children who are internally displaced as a direct result of the conflict, leave the conflict-afflicted zones to find jobs as well as protection. Maoist insurgents reportedly abduct and forcibly conscript children to serve in their ranks. A continuation of the conflict runs the risk causing mass migration and the attending threat of trafficking in such internally-displaced populations.

2. MAJOR CHARACTERISTICS OF THE COUNTRY RELEVANT TO THE DRUG AND CRIME PROBLEM

Nepal features among the poorest countries in the world in terms of human development (UNDP 2003). Nepal's human development indicators remain well below the average for the South Asia region: more than 40% of the Nepali population live below the national poverty

line, nearly half of all children below 5 years are underweight and nearly 60% of all adults are illiterate. Additionally, women traditionally have a lower status than men and gender inequality is deeply rooted. Nepal is one of the few countries worldwide in which men live longer than women. More boys than girls receive any form of education. Women generally work longer hours than men. Men have better access to services, including health. In Nepal, the topography, environmental degradation, poverty and economic migration are all linked, and they combine with other factors to increase vulnerability to drug-abuse-driven HIV infection.

3. DRUG SITUATION

3(a) Production and cultivation

Cannabis has been used traditionally in Nepal for centuries. It can be found growing wild in the high hills of the central, mid-west and far western parts of Nepal where crop eradication is very difficult and expensive due to the difficult terrain.

In the southern part of the country law enforcement agencies have, in recent years, carried out eradication campaigns. The Narcotics Drug Control Law Enforcement Unit (NDCLEU) has reported the following destruction figures

Destroyed areas of illicit drugs cultivation (in hectares) (1991- 2004)

Year	Cannabis	Opium	Remarks
1991	1,409	-	-
1992	369	42.67	Young plants of cannabis (ready for cultivation) sufficient for cultivating an area of 47.96 were destroyed.
1993	249	1.42	45,110 cultivated plants of cannabis were destroyed.
1994	82	0.13	23,752 cultivated plants of cannabis and 562 cultivated plants of opium were destroyed.
1995	505	-	-
1996	58	1.80	-
1997	367	0.65	Bhang 0.103 hectare.
1998	54	1.67	-
1999	451	1.68	-
2000	780	0.10	57,584 plants of cannabis were destroyed
2001	56	1.72	
2002	330	11.34	25,639 cannabis plants destroyed
2003	198	19.42	-
2004	126	-	-

Source: NDCLEU

3(b) Manufacture

Nepal does not manufacture heroin, but produces high-quality cannabis resin. Its legal drug requirements are met through imports.

Nepal does not produce any of the precursors scheduled in the 1988 UN Convention.

3(c) Trafficking

Cannabis produced in Nepal is processed into hashish (cannabis resin), which is routinely smuggled into the Indian states of Uttar Pradesh and Bihar. From there it finds its way to

Delhi and Mumbai (NCB 2001; NCB 2002). Current indications are that both trafficking through Nepal and drug abuse within Nepal are on the rise. This appears to be the case especially near the border with India, along the main roads, and in the cities. Shipments of hashish are being intercepted en route primarily to China, India, Canada, the United States and Germany.

Opium and its derivatives (both "brown sugar" and white heroin) and banned pharmaceutical products are brought in to Nepal for local consumption. Much of the heroin available in the country is sourced from India.

In recent years there has been evidence that the Tribhuvan International Airport (TIA) in Kathmandu is being used for the transhipment of drugs, mainly heroin and cannabis. TIA has direct flight connections with Thailand, Bangladesh, India (five destinations), the Middle East (three destinations), Singapore, Hong Kong, China, Bhutan, the Netherlands, Germany, Austria, Russia and the U.K. The improved capacity of the NDCLEU has resulted in a recent increase in drug seizures at TIA, including heroin from Afghanistan and Pakistan, moving through TIA to destinations in Africa and Europe.

Nepal – Seizures (in kg)

Drugs	1997	1998	1999	2000	2001	2002	2003	2004	2005
Heroin	11.0	9.0	1.5	1.7	9.4	3.7	22.7	7.7	4.2
Cannabis /ganja	2,040	6,409	4,064	8,025	4,127	3,320	5,091	1,790	5,143
Hashish	981	2,585	1,671	2,539	694	850	921	1,598	1,387

Source: NDCLEU (note 2005 figures represent to 15 July)

The armed Maoist insurgency has however led to the withdrawal of the police from most rural areas. This compromises the ability of the latter to effect counter-narcotics interdiction. There is evidence that the Maoist insurgents both charge a levy on hashish passing through territory they control and operate a system whereby growers are authorized to cultivate a certain hectareage per year for the payment of a fee.

3(d) Diversion of drugs and precursors

Nepal does not manufacture or export precursors. It imports precursors to meet its requirements. There are no reports of the diversion precursors from licit trade in Nepal. However, there have been seizures of precursors (acetic anhydride) destined for Pakistan via Nepal by air. The geographical location of Nepal between India and China – the two largest producers of ephedrine and pseudoephedrine – as well as its proximity to Myanmar, which has a large illicit demand for these two precursors, makes Nepal crucial in any scheme of precursor control in the region. There is, as yet, no law to regulate precursors. The Nepalese government constituted a committee in 2003 to frame precursor control laws. With assistance from the UNODC Regional Precursor Control Project for SAARC Countries, the team drafted precursor control legislation, which is under consideration. Nepal has been actively participating in all meetings and seminars on precursor control. It has also drafted a national precursor control training strategy with help from UNODC. While there is no evidence of a large-scale diversion of drugs (including pharmaceuticals), codeine-based cough syrups are widely diverted and abused (INCSR 2003).

3(e) Drug prices

The drug prices are more or less in tune with the drug prices in other countries in the region except for cannabis, which is much cheaper than in the neighbouring countries. This can be explained by the extensive wild growth as well as cultivation of cannabis in the country.

3(f) Demand

Drugs such as cannabis and alcohol have been used traditionally in Nepal. The use of cannabis (ganja), when regulated by traditional social norms, appears not to have created major public health problems within the social structure of Nepal. The history of modern drug abuse in Nepal appears to date from the 1960s, when contact with the outside world began to expand. Reported sporadic abuse in the 1960s increased in subsequent decades. The types of drugs or substances abused have expanded from cannabis to synthetic opiates and sedatives-hypnotics, and their modes of administration also changed from smoking or ingesting to injecting (Chatterjee et al 1996).

In the mid-1990s a rapid situation assessment was conducted at different sites, including eight municipalities in the five development regions of the country (Chatterjee et al 1996) using methods such as semi-structured interviews, in-depth interviews and focus group discussions. The sample was recruited from the community, from treatment centres and from prisons. Additionally, secondary data from treatment centres and prisons was also analysed. The study revealed that most of the drug users were young adult males. More than one-third of the subjects in the sample were unemployed and one-fifth were students. Only about 29% were married. A large majority (90 per cent) of the drug users resided with their families. Apart from tobacco and alcohol, the major drugs of abuse were cannabis, codeine-containing cough syrup, nitrazepam tablets, buprenorphine injections and heroin (usually smoked, rarely injected). The commonest sources of drugs were other drug-using friends, cross-border supplies from India or medicine shops. A clear trend towards the IDU was noted among users who smoked heroin or took codeine cough syrup. The reasons cited for switching to injections were the unavailability and rising cost of non-injectable drugs and the easy availability and relative cheapness of injectables. The authors recommended cost-effective drug treatment and HIV prevention programmes for IDUs urgently.

Another RSA was conducted in 1999 in most of the urban areas of the southern part of the country, Kathmandu and Lalitpur, as well as the tourist area of the Pokhara valley (FHI 1999). It reported that among the 1,108 current drug users interviewed more than two-thirds had started taking drugs below the age of 20 years. At the time of interview, the majority of drug users were taking buprenorphine, nitrazepam, codeine-containing cough syrup and herbal cannabis. In the sample, about 73% of drug users were IDUs, 65.1% of whom freely shared injection equipment with others. On the basis of key informant interviews with government officials in Nepal this RSA estimated the total number of drug users in Nepal to be between 40,000 - 50,000.

Street children have also been noted as a group vulnerable to drug abuse and HIV/AIDS in Nepal. Dhital et al (2002) conducted a study on alcohol and drug abuse among 180 street children selected at six urban sites. The findings revealed that more than two-third of such boys had ‘ever’ taken alcohol while 40% of such girls had ‘ever’ taken it. Overall, more than

one-third of respondents had taken alcohol within last one month. One-quarter of the respondents had 'ever' taken drugs, while the figure for current users was about 20%. The most commonly used drug was cannabis, followed by inhalants, tranquillizers, opiates and heroin.

In Nepal, the total number of prisons is 73. The capacity of these prisons ranges from 15 to 1,500 prisoners, out of which the majority are male. Nepalese prisons come under the purview of the Ministry of Home affairs and the Prison Management Department. The prison population rate in Nepal is low (in 2002, 29 prisoners per 100,000 inhabitants), but there is an overcrowding problem at the level over 40% of official capacity (ICPS 2004). Twelve percent of prisoners in the Nepalese prisons are there for drug-related offences. The drug-related offences committed in Nepal are illegal production, sale and distribution, export and import of drugs, storage and consumption of drugs and chemicals. The major drug problem at present is that drug dependents do not receive regular treatment and rehabilitation and no psychiatrists are available in the prisons.

3(g) Costs and consequences

The literature describes various adverse consequences of drug use in Nepal. Chatterjee et al (1996) reported adverse economic consequences of drug use in the RSA. Various high-risk behaviours have been observed among drug users in Nepal. About one-half of the injecting drug users commonly reported sharing injecting equipment which had been inadequately cleaned with water (Chatterjee et al 1996). Notably, among those IDUs operating in a region which witnessed a functional needle exchange programme, a much smaller proportion reported the sharing of equipment. Although an overwhelming majority (99.4 per cent) of the respondents reported some knowledge of HIV/AIDS, a significant prevalence of high-risk sexual behaviour was found. About one-third of respondents reported last sexual activity with casual sex partners, mostly commercial sex workers.

Similarly, in the 1999 RSA (FHI 1999), most of the respondents (72.2%) admitted to premarital sex with multiple partners and most of these sexual encounters (64.7%) had been without a condom. At the time of interview, 51.7% admitted to unsafe sex, with more than one sexual partner. Among the entire group of drug users interviewed, 8.1% of the non-drug injectors were found to be HIV positive, whereas among injecting drug users, the prevalence was 40.4%.

A situation analysis of HIV/AIDS in Nepal (largely qualitative) also noted the increasing number of IDUs in Nepal, their vulnerability to high-risk behaviour and increasing prevalence of HIV among IDUs (Pokharel et al 2000). The report also noted with concern, inadequacy of harm-reduction initiatives in Nepal.

In another study examining the risk behaviours of male IDUs in the Kathmandu valley (CREHPA 2002), 41 out of 63 respondents shared both syringes and drugs with their group members currently while another 22 reported that they used to share earlier. Most respondents shared with two or three members of their groups. The specific sharing partners varied from day to day within the groups. About two-thirds of the unmarried respondents had sexual relations with multiple partners such as sex workers, girlfriends, female IDUs, and foreigners (tourists). Out of 34 unmarried men, 12 reported their last sex partner to be a sex worker and 11 reported it to be their girlfriend. Out of the 63 informants, 18 reported that

they had indulged in group-sex, an activity during which condom use was reported to be particularly low. The majority of IDUs reported that they did not use condoms consistently.

A high HIV prevalence among IDUs in Nepal is seen as a matter of concern. Nepal has entered the stage of a "**concentrated epidemic**", with HIV/AIDS prevalence consistently exceeding 5 percent in high-risk groups (World Bank 2003). In Nepal, IDUs are seen as a major high-risk group, among others such as sex workers. Migration and trafficking to neighbouring countries, such as India, is also seen as high-risk factor for HIV/AIDS vulnerability in Nepal. Nepal has witnessed rapid increases in HIV prevalence rates among sex workers and IDUs in recent years (World Bank 2002).

An analysis (Hellard and Hocking 2003) of secondary data on the relationship between HIV, sex workers and IDUs in Nepal reported a steadily increasing prevalence of HIV among IDUs throughout the 1990s. Regarding the relationship between IDU and sex work, the authors reported that 12% to 58% of female IDUs had at some time worked as sex workers. In this sub-group the prevalence of HIV was estimated to be 75% to 80%. Factors associated with an increased risk of HIV among sex workers include being street-based, having undertaken previous sex work in India, or a history of injecting drugs. This review also identified that a high proportion of IDUs visit sex workers and often had sex without using a condom.

The sudden rise in HIV prevalence among IDUs in Nepal in the recent past has highlighted the need for reaching out to a critical mass of IDUs in any city/country with adequate safer injecting options, as part of a comprehensive package of drug demand reduction options, once an effective mechanism for outreach to IDUs is developed.

3(h) Money laundering

There is no law criminalizing money laundering in Nepal. While Nepal is not a major financial centre for money laundering, an informal alternative system of remittance (called hundi-hawala) does exist (INCSR 2003). The casinos in Kathmandu are also known to be used by individuals trying to launder black money.

4. CRIME SITUATION

The trends in different categories of crime are provided in the table below:

CRIME IN NEPAL				
	2001-02	2002-03	2003-04	% difference 2003-04 and 2001-02
Murder, homicide, attempted homicide and accidental deaths	2,568	2,776	2,606	1.48
Suicide	2,329	2,409	2,096	-10.00
Organised and financial crime	864	1,084	876	1.39
Social crime	1,552	1,487	1,325	-14.63
Crime against women and children	246	327	317	28.86

Traffic accidents	2,150	2,240	2,083	-3.12
Other crimes	421	355	396	-5.94
Total	10,130	10,678	9,699	-4.25

Source: Nepalese Police Force

General crime trends: On an average, about 10,000 crimes are committed every year in Nepal of which murders, homicides, attempted murders (26.1%), suicides (22.0%) and traffic accidents (21.2%) account for 69.7%. The total number of crimes committed declined marginally by 4.3% during the two years for which the most recent statistics are available. Social crime (a term used in Nepal for offences related to public property, citizenship, etc.) declined (by 14.63%) followed by suicides (10%). In fact, there has been a steady decline in the social crime during the period while suicides increased marginally during 2002-03 before declining in 2003-04. However, murders and homicides (1.5%) and organized and financial crime (1.4%) grew marginally.

Crime rates: The overall crime rate per 100,000 population in the country was 42.2 (2001-02) 44.4 (2002-03) and 40.4 (2003-04) during the three years under review.

Crime against women: In stark contrast to the general decline in crime in Nepal during the period, crime against women and children rose by almost 30% during the period. These include rape, attempted rape and trafficking, etc. This trend is similar to the trends observed in other countries in South Asia where crimes reported against women have been rising much faster than average crime. This trend may be due either to an actual increase in crime or due to greater willingness among women to report crime as the society becomes increasingly open**.**

Murders and homicides: The rates of murders and homicides have been 3.02(2001-02), 3.00 (2002-03) and 3.99 (2003-04). The average rate of murders plus homicides thus works out at 3.66.

Corruption

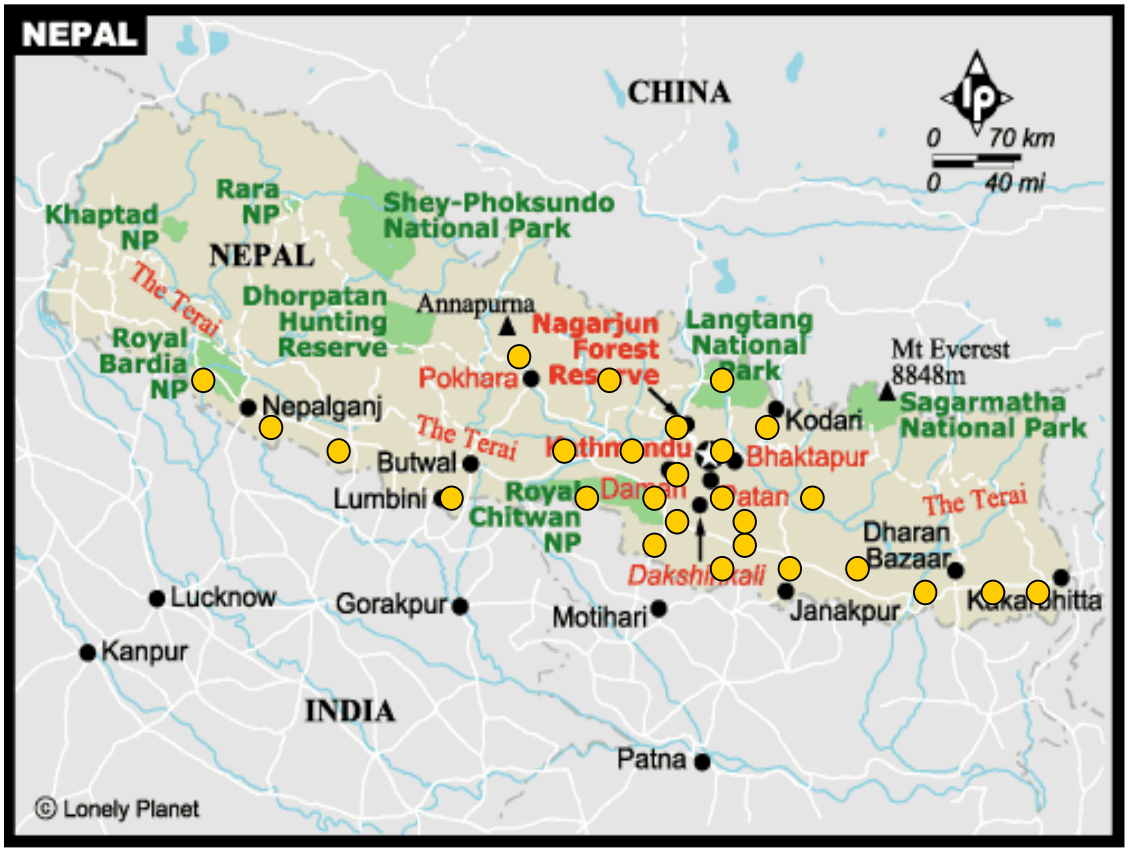
In the first comparative study of corruption in South Asia examining what users of key public services actually experience, respondents in Nepal considered the land administration to be the most corrupt public agency, followed by the customs department, police and the judiciary (TI 2002). About 48% of those who had used the services of the police said they had faced corruption. The figure for the judiciary was 42%.

Trafficking in Human Beings

Nepal is a source country for women and girls who are trafficked into India for primarily for work in brothels. Some women and children are also trafficked for the purpose of domestic work and other forms of forced labour, often to neighbouring countries and to countries in the Gulf region. Some of these women are trafficked onwards to SE Asia. It is estimated that between 100,000 – 200,000 Nepalese women and girls are currently working in the brothels of India (ADB 2002). Of these, approximately 25% are below the age of 18. Estimates of the number of women and girls trafficked annually range from 12,000 (for the purpose of sexual exploitation) contained in an ILO report (Kumar et al 2001) to the commonly recycled figure of 5,000 – 7,000. Many women and girls are also internally trafficked from rural areas

across Nepal to be sexually exploited in so-called cabin restaurants, massage parlours or in street prostitution.

Most of the trafficking occurs through false promises by recruiting agents, but there is also evidence of a pattern in Nepal where families send their daughters to work in brothels in India. Anecdotal reports indicate that this practice is decreasing. Some NGOs cite an absence of shelters and legal and public policies to combat male violence against women and girls as one important underlying reason for the trafficking especially in women and girls. According to this perspective, women and children flee their family homes as a result of having been subjected to different forms of violence such as physical, sexual and emotional abuse by male relatives, to an uncertain future, often in urban areas, where they risk being recruited and trafficked for prostitution purposes or for forced labour within Nepal or to other countries in the region (Ekberg and Manandhar 2005).



The government of Nepal has identified 26 (of a total of 75) districts as 'vulnerable' to human trafficking i.e., where women and girls have disappeared or to which they have returned following a trafficking experience. These are depicted above in yellow dots.

The ongoing internal armed conflict has caused a deterioration in the trafficking situation. In many cases, women and children who are internally displaced as a direct result of the conflict, leave the conflict-afflicted zones to find jobs as well as protection (Ekberg and Manandhar 2005). Maoist insurgents reportedly abduct and forcibly conscript children to serve in their ranks.

Both at the central and district levels, the Ministry of Women, Children and Social Welfare provides funds for NGO-based efforts to provide victim rehabilitation and assistance. There are also high-profile NGO-based awareness campaigns in place assisted by the government and Unifem. All workers intending to travel abroad are required to attend an orientation session where they are informed of their rights and the risks they may face.

5. POLICY – DRUGS

5(a) National drug control framework

Convention adherence

The Government of Nepal has ratified the two UN Conventions related to narcotic drugs, namely, the Single Convention on Narcotics Drugs, 1961 (as amended by the 1972 Protocol) and the United Nations Convention against Illicit Traffic in Narcotics Drugs and Psychotropic Substances, 1988. Nepal is still not a party to the 1971 Convention.

Legislation

In Nepal, the Narcotic Drugs Control Act, 2033 (1976) is the legal framework for drug control issues. Section 3(a) stipulates narcotic drugs as: cannabis, medicinal cannabis, opium, processed opium, plants and leaves of coca, any substance prepared with mixing opium, coca extract which include mixtures or salts, any natural or synthetic narcotic drug or psychotropic substance and their salts and other substance as may be specified by the Nepal Gazette notification. Any person violating this act shall be punished by up to life imprisonment and a fine. While the non-physician-prescribed consumption of narcotics drugs is a criminal offence the Act makes provision for the prevention and treatment of drug users. Rules under this Act have, as yet, not been framed.

The Narcotic Drug Control Act from 1976 was subject to a comprehensive and important amendment in 1993. The Act was revised by the Ministry of Home Affairs and reviewed by the Ministry of Law. The amendment which came into force on 14 June 1993 included: (i) incorporation of the SAARC convention of 1992 on Narcotics Drugs and Psychotropic Substances[37]; (ii) inclusion of the provisions of the 1961 Single Convention (including the 1972 Protocol amending that Convention) and the 1988 UN Convention on Illicit Trafficking of Narcotic Drugs and Psychotropic Substances; (iii) legalisation of controlled delivery; (iv) increased penalties for drug offences; (v) an asset seizure section; (vi) a section on money laundering (including a bank secrecy act); (vii) legislation of advanced investigation techniques and methods of gathering evidence such as wire tapping (including room and telephone bugging) and surveillance photography; (viii) authorisation of NDCLEU to prosecute drug law offences; (ix) a reward scheme; and (x) the destruction of seized drugs.

Following these amendments, discussions were held during the period 1994-1995 between UNDCP and HMGN regarding the formulation of separate legislation in the areas of money laundering, asset forfeiture and criminal conspiracy. Terms of Reference were developed for

[37] The SAARC Convention provides for regional information sharing and extradition of drug-related offences even in the absence of formal extradition treaty.

a UNDCP legal mission for finalising these matters. A legal consultation mission to Nepal was carried out. Working together with a government lawyer with considerable experience in narcotics control, the mission successfully drafted: (i) an amendment to the Narcotics Drug Control Act; (ii) a Witness Protection Act; (iii) a Mutual Legal Assistance Act; (iv) a Crime Proceeds Act; and (v) a Controlled Chemicals, Equipment and Materials Rule Act. The draft bills were translated into Nepali by a local translator and submitted to HMGN for consideration. The Ministry of Home Affairs however considered the bills to be too complex in their draft form and therefore deemed them not suitable for local conditions in Nepal.

Institutions and national policy

The Department of Narcotics Control and Disaster Management, under the Ministry of Home Affairs (MoH) has overarching responsibility for narcotics issues in Nepal. The MoH has established a National Co-ordination Committee for Drug Abuse Control (NCC) under the chairmanship of the Home Minister. This includes the Secretaries of Home, Health, Finance, Education, Foreign Affairs and Communications, together with the Inspector General of Police, Members and Secretary of the Planning Commission, and members of NGOs and other professional organisations. Generally, it has met less than once a year. Below the NCC is an Executive Committee, of which members include joint secretaries from the ministries of Education, Finance, Law and Justice, Health, and Women and Social Welfare, a Deputy Inspector General of Police (DIGP), National Project Director of the Drug Abuse Demand Reduction Project, and the Chief of the National Drug Control Law Enforcement Unit (NDCLEU). This committee meets more regularly than the NCC, and is working towards closer co-operation and co-ordination of national efforts, and a strengthening of management procedures, policy and strategy.

The NDCLEU is a specialized unit assigned to function on all narcotic drug related operational and investigative matters. The NDCLEU specializes in undercover operations, international joint investigations, and coordination with international law enforcement agencies.

The Customs Department of HMGN is also one of the main drug law enforcement agencies. At present there are 22 customs points in the country including Tribhuvan International Airport in Kathmandu.

5(b) Licit control (drugs and precursors)

Nepal does not produce any of the substances scheduled in the 1988 UN Convention. The country has, however, been used as a transit point to traffic narcotic drugs and precursor chemicals to neighbouring countries where drugs are illicitly manufactured. His Majesty's Government of Nepal (HMGN) has established an Inter-departmental Coordination Committee on Precursor Control (ICCPC). Besides the substances in Table I of the 1988 Convention, seven precursor chemicals listed under Table II are being regulated and controlled for importation and consumption. Precursor Control Rules and Regulations have been drafted to regularise importation, storage, transportation, distribution and consumption.

5(c) Supply reduction

In Nepal the policy of supply reduction is laid down in the Narcotic Drugs Control Act 1976 which was amended in 1993. The Master Plan designed with the assistance of UNODC indicated, as a long-term objective, "To contain and reduce the disruptive effect and damage to individuals, families and the social fabric of society caused by drug abuse and illicit trafficking".

5(d) Demand reduction

In 1992 the Ministry of Home Affairs in cooperation with UNODC formulated a master plan for Drug Abuse Control, which is still in operation. The Master Plan includes the key areas of national drug control administration, legislation, law enforcement, preventive education, treatment and rehabilitation.

In Nepal the policy of demand reduction is laid down in the Narcotics Control Act 1976 which was amended in 1993. The long-term objective for drug control is "To contain and reduce the disruptive effect and damage to individuals, families and the social fabric of society caused by drug abuse and illicit trafficking".

The Ministry of Home Affairs through the Community Recovery Centre conducts treatment and rehabilitation programmes in prison for drug addicted prisoners. Carrying out counselling, treatment programmes and skill development programmes for prisoners involves non-Governmental Organizations in Nepal in minimizing the use of drugs. Community Based Organizations are involved in carrying out anti drug programmes at schools and the community in Nepal.

According to the National Drug Demand Reduction Strategy (Shakya 2004), the Government of Nepal has adopted a two-pronged approach: Preventive Education and Information Strategy and Treatment and Rehabilitation strategy. Regarding the former, the strategy envisages communication of drug abuse prevention messages in the formal as well as non-formal educational sectors and through the use of mass media. Regarding the latter, the strategy envisages provision of detoxification, after-care and rehabilitation services for all drug users at primary, secondary and tertiary levels of care, including the government, NGO and prison based services. The strategy, importantly, also supports harm reduction procedures including substitution treatment.

The HIV/AIDS programme in the country is part of the activities of the Ministry of Health. The national coordinating body for HIV/AIDS prevention and control is the National AIDS Coordination Committee (NACC), which is chaired by the Health Minister. There is a need for closer cooperation between the Ministry of Home Affairs and Ministry of Health in matters relating to drug-related HIV/AIDS.

The National AIDS Prevention and Control Programme (NAPCP) was established in 1987.

Nepal was, indeed, the first developing country in which an NGO established a "harm reduction" programme with needle exchange for IDUs. The National HIV/AIDS strategy of Nepal (National Centre For AIDS and STD Control 2002), recognized IDUs as the population sub-group in which HIV threatened to rise most rapidly and expressed concern that neither governmental nor non-governmental capacity and policy were positioned to

mount an effective response. The strategy lays down emphasis on creation of an enabling environment, harm reduction (including drug substitution), care and support of seropositive IDUs and their partners, and demand reduction (i.e. IEC based prevention programmes).

An analysis of policy issues in Nepal was under taken as a part of a UNODC ROSA project (Shakya 2004). The highlights emerging from the analysis were as follows:

- A balanced approach to harm reduction, especially regarding needle exchange is lacking between the Ministry of Health and the Ministry of Home.
- Government has been slow to provide resources and to implement comprehensive harm reduction programmes.
- NGOs have implemented harm reduction and community outreach initiatives but they are too few and too limited in scale to reach the majority of those in need and to have a major impact on the epidemics.
- There is a fear in the mind of some policy makers that syringe exchange might increase addiction among the youth.
- A minimum standard of services should be fixed for organizations involved in service delivery.

An analysis of national policies pertaining to drug use and HIV/AIDS (UNAIDS and UNODC 2000) found that the responsibility for drug policy planning in Nepal resides solely within the Ministry of Home Affairs, which had not, till then, placed substantial emphasis on the public health aspects of drug abuse. Many senior officers within the Ministry of Home Affairs saw needle and syringe exchange treatment as being against the law and counterproductive. It was further observed that the legal situation pertaining to the use of methadone for purposes of drug substitution treatment was unclear and although government was supportive in a limited and non-formalized sense, there was no written policy on the matter.

5(e) Money laundering control measures

Current provisions under the Foreign Exchange (Regulation) Act, 1982, are not adequate to deal with sophisticated and complicated financial crimes such as money laundering and the investigation of drug proceeds. There is also no ceiling for money transactions in Nepal. HMGN has drafted a Money Laundering Act but this has not to date been approved. The Department of Narcotic Control and Disaster Management has meanwhile initiated a Proceeds of Crime Act which is currently under consideration.

Agencies, which have the authority to investigate financial offences, include Nepal Rastra Bank, Revenue Investigation Department, Special Police Department, NDCLEU and the Commission for the Investigation of Abuse of Authority. The multiplicity of agencies, lack of sharing of criminal intelligence, and division of authority for financial investigation and drug crime investigation between different ministries result in a very low detection rate of money laundering and related crime.

5(f) International cooperation

Nepal is actively participating in international and sub-regional meetings and conferences. Drug Liaison Officers from USA, Germany and UK visit the country regularly for exchange of information and to make assessment of drug problems.

The Government is a signatory to the 1990 SAARC Convention on Narcotic Drugs and Psychotropic Substances.

6. POLICY – CRIME

Criminal justice system: The constitution promulgated in 1990 reorganized the judiciary, reduced the king's judicial prerogatives, and made the system more responsive to elected officials. Under the new system, the king appoints the chief justice of the Supreme Court and the other judges (no more than 14) of that court on the recommendation of the Judicial Council. Beneath the Supreme Court, the constitution established 54 appellate courts and numerous district courts. The king on the recommendation of the Judicial Council also appoints the judges of the appellate and district courts.

The Judicial Council, established in the wake of the pro-democracy movement and incorporated into the constitution, monitors the court system's performance and advises the king and his elected government on judicial matters and appointments. Council membership consists of the chief justice of the Supreme Court, the minister of justice, the two most senior judges of the Supreme Court, and a distinguished judicial scholar. All lower court decisions, including acquittals, are subject to appeal. The Supreme Court is the court of last resort, but the king retains the right to grant pardons and suspend, commute, or remit any sentence levied by any court.

Crime control institutions: Nepal's police system owes its origins to the Nepal Police Act of 1955. Besides defining police duties and functions, the act effected a general reduction in the size of the police force and a complete reorganization of its administrative structure along Indian lines. At the apex of the system is the Nepalese Police Force, centrally administered by the Ministry of Home Affairs. The Central Police Headquarters, commanded by the inspector general of the Nepalese Police Force, has a criminal investigation division; intelligence, counter-intelligence, motor transport and radio sections; a traffic policy branch; and a central training center.

Human trafficking: The Human Trafficking Control Act of 1986 is the main piece of legislation currently in place. It criminalizes the trafficking in human beings. There is in place a National Plan of Action against Trafficking in Children and Women for Sexual and Labour Exploitation. Through this document, Nepal has had the first plan of action against trafficking for all South Asian states. The government had also prepared an anti-trafficking Bill, which, due to the suspension of the Parliament, is yet to be enacted. The current extradition treaty with India does not cover trafficking. There is also no provision for repatriation in the current legislative framework. Thus if Indian NGOs rescue trafficked victims, there is currently no legal process to be used to return them to Nepal. In August 2002, the Office of the National Rapporteur on Trafficking in Women and Children (ONRT) was established as a three-year project at the National Human Rights Commission (NHRC) in Nepal through a Memorandum of Understanding between NHRC and the Ministry of Women, Children and Social Welfare (MWCSW). This initiative is the first of its kind in the South Asia region. The ONRT started its operations in January 2003 (Ekberg and Manandhar 2005).

Corruption: The legislature has amended the Anti-Corruption Act and made one of the constitutional bodies – the Commission for Investigation of Abuse of Authority – stronger. In February 2005, the king created an extremely powerful anti-corruption body through an emergency order. It is a six-member Royal Commission on Corruption Control (RCCC). The RCCC has the power to investigate and indict suspects, hear cases and order sentences in relation to smuggling, revenue-related crimes, irregular contracting procedures and kickbacks, and 'any other act deemed to be corruption under existing laws'. The rules for the RCC were approved in March 2006. In April 2006, the king extended the term of the RCCC through a separate order under Article 127 of the constitution which allows him extraordinary powers to remove obstructions to the implementation of the constitution (EIU Nepal 2005).

Convention adherence: Nepal is a signatory to the Transnational Organized Crime Convention of 2002 but not the three related Protocols on human trafficking, migrants and firearms. It is also a signatory to the 2003 Corruption Convention.

7. TERRORISM

Currently the main source of activity linked to terrorism in Nepal is the Maoist insurgency which is responsible for hundreds of deaths of security personnel and civilians.

The key pieces of national legislation against terrorism were both promulgated as ordinances in 2001: (a) the constitution's emergency provisions and (b) the terrorism ordinance. There is no law against terrorist funding.

Convention adherence: Nepal is a party to five of the 12 international instruments related to the prevention and suppression of international terrorism. It is not a party to the 1999 International Convention for the Suppression of the Financing of Terrorism.

SRI LANKA

1. EXECUTIVE SUMMARY

- Sri Lanka does not cultivate opium. There is illicit cultivation of cannabis. Seizure figures demonstrate that the number of arrests and court cases have both increased in the recent past.
- The single most significant drug problem is the trafficking of heroin from India for local consumption.
- Sri Lanka serves as a transhipment hub for heroin trafficked into the country mainly from Indian locations.
- Long-standing violence and political tension has diminished the ability of law enforcement to address drug trafficking concerns adequately.
- It is estimated that there are currently about 45,000 regular users of heroin and about 600,000 users of cannabis in Sri Lanka. It is further estimated that between 1–2 % of heroin users are IDUs.
- Sri Lanka is a low HIV-prevalence country. There appears to be little IDU in the country. National authorities are making efforts to ensure that this situation remains the case.
- There are rising levels of crime caused by army deserters and other criminal gangs (even before the anticipated formal demobilization of some troops which may only worsen the situation).
- With the ongoing peace process there is a risk that individuals with few skills to maintain a sustainable livelihood other than in a military or paramilitary setting may become involved in drug use or trafficking or other criminal activities.

2. MAJOR CHARACTERISTICS OF THE COUNTRY RELEVANT TO THE DRUG AND CRIME PROBLEM

Sri Lanka was one of the first developing nations to demonstrate the importance of investing in human resources and promoting gender equality. Educational achievements include primary education completion rates of nearly 100 percent. Sri Lanka's literacy rates – for adults and children – are on par with the more developed countries of the world. As a result, along with the Maldives, it features the highest human development rates in SAARC. These are attributes, which can be used to convey effective drug use preventive messages in the school context.

The social and economic cost of the conflict since 1983 has retarded the country's development potential. The overall impact of two decades of conflict on the country’s public sector institutions and governance has not been determined.

3. DRUG SITUATION

3(a) Production and cultivation

Opium poppy is not grown in Sri Lanka. Cannabis is cultivated on a large scale in the provinces of eastern and southern Sri Lanka. A total quantity of 73,714 kg of cannabis was detected in the year 2003 compared with 25,834 kg in 2002 (NDDCB 2003). The Sri Lankan Excise department and the police have been conducting eradication campaigns periodically to curtail the cultivation of cannabis. The estimated land area under cannabis cultivation is 500 hectares (ARQ 2003).

3(b) Manufacture

There is no evidence of the ongoing illicit manufacture of drugs in Sri Lanka. In the early 1980s an attempt to manufacture heroin in Hikkaduwa was foiled by police and the laboratory destroyed (SRL 2002). Since the island produces no opium, the seizures in 2002 and 2003 of quantities of opium (see the table below) would therefore lend credence to the view that there are efforts underway to manufacture heroin on the island. More circumstantial evidence appeared in July 2004 in the form of unconfirmed press reports that opium was being smuggled to Sri Lanka for the purpose of manufacturing heroin.[38]

Sri Lanka also does not manufacture any precursors.

3(c) Trafficking

Seizures (in kg)

Drug	1997	1998	1999	2000	2001	2002	2003
Heroin	55	57	68	94	102	63	54
Cannabis herb	113,238	24,825	80,000	37,550	77,021	25,834	73,714
Hashish/cannabis resin	18	N/A	0.2	0	0	0	0
Opium				36.4	1.7	16.7	3.9
Cocaine					0.640		

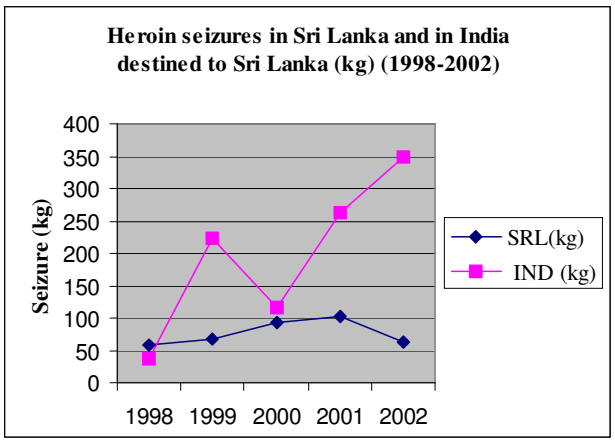
Source: NDDCB 2003

Heroin: Over the past decade, Sri Lanka has been used as a trans-shipment point for heroin from South West Asia and India to other destinations outside of the subcontinent. From even a cursory examination of the arrest and seizure statistics it is evident that, with only a fraction of the region's population and modest seizure volumes, Sri Lanka accounts for a disproportionately large number of arrests. Such arrests are heavily skewed towards heroin. To get a fuller picture of the trafficking patterns to and within Sri Lanka, seizures of heroin in the island country should be studied along with heroin seizures in India destined for Sri Lanka. This information is depicted in the figure below. On average, heroin seized in India which is destined for Sri Lanka is roughly 2-3 times the quantity of heroin seized in Sri Lanka itself. Using a rule of thumb for seizures which is commonplace among the law enforcement community (which assumes that seizures represent 10% of total trafficking), the

[38] "Lanka, Maldives emerge as opium distillation centres," *The New Indian Express*, Chennai, 13 July 2004.

total heroin smuggled into Sri Lanka can be estimated at around 3.5 tons per year. This would be considerably in excess of the requirements of drug-dependent persons in the country.

However, there is no definitive or consistent information regarding the final destination of the 'excess' heroin trafficked into the country. Neither Indian nor Sri Lankan authorities appear to possess any evidence of heroin being smuggled out of Sri Lanka. There are no significant seizures of heroin exiting Sri Lanka, nor are there any major seizures of heroin sourced to Sri Lanka taking place elsewhere in the world.[39]



India routinely reports the trafficking of large-scale consignments of heroin from the southern part of that country into Sri Lanka via the Palk Straits. It is clear that heroin is smuggled from the Southern Indian coasts to Sri Lanka. For example, India's NCB indicates that seizures in the Indo-Sri Lankan sector rose from 38kg (6% of total Indian seizures) during 1998 to 350 kg (37% of total Indian seizures) during 2002 (NCB 2002). According to this source, heroin is smuggled "Between southern India, especially southern Coromandel coast and the north western coast of Sri Lanka by sea, mainly by small country craft" (NCB 2002). Sri Lanka has limited interdiction capacity along this lengthy coastline since it is possesses no coastguard.

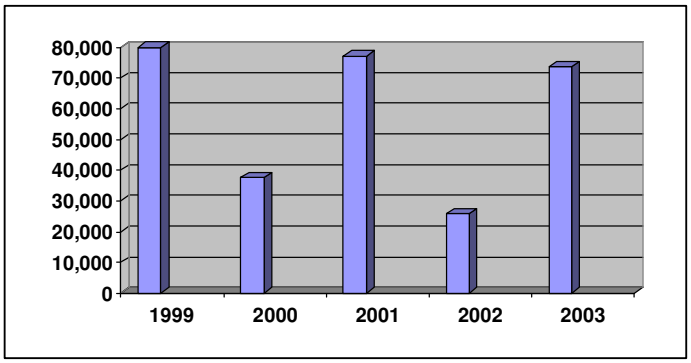
The Indian Directorate of Revenue Intelligence (DRI) has identified Sri Lanka as a transit point for smuggling of other narcotics in containerized cargo. This view seems to be confirmed by reports that 2.5 million amphetamine tablets and 31kg of heroin seized in Djibouti and Southampton respectively in 2001 were reported to have transited through Sri Lanka.

Cannabis: Cannabis is the only drug that is grown illicitly in the country. This occurs mostly in the dry zones of the country in the Eastern and the Southern provinces. The estimated land area under cannabis cultivation is 500 hectares. The estimated number of cannabis users in the country was 600,000. The quantity of cannabis seized island-wide was 73,774 kg and the number of cases in 2003 was 9,556, of which 3% involved women. The number of cases of cannabis related arrests had increased by 29% in 2003 compared with the number reported in 2002. The prevalence of cannabis-related arrests is put at 50 per 100,000 population (ARQ 2003).

Anecdotal, but undocumented, evidence supports the view that cannabis (hashish) is smuggled into Sri Lanka from Pakistan. But details regarding quantities or destinations of these consignments are unavailable.

[39] There is no information on the situation in areas under the control of the LTTE.

Cannabis seized by law enforcement agencies from 1999-2003 (in kg)



Source: NDDCB 2004a.

3(d) Diversion of drugs and precursors

Opium is used in the Ayurveda[40] medical pharmacopoeia and the government makes it available for the preparation of Ayurvedic medication through the Ministry of Health and its local establishments. The government imported 279 kg of opium into Sri Lanka in 2003. Approximately 4 kg of illicit opium and 1 kg of morphine was also seized during that year. The illegal opium was seized from Puttalam and Mannar districts. This could reflect a resumption of drug smuggling between India and Sri Lanka using these old routes of smuggling with the return of peace.

Precursors required by various industries, pharmaceutical companies, laboratories and other establishments are imported into Sri Lanka (SRL Paper 2004).[41] The main precursors imported into the country in the past two years are sulphuric acid, potassium permanganate, hydrochloric acid, acetic anhydride, acetone, ethyl ether, methyl ethyl ketone, and toluene. None of these precursors are produced in the country.

As Sri Lanka does not manufacture any precursors, whatever substance is needed for use in the pharmaceutical or industrial sector must be imported. This makes the task of the regulating authorities easier, in that maintaining a record of imports is a fairly straightforward task. Anyone who intends to import any precursor into the country for a licit use has to do so by applying for an import permit under the Import and Exports Act No. 1 of 1969. The Ministry of Industries and the Ministry of Health are authorized to issue permits in respect of precursors required by them for manufacture of their respective products. Thus a record of

[40] Ayurveda ('Ayur' means life) is the Indian system of medicine derived from the Rig Vedas. The system is based on the imbalance of the three humors (derived from five elements: ether, air, fire, water, and earth); "vata" (combination of ether and air), "kapha" literally phlegm (combination of fire and water) and "pitta" (combination of water and earth). Ayurvedic medicines and practices (yoga exercises) are supposed to restore the balance between these humors; medicines are usually made of botanical preparations – opium being one such botanical ingredient. Opium, when used, dries up secretions (e.g., diarrhoea/dysentery) and is a potent pain reliever.

[41] References in this section are derived to a large extent from the Sri Lanka Country Paper, presented at the "Regional Seminar for Director's General/Heads of Narcotics Law Enforcement Agencies to Review UNGASS Goals on the Control of Precursor Chemicals", 3-4 August 2004, Islamabad, Pakistan (bibliographical reference: SRL Paper 2004).

precursors imported by them with the relevant quantities will be available with them (NDDCB 2003).

There have been no prosecutions for misuse of precursors within the country as at this date. The information received through pre-export notifications is shared with relevant agencies such as the Sri Lanka Customs, the Competent Authorities and the Department of Police.

Quantities of Table I Precursor Chemicals Imported and Exported from Sri Lanka in 2003

Precursor chemical	Imports (Kg)	Exports (Kg)
Acetic anhydride	6.44	0
Ephedrine	557	0
Isosafrole	56	0
Piperonal	75	0
Potassium permanganate	25,339	0
Pseudoephedrine	187	0

Source: NDDCB 2004.

Quantities of Table II Precursor Chemicals Imported and Exported from Sri Lanka in 2003

Precursor chemical	Imports (Kg)	Exports (Kg)
Acetone	1,523,517	2,012
Ethyl ether	19,726	0
Hydrochloric acid	1,392,362	4,554
Sulphuric acid	2,656,199	9,215
Methyl ethyl ketone	726,447	0
Toluene	4,226,112	0
Piperidine	1	0

Source: NDDCB 2004.

3(e) Drug prices

The average street price per kilogram of heroin in 2003 was 2.45 million Sri Lankan rupees (SL rupees) (equivalent to approximately US$24,500) for locals and it was SL rupees 3.1 million for foreigners (approximately US$30,100). The street price of heroin had increased by a fifth for the locals and nearly a third for the foreigners in 2003 compared with that of 2002. The average di-acetyl morphine content, also known as the purity[42], of street level heroin in Sri Lanka was 44% in 2003, representing a decrease by 2% on the average purity level in 2002.

The price per kilogram of cannabis was Sri Lanka Rupees 1,500 (approximately US$15) for locals and Rupees 2,000 for foreigners (approximately US$20). The price of cannabis showed no increase for locals while there was a 5% increase for foreigners.

The average street price of illicit opium per kilogram for locals was SL rupees 500,000 (approximately US$5,000) and for foreigners SL rupees 800,000 (approximately US$8,000) during 2003. The price has increased by 1% for locals and none for foreigners compared to 2002.

[42] Caffeine, diazepam, glucose, lactose, strychnine and acetaminophen are the commonly used adulterants of street heroin available in Sri Lanka.

3(f) Demand

Sri Lanka has a long history of drug use. Traditionally – and not unlike most countries in the region – cannabis, opium and alcohol have been the drugs of choice. Cannabis and opium were often part of indigenous medicinal preparations. Alcohol is the most prevalent drug used in Sri Lanka (Reid and Costigan 2002).

In the 1920s, it was believed there were between 60,000 - 68,000 opium users in the country. Until the middle of the twentieth century government medical officers distributed opium to registered opium users. Detoxification of opiate addicts using methadone during the 1970s was also reported. In the early 1980s, it was estimated there were between 10,000 - 15,000 opium users in Sri Lanka (UNODC ROSA 1998a).

In the late 1970s and early 1980s, evidence began to emerge of a close link between drug smuggling, arms smuggling and applications for asylum. Reports started to emerge of heroin becoming a drug of choice. It was also reported that members of certain groups were becoming part of an international smuggling operation, the proceeds of which were being used to supply arms (Jayasuriya 1995). Since the early 1980s Sri Lanka has had to face a growing problem of drug abuse (mainly heroin) among its youth, originally introduced – according to the NDDCB – by tourists.

A survey (Mendis 1985) was carried out on the records of the University Psychiatry Unit of the General Hospital at Colombo during the early 1980s. It studied 100 heroin addicts who were treated in the Psychiatry Unit from January 1983 to March 1984. Most subjects inhaled heroin, and the average amount consumed was 340 mg per day. The majority of them had used heroin for a period of less than one year, while 9 per cent had used it for more than two years. All the addicts in the study were males. Only 6 per cent were older than 34 years; 5 per cent were unemployed at the time they started using heroin; 67 per cent were single; and 93 per cent had left school before the tenth grade.

Reid and Costigan estimated that there were between 240,000 - 300,000 drug users in Sri Lanka at the turn of the century, out of which about 2% are IDUs (Reid and Costigan 2002). The most common way to take heroin in Sri Lanka is by 'chasing the dragon' known locally as the 'Chinese way'. Some cases of injecting have been detected but the number is too small to identify a trend.

In 2000,[43] treatment admissions showed the following profile: the majority were heroin users (88%); the route of use was the 'Chinese' method (67%) and smoking (25%); many were aged between 20-29 years (39%); nearly all were male (98%); over half were single (52%); and educational levels were generally low, with 12% having below five years and 22% between five and eight years of schooling. In 1996 there were 1,816 people admitted for treatment as a result of heroin; by the year 2000 this number had increased to 3,550 (NDDCB 2000).

It has been suggested that the low prevalence of injecting may be a result of the high level purity of heroin that is available on the market and that the desired effect may be obtained simply by 'chasing'. However, during times when heroin is scarce, some drug users are

[43] In 2000, the following sources accounted for the total: 2,164 (government); 24 (private); 47 (NGOs); 5 (law enforcement agencies) and 289 (prisons). Of these, 2,250 persons had received institutional care at the NDDCB Treatment Centres, 160 Ayurvedic treatments, 86 allopathic treatments and 1 homeopathic.

reported to switch to injecting, and then mostly pharmaceutical drugs are used (Reid and Costigan 2002). Without giving a specific timeframe, Reid and Costigan (2002) also report other recent studies in which the prevalence of injecting among heroin users had increased from 1% to 13% in a span of 4 years.

Reid and Costigan (2002) based on their review of secondary data, reported that the majority of heroin users are 20 to 35 years old, generally from urban areas and predominantly young men . High-risk groups include manual labourers, street vendors, taxi drivers, commercial sex workers and tourist industry workers in Colombo. Heroin users have been found to generally come from a higher socio-economic stratum than the poor of the society and most live at home with their families (Reid and Costigan 2002).

In Sri Lanka, a Rapid Prevalence Survey (NDDCB 2002) was conducted using the snowballing technique in 18 cities representing all the provinces of the country. A total of 6,664 heroin users were identified. The highest percentage of heroin users (86%) was in the age group 21 – 40 years. A large majority of these were literate (94%) and a large number were unskilled labourers (47%). Most of them had been introduced to heroin by a friend (79%). Almost half (48%) were married. Almost one-third had been using heroin for 6-10 years. All heroin users were multiple-substance users. About 47% of them also used sedatives in case of heroin non-availability, and about 40% consumed cannabis. About 36% reported having sought treatment earlier, most (73%) had sought treatment from a private hospital or practitioner.

The most recent figures on drug use in Sri Lanka come from the NDDCB. It is estimated that there are currently about 45,000 regular users of heroin and about 600,000 users of cannabis in Sri Lanka. It is further estimated that about 1% of heroin users are IDUs (NDDCB 2004a).

In 2002, out of 4,107 patients[44] admitted for drug abuse treatment at various government and non-government treatment centers at Sri Lanka (NDDCB 2003), 50% were heroin users, 15% were cannabis users and 10% were alcohol users. IDUs comprised 0.5% of the total admissions. Most (65%) of drug users were in the age group 20-35 years. About 56% were single and 7% had never been to school. Drug users were proportionally distributed among all ethnic and religious groups in Sri Lanka (NDDCB 2003).

In the year 2003, 4,664 individuals were treated for drug dependence at various treatment centres across Sri Lanka. The prevalence of drug dependents that received treatment was 24 per 100,000 inhabitants in 2003. Four out of five drug dependents followed residential institutional type drug treatment programmes. Two-thirds were treated at the NDDCB treatment facilities. Nearly one-third followed prison drug treatment programmes. Almost two-thirds of the persons were aged between 20 and 35 years. Among the heroin users, chasers (Chinese method) were the majority followed by those who smoked and sniffed. Heroin injectors constituted only 1% of heroin users (NDDCB 2004a).

In Sri Lanka, rehabilitation and reformation of convicted offenders and their re-integration into society with the support of the community is one of the goals of the Sri Lanka prison system. Among the convicted prisoners at present, 45 per cent are there for drug-related

[44] In 2002, the following sources accounted for the total: 2,482 (government); 1,155 (private); 0 (NGOs); 0 (law enforcement agencies) and 451 (prisons). Of these, 3,125 persons had received institutional care at the NDDCB Treatment Centres, 2 Ayurvedic treatments, 442 allopathic treatments and 1 homeopathic

offences, the largest category. Drug dependence is viewed to have a strong correlation with property crimes such as burglaries and theft in the country.

There are also isolated reports of the limited abuse of cocaine and ecstasy by a few foreigners and affluent locals in Colombo, although the drug is not easily available in the market. The estimated demand for heroin in Sri Lanka is approximately 763 kg per year. According to the reported data, the percentage of injecting drug users is less than 1% (NDDCB 2004a).

3(g) Costs and consequences

The relationship between illicit drugs, dealing in arms and terrorism is known in the Sri Lankan context (Jayasuriya 1995). With the ongoing peace process there is a risk that individuals with few skills to maintain a sustainable livelihood other than in a military or paramilitary setting may become involved in drug use or trafficking or other criminal activities.

Reid and Costigan (2002) reported that IDUs in Sri Lanka were having sex with multiple partners, that sharing needles and syringes was relatively common and that the IDUs of Sri Lanka were at high risk of an HIV/AIDS epidemic.[45] In Sri Lanka, HIV transmission by injecting drug use has yet to be seen. Unlike in India, Bangladesh and Nepal, injecting drug users have not been specifically identified as a vulnerable population to test for HIV. This may explain why HIV infections have not been found in this group.

3(h) Money laundering

Provisions regarding money-laundering offences have been included in the revision of the 1990 Narcotics Control Act. The Money Laundering Act was passed in 2002.

Sri Lanka does not appear to be a major centre for money laundering. There are strict bank secrecy laws under which the Government of Sri Lanka is required to obtain a court order to obtain banking information of bank customers. A system of remittances exists (resembling the Hawala) for the repatriation of money and can be used to facilitate money laundering (INCSR 2003).

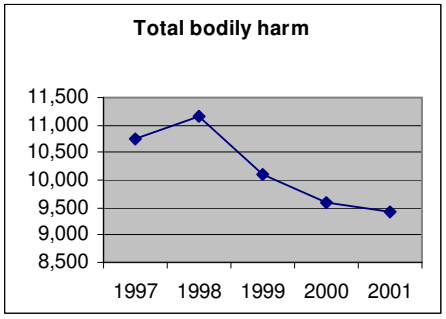
4. CRIME SITUATION

4a. Main characteristics

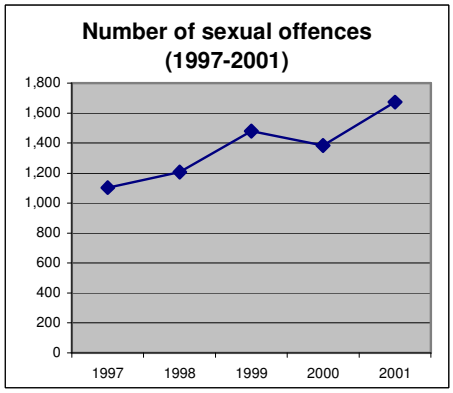
Considering the population of the country which is about 20 million, the crime rate is 283 (per 100,000 population).

[45] There is an unusually high male-to-female ratio of HIV sero-positivity (1.4 : 1). It has been observed that the natural history of the HIV/AIDS epidemic witnesses a much higher proportion of males among HIV-positive people far exceeding that of females in the early stages of the epidemic. A relatively higher proportion of HIV-positive females would seem to indicate that the epidemic has spread to the general population. One cause of this could be the fact that many females from Sri Lanka work abroad (especially in the Middle East) and are tested as part of their emigration requirements. In reality probably far more males are HIV positive.

Homicide, attempted homicide and other forms of bodily harm: Since 1988, there has been a decline in offences involving bodily harm to others such as homicide, attempts to commit homicide and grievous bodily harm. However, the first six months of 2002 showed a significant increase in such offences. Crime rate of homicides is about 9 per 100,000 population.



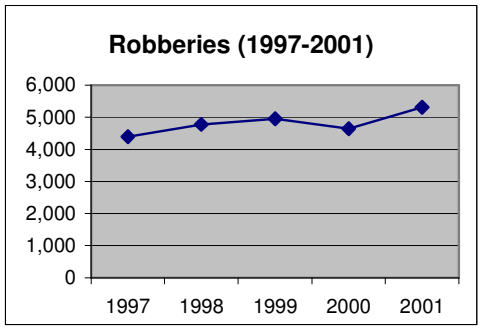
Sexual offences: Contrary to other offences, sexual offences including rape, incest and unnatural offences (a term used in the legal parlance in South Asia to refer to homosexuality and beastiality, etc.) and sexual abuse have been steadily rising in Sri Lanka. These offences have been rising at an average of 11% during the past few years. Incidence of rape is about 6.1 per hundred thousand of the population compared to 1.6 in India.



Robberies: Robberies also appear to be on the rise although the increase is not as high as sexual offences. Robberies have been growing at an average rate of 5% per annum. The rate of robberies is about 22 per hundred thousand population.

4(b) Trends

There is evidence of a significant increase in criminal acts in the post-conflict situation. This may call for the integration and training of ex-combatants and deserters into civil society. There has been no comprehensive crime survey in the country.



4(c) Issues of specific concern

Organized Crime

There are rising levels of crime caused by army deserters and other criminal gangs (even before the anticipated formal demobilization of some troops which may only worsen the situation).

Trafficking in Human Beings

Sri Lanka is one of the primary sending countries of young female domestic workers to the Gulf countries. Many are trafficked; often they end up in conditions which leave them vulnerable to sexual abuse. On the island itself, young people of both sexes are coerced into involvement in the sex trade involving paedophile tourists.[46]

[46] A recent study by the International Labour Organization (ILO) referred to earlier work concluding that in 1998 there were 30,000 children who are sexually exploited in Sri Lanka (ILO 2002).

The National Child Protection Agency (NCPA) has instituted a Cyber Watch Project to monitor suspicious chat rooms and has conducted sting operations on this basis (TIP 2004). The Sri Lankan Penal Code specifically criminalizes trafficking in human beings. The government provides medical and counselling services for the victims of trafficking. The NCPA runs campaigns including public awareness on the issue of human trafficking.

Despite agreeing to an Action Plan for Children Affected by War with the Sri Lankan government, the Liberation Tigers of Tamil Elam (LTTE) have continued to force children to serve as child soldiers or to perform forced labour. As of the end of 2003, UNICEF had documented cases of over 1,300 children below the age of 18 years serving in the ranks of the LTTE. Over 700 of these children had been recruited in 2003 alone (UNICEF 2004).

Corruption

In 1994, the government established a permanent commission to investigate charges of bribery and corruption against public officials.

According to the Transparency International Corruption Perception Index in 2003, Sri Lanka scored 3.4 and was ranked 66th in terms of the level of perceived corruption (TI 2003). In 2004 its score was 3.5 and rank 67.

In the first comparative study of corruption in South Asia examining what users of key public services actually experience, respondents in Sri Lanka considered the police to be the most corrupt public agency, followed by health and education (TI 2002).

5. POLICY – DRUGS

5(a) National drug control framework

Convention Adherence

Sri Lanka is a signatory to all three UN Conventions on drug abuse and trafficking, namely Single Convention on Narcotic Drugs 1961, Convention on Psychotropic Substances 1971 and United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988.

The strategies envisaged in the UN Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control and Global Programme of Action have been incorporated in the national policy for the Prevention and the Control of Drug Abuse.

Legislation

Legislation pertaining to drug control in Sri Lanka is the poisons, opium and dangerous drugs act, the penal code, cosmetic, devices and drugs act, customs ordinance and indigenous medical act.

The Poisons, Opium and Dangerous Drugs Ordinance of 1935, which has undergone many amendments, most recently in 1984 (Act No. 13), is the principal statutory enactment

regulating poisons, opium and dangerous drugs in the country. Other statutes with provisions relating to drugs include:

- **The Penal Code** (Ordinance no. 2 of 1983 as subsequently amended) in particular Chapter 14, which covers public health and safety.

- **The Cosmetics, Devices and Drugs Act** (Act No. 27 of 1980, as amended by Act No. 38 of 1984). The Act regulates the manufacture, sale, distribution, labelling and advertising of all commercial drugs.

- **The Ayurveda Act** (Act No. 31 of 1961 as amended by Act No. 5 of 1962) entitles ayurvedic physicians to obtain opium and cannabis for manufacture of their medicinal preparations.

- **The Customs Ordinance** (Ordinance No. 17 of 1869, imposes prohibitions and restrictions of both import and export of substances prohibited under the Poisons Opium and Dangerous Drugs Ordinance).

In Sri Lanka, draft legislation that would allow limited and controlled cultivation of cannabis for use by the estimated 16,000 locally registered Ayurvedic practitioners is currently under discussion. At present, the practitioners use powdered cannabis processed from seized cannabis and sold to them by the Ayurvedic Drugs Corporation. As the use of powdered cannabis does not conform to traditional methods, the proposed legislation would allow the Commissioner of Ayurveda of the Department of Ayurveda of Sri Lanka to grow cannabis in one central location, after having estimated the quantities required and taking into account the necessary protection and control measures (INCB 2004).

Institutions

In Sri Lanka at present, the Ministry of Public Security, Law and Order has overall responsibility for counter narcotics and demand reduction activities. The National Dangerous Drugs Control Board (NDDCB) is in charge of overseeing and coordinating all drug control activities of law enforcement and prevention, treatment and rehabilitation through a number of agencies. In 1984 the government created the National Dangerous Drugs Control Board (NDDCB) under the Ministry of Defence. The Board is made up of representatives from the Ministry of Education, Ministry of Health, Department of Police, Department of Customs, Government Analyst, Department of Ayurveda and Ministry of Finance. The representation of various ministries and departments on the Board provides for the formulation of coordinated action, with its enforcement sub-committee coordinating the action of all enforcement agencies.

The Board is responsible for coordination of the implementation action based on the policies and guidelines approved by government. Those policies and strategies are outlined in the Sri Lanka National Policy for the Prevention and Control of Drug Abuse and the Master Plan for Drug Control in Sri Lanka. The government strategies are based on enforcement; preventive action; treatment and rehabilitation; and international and regional cooperation.

The national coordinating body for HIV/AIDS is the National AIDS Committee. It is a multi-sectoral body comprising different government ministries and institutions and some key NGOs.

The **Ministry of Health** endorsed a national AIDS plan in 1994. HIV/AIDS policies allow needle exchange and substitution programmes. The Ministry enforces the Cosmetics, Devices and Drugs Act. It imports all legal requirements of narcotic substances and methyl phenidate for medical and scientific purposes through the Director, Medical Supplies Division under the ultimate authority of the Director General of Health Services (DGHS). Other psychotropic substances are imported by the State Pharmaceutical Corporation or other private licenses importers (about 25 in number) who receive their licenses through the Director, Medical Technology and Supplies Division acting on behalf of the DGHS and under whose immediate purview the Medical Supplies Division falls. The Minister of Health is empowered to make regulations for the purposes of giving effect to the provisions of the Poisons Opium and Dangerous Drugs Ordinance.

The **Police** is vested with more powers than other agencies under existing law with regard to illegal drugs. The police is the premier enforcement agency handling drug law enforcement. This is carried out through the 324 police stations across the islands, which have drug law enforcement as part of their responsibilities. In the past, the political tension and security imperatives resulting from the civil war required the police to divert resources otherwise intended for counter-narcotics efforts into other security matters. This is no longer the case. The **Police Narcotics Bureau (PNB)**, a specialized central unit of approximately 170 officers, is headed by a director and coordinates drug enforcement functions of all police stations. The PNB also investigates major drug cases, responds to international requests with regard to drug law enforcement and is a repository of statistics. The PNB also uses trained drug detector dogs and undertakes some public awareness and preventive education programmes.

The **Customs** department, headed by a Director General controls exit and entry points in the island. Drugs, which are prohibited or restricted from import or export under the Poisons, Opium and Dangerous Drugs Ordinance, are also prohibited or restricted from import or export under the Customs Ordinance. The customs has a Baggage Division under a director and in response to the increasing problem the customs have a Preventive Division under a director with a specialized Narcotics Unit, which works in close liaison with the PNB who handle the case once the detection is made.

The **Excise** department is headed by a Commissioner General and is vested with powers under the Poisons, Opium and Dangerous Drugs Ordinance [Section 77(3)] and the Code of Criminal Procedure Act, No 15 of 1979 [Section 136 (b)] to undertake drug law enforcement and they have a specialized unit for this purpose which coordinates the efforts of the other units which are spread throughout the country and work in close collaboration with other drug law enforcement agencies.

National Policy

The National Dangerous Drugs Control Board formulates and reviews national policy and plays its role in supporting and coordinating the efforts of various drug control agencies while modifying policy to meet the changing needs of drug control efforts.

5(b) Licit control (drugs and precursors)

Sri Lankan police, excise and customs are the three Government departments entrusted with responsibility for preventing the production, distribution and smuggling of all narcotic drugs. The responsibility of interdiction of the entry and exit of all narcotic drugs and psychotropic substances as well as the monitoring of precursors in entrusted to the Sri Lankan Customs.

The National Dangerous Drugs Control Board (NDDCB) receives pre-shipment notifications of intended shipments of precursor chemicals for verification of the legitimacy of transactions. Sri Lanka does not manufacture any precursor chemicals. However, a considerable amount of chemicals listed in Tables I and II are imported for legitimate industries. Under the NDDCB, a Sub-Committee on precursors comprising representatives of various related Government agencies has made recommendations to bring a few of the listed precursors under import control.

Sri Lanka established a limited regime for the regulation of precursors as far back as 1984, even before the 1988 Convention. The Poisons, Opium and Dangerous drugs amendment Act, No. 13 of 1984 introduced a new section 79A, which makes it an offence for any person to have in their possession an acetylating substance, unless they prove that they are licensed or authorized to possess such substance or that such acetylating substance is in their possession for a lawful purpose.[47] As a result of this 1984 regime, acetic anhydride was controlled under the law of Sri Lanka.

Compliance with Article 12 of the 1988 Convention: Article 12 of the 1988 Convention requires that all national authorities empowered to control, regulate or enforce precursors and chemicals be listed. Sri Lanka has complied with this requirement and has nominated the Director-General of Health Services as the Competent Authority for the purposes of such Article. As a result, there exists an authority additional to the Customs Department and the Department of Imports and Export Control Department, which is aware of the import of precursors into the country. However, the authority so nominated is not empowered by law to monitor, or in any way control, the use of such substances.

The Legislation Sub-Committee of the NDDCB which was mandated to look into the laws available in Sri Lanka on the use of precursors was of the opinion that the Law which was being introduced to implement the 1988 Convention was very clear on its position on the use of precursors. It made the use of any of the substances set out in Table I or Table II of the Convention an offence only if it was used for the manufacture of a narcotic drug or psychotropic substance. Therefore the legal position was that any licit use of the precursors was permitted. The Legislation Sub-Committee however is considering the need for legislation to regularize and monitor the procedure regarding imports of precursors and their use within the country.

Sri Lanka is now in the process of enacting legislation to give effect to the 1988 treaty obligations. The Draft Law states that the use of the substances listed in Table I and Table II (precursors) of the Convention, for the manufacture of any narcotic drug or psychotropic substance will be illegal, and will constitute an offence under Sri Lankan law. The draft law in section 2 provides for punishment for the commission of the offences specified in the

[47] "Acetylating substance" is described as a substance that can introduce one or more acetyl groups into another substance by a chemical process.

Convention and which are set out in the Schedule to the Draft Act, a term of imprisonment for a minimum period of ten years and to a maximum of fifteen years.

Cooperation with chemical industry: A Precursor Control Coordinating Committee exists. It consists of representatives of the main government agencies concerned and the private sector appointed by the NDDCB.[48] The involved agencies are as follows: the Police Narcotics Bureau, the Ministry of Industries, the Department of Customs, the Department of Excise, the Ministry of Health, the Department of Imports and Export Control, the Private Sector and National Dangerous Drugs Control Board.

5(c) Supply reduction

The NDDCB is not vested with executive authority to carry out enforcement. Drug law enforcement action is therefore principally in the hands of the National Police. Within the police service a separate Narcotics Bureau undertakes anti-drugs operations and collates intelligence, but only from police sources. It also houses the **SAARC Drug Offences Monitoring Desk (SDOMD)**. The excise department also conducts enforcement operations at street level and makes several hundred arrests each year. It is also active in eradicating cannabis plantations. The customs department is confined to ports and airports and is required to pass drugs detections to the police for further investigation. Both the customs and the excise departments maintain independent intelligence gathering systems.

The enforcement strategy is vigorous in order to reduce the illicit availability of drugs, to deter drug related crime and disease and create an environment favourable to drug abuse prevention.

The penalties for drug offences now range from fines to death or life imprisonment. The penalty of death or life imprisonment accrues for the manufacture of heroin, cocaine, morphine or opium and the trafficking, possession, import or export of a minimum amount of (a) 500 grammes of opium (b) 3 grammes of morphine (c) 2 grammes of cocaine or (d) 2 grammes of heroin. Less severe offences, including the regulatory ones, warrant sentences of fines or imprisonment, the amount of the fine or the length of imprisonment depends on the quantity of drug, the gravity of the offence and the courts having jurisdiction.

5(d) Demand reduction

In the Sri Lankan National Policy for the Prevention and Control of Drug Abuse (NDDCB 2004), a multi-pronged approach has been employed. The major components are preventive education and public awareness, treatment rehabilitation and after-care; and international and regional co-operation.

The government's strategy on preventive education and public awareness has been to recognize that prevention is more efficient and cost-effective than either enforcement or treatment. It is expected to facilitate better use of all opportunities for the prevention of drug use and to constantly evaluate effectiveness of different prevention philosophies and

[48] Recent initiatives on precursor control commenced in early 1997 with a National Precursor Control Policy Formulation Workshop held in Colombo in collaboration with the UNODC Regional Precursor Control Project and the chemical trade and industry in Sri Lanka. Subsequent to this workshop a number of training programmes were conducted and a large number of officials of both the government and private sector were trained. A set of guiding principles was developed and adopted.

strategies. While developing and refining strategies, the need to make preventive responses internally consistent, comprehensive, participatory and directed not only to short-term goals is recognized.

The government's record on demand reduction is regarded as among the best in South Asia. Many initiatives in this area are funded by the Sri Lanka-based Colombo Plan whose Drug Advisory Programme receives funding from the US.

The treatment strategy is to integrate detoxification, treatment, rehabilitation and after-care facilitating the integration of former drug dependants into society. 'Treatment' is seen as a field, which is open to everyone to contribute to, according to their capabilities, rather than the exclusive territory of 'specialists'. Approaches will be aimed at generating optimism, increasing control that people have over their lives, and demystifying the recovery process or growth. The government believes that no country can tackle its drug problem in isolation. Relevant government agencies and NGOs are encouraged to actively engage in formal international cooperation through bilateral, regional and international collaboration.

There are four government treatment centres in Sri Lanka with a total capacity of 143 beds in total. These centres are dedicated to de-addiction. The prison department introduced a specific programme for drug dependents through the "Prisoner Diversion Scheme" in collaboration with NDDCB and the UNDCP in 1995. Today, the programme is implemented in 9 out of 62 prisons throughout the country. Although Sri Lanka's prison population is relatively low (110 prisoners per 100,000 inhabitants), 48% of prisoners are in remand and there is a 90% excess of prisoners over official prison capacity (ICPS 2004). This is a risk factor for spreading HIV/AIDS and other contiguous diseases. The Sri Lanka Federation of Non-Governmental Organizations Against Drug Abuse (SLFONGOADA) serves as an umbrella organization for the active network of NGOs in drug demand reduction in Sri Lanka.

A regional workshop (Mittal 2002) for prison officials on treatment and rehabilitation of drug dependents in prisons was organized by NDDCB with assistance from UNODC in October 2002 in Sri Lanka. It recommended, *inter alia*, that remand prisoners have a right for treatment and rehabilitation services. An institutional framework should be created for treatment and rehabilitation of drug users in the prisons. Any available resources for this purpose should be identified and used. Community mobilization in this connection is necessary. Care, support and aftercare for drug dependent prisoners are required. Technical experts and resource persons should be exchanged within the region.

5(e) Money laundering control measures

Money laundering provisions are being integrated in the comprehensive amendments to the drug laws.

5(f) International cooperation

The National Dangerous Drugs Control Board (NDDCB) has displayed a special interest in supporting drug control efforts, and has provided support to the visits of consultants for sub-regional programme development, as well as hosting study tours.

The Board co-ordinates with UN agencies[49], the Colombo Plan Bureau and various government and non-government agencies in the areas of drug demand reduction and supply reduction.

The Board has been successful in helping the coordination of law enforcement and regulatory authorities in the country. A dialogue on enforcement and related issues was maintained between the Board and law enforcement institutions and regulatory bodies on a continuous basis through its sub-committees, namely the Sub Committee on Law Enforcement and the Precursor Regulation Coordinating Committee. The involved agencies are the Attorney-General's Department, the Excise Commissioner's Department, Sri Lanka Customs, the Ministry of Industrial Development, the Police Narcotics Bureau, the Ministry of Health, the Department of Prisons, the Import and Export Control Department, the Legal Draftsman's Department, the Government Analyst, the Ministry of justice.

The Government is a signatory to the 1990 SAARC Convention on Narcotic Drugs and Psychotropic Substances.

6. POLICY – CRIME

Criminal Justice System: Although Sri Lanka's colonial heritage fostered a tradition of judicial freedoms, this autonomy has been compromised since independence by constitutional changes designed to limit the courts' control over the president and by the chief executive's power to declare states of emergency. In addition, parliament's willingness to approve legislation, such as the 1979 Prevention of Terrorism Act, vested the government in the late 1980s with broad powers to deal with subversives, or those deemed subversive, in an essentially extralegal manner. Under the constitution, the highest court is the Supreme Court, headed by a chief justice and between six and ten associate justices. The president appoints Supreme and High Court justices. Superior Court justices can be removed on grounds of incompetence or misdemeanour by a majority of Parliament, whereas only a judicial service commission consisting of Supreme Court justices can remove High Court justices. The Supreme Court has the power of judicial review; it can determine whether an act of parliament is consistent with the principles of the Constitution and whether a referendum must be taken on a proposal, such as the 1982 extension of Parliament's life by six years. It is also the final court of appeal for all criminal or civil cases.

Legislation: The passage of the Penal Code, Ordinance Number 2 of 1883, marked an important stage in the island's transition from Roman Dutch to British law. Despite the wide variety of amendments to the code, it remained substantially unchanged, and established a humane and unambiguous foundation for criminal justice. Crimes are divided into a number of categories that include offences against the human body, property, and reputation; various types of forgery, counterfeit, and fraud; offences against public tranquillity, health, safety, justice, and the holding of elections; and offences against the state and the armed forces. The code provides for different types of punishment: death by hanging, rigorous imprisonment (with hard labour), simple imprisonment, forfeiture of property, and fine. In cases of

[49] The three-year joint project with UNODC on strengthening selected demand reduction programmes in Sri Lanka, to strengthen achievements of demand reduction work of the Board commenced. The project has UNODC inputs of US$287,000. The project commenced in December 1999. The immediate objectives of the project were (i) to strengthen the Drug Abuse Monitoring System (ii) to improve outreach prevention for high-risk groups and (iii) to improve the quality of treatment services.

imprisonment, the Penal Code specifies a maximum sentence permissible for each offence, leaving the specific punishment to the discretion of the judge. Imprisonment for any single offence may not exceed twenty years. The death penalty is limited to cases involving offences against the state (usually of open warfare), murder, abetment of suicide, mutiny, and giving false evidence that leads to the conviction and execution of an innocent person. If the offender is under eighteen years of age or pregnant, extended imprisonment is substituted for a death sentence.

Crime Control Institutions: The Police Force functions under the Ministry of Internal Affairs. A Minister appointed as the Minister of Internal Affairs holds the Internal Affairs Portfolio. The command and control structure of the Police Force today is divided into two parts. The Inspector General of Police at Police Headquarters, at the apex is the Chief Executive of the Force. The two structures are (a) Functional Command and (b) Territorial Command. The Criminal Investigation Department (CID), which undertakes Investigations on the orders of the Inspector General of Police, reports directly to the Inspector General of Police. It functions under a Deputy Inspector General of Police.

> Functional Command (FC): The FC provides expertise, logistical and other specialized support to the Territorial Units as well as the Para-Military units in order for them to function effectively. At present there are 36 units under the Functional Command, each headed by a Director of the rank of Senior Superintendent of Police or Superintendent of Police, while five Senior Deputy Inspector Generals of Police (SDIG) supervise them.
>
> Territorial Command (TC): At present, there are 331 Police Stations, which are graded into six categories, namely A1, A2, A3, B, C and D. Each of these police stations is in charge of a Police Officer of the rank of Chief Inspector of Police, Inspector of Police, or Sub-Inspector of Police, according to their grading.

Police stations are further grouped into 110 territorial districts and an Assistant Superintendent of Police heads each of these districts. These Districts, in turn, are grouped into 35 Police Divisions and each Division is in-charge of a Senior Superintendent of Police / Superintendent of Police. To obtain better command and control, a Deputy Inspector General (DIG) of Police is in-charge of a Province, which has several Police Divisions under its command. There is a total of nine Administrative Provinces. Considering the workload involved, the Western Province is divided into three Ranges while the Northern Province is divided into two. Each Range is in charge of a Deputy Inspector General of Police (DIG).

The Special Task Force is the Para-military arm of the Sri Lanka Police, deployed essentially for counter-terrorist and counter-insurgency operations within the country. They are also deployed in the close protection Units providing security for key installations.

Convention Adherence: Sri Lanka is a signatory to the Transnational Organized Crime Convention of 2002 as well as two of the three related Protocols (human trafficking and migrants). It is also a signatory to the 2003 Corruption Convention.

7. TERRORISM

The main source of activity linked to terrorism in Sri Lanka, is the Tamil secessionist campaign which is led by the Liberation Tigers of Tamil Eelam (LTTE), although, a number of militant Tamil organisations have operated in Sri Lanka with the aim of creating a separate state in the east and north of the island through military means. Currently, however, a ceasefire signed between the Government of Sri Lanka and the LTTE is holding.
The major pieces of legislation in place which cover terrorism are: (a) the Suppression of Unlawful Acts against the Safety of Maritime Navigation Act, 2000, (b) the Prevention of Hostage Taking Act, 2000, (c) the Emergency Regulations No. 1 of 1989; (d) the Law of Compulsory Conscription; (e) the Prevention of Terrorism (Temporary Provisions) Act No. 48 of 1979 and (f) the Public Security Ordinance (Ordinance No. 25 of 1947).

Convention adherence: Sri Lanka is a party to ten of the 12 international terrorism conventions, including the 1999 International Convention for the Suppression of the Financing of Terrorism.

GAP ANALYSIS

BANGLADESH

- **Pharmaceutical drugs:** The smuggling in of (often spurious) pharmaceuticals originating from India and their diversion and abuse, is one of the most important drug problems in Bangladesh, as these pharmaceuticals are generally injected. This has direct implications for the spread of HIV/AIDS in the country. Limited capacity to intercept the movement of these substances and weak controls along the porous land Indo-Bangladesh border is one of the major gaps. There is a need for increased cross border operational cooperation for intelligence sharing, tracking from source to destination, as well as strengthening of internal control mechanisms through training of drug controllers and drug law enforcement officers.

- **Drug abuse:** Prevention, treatment and rehabilitation capacities both in government institutions and in NGOs are insufficient to cope with demand. Quality services are often not available and interventions targeting vulnerable groups are too small. There is a need to enhance the technical capacities of service providers through training and developing low-cost models for increasing coverage of drug prevention programmes across the country.

- **Drugs and HIV:** The HIV epidemic has changed rapidly in recent years. Neither the public sector nor the communities themselves appear prepared to address the needs of marginalized and stigmatized groups, whose access to services and information was already restricted. Denial of the seriousness of the epidemic is still evident, and recent data shows a very low level of HIV awareness and risk perception, especially among women. Moreover, the social environment needed for successful interventions is far from supportive. Common reactions include stigmatisation and exclusion. These inhibit effective interventions. There is a need to mainstream HIV concerns into ongoing drug demand reduction initiatives and empower communities to develop comprehensive community wide programmes for drug related HIV prevention. The NASROB study has recommended that urgent attention be given to the problem of opiate drug use in Bangladesh, in the interest of both HIV/AIDS and drug abuse prevention. Addressing HIV-related consequences among drug users and launching focussed interventions to raise awareness of HIV consequences among the larger community of drug users – early in the epidemic – would be a strategic objective and a cost-effective development option. At present HIV mitigation services are limited to current injectors in programmes run by NGOs.

- **Precursor control:** Rules to control precursor chemicals have been framed under Section 55 of the Narcotics Control Act, 1990. These rules, *inter alia*, provide for licenses for the production and import of all Table I and Table II substances. It may be useful to provide detailed statutory procedures to give effect to the legal provisions, restricting or prohibiting production, use, import, export, transportation, storage, etc., of precursors. At present, individual organizations such as Customs, the

Department of Drug Administration, etc. maintain their data manually. It will be useful to have a national focal point maintaining a computerized database on precursors. There is also a need to develop regular precursor control training facility in the country and to increase cooperation with the chemical trade and industry. It has been observed that the level of coordination between agencies dealing with precursor controls is not optimal.

- **Drug Law enforcement:** Law enforcement agencies have not yet achieved the capacity required for a well-coordinated effective national enforcement service for drug control. Weak institutional structures, insufficient coordination, lack of systematized anti-drug policies and strategies, limited knowledge of current investigation approaches and techniques, insufficient logistical support, and a lack of adequate training facilities are some of the gaps identified in the country. In view of the increased trafficking of narcotic drugs and psychotropic substances in the country through land, air and sea routes, the technical capacities of competent authorities currently engaged in drug law enforcement need to be strengthened especially through training. There is a need for strengthening the overall capacity of DNC including establishing proper training facilities: (i) improving coordination mechanisms and cooperation between the different law enforcement agencies; (ii) training of law enforcement officials at different levels; and (iii) enhancing the capacities of law enforcement agencies through the provision of equipment.

- **Crime and terrorism convention adherence:** Bangladesh is not a party to any of the international crime conventions. It is a party to only three of the 12 universal anti-terrorism instruments.

- **Prison Populations:** There is overcrowding of 290% in the 65 central and district prisons with de-addiction programmes for incarcerated prisoners. There is a need for drug de-addiction and HIV prevention programmes for incarcerated prisoners. With 71% of prisoners being in remand, appropriately designed services for remand prisoners need to be developed.

- **Human trafficking**: There is a need to build the capacities of law enforcement agencies to prevent trafficking of human beings, especially children. This should involve developing and improving functional databases on the routes, structures, and modalities used by traffickers of human beings. It will also improve the protection and support system for victims and witnesses.

BHUTAN

- **Situation assessment and derived national strategy:** A systematic assessment of the extent and nature of the drugs and crime situation in the country is hampered by the absence of reliable data. However, HIV has begun to emerge as a serious health issue. It is necessary to capture and analyse the current trends in drug use and related risk. It is further necessary to develop a national drug control strategy based upon these findings.

- **Drug demand reduction:** There is no single recognized competent authority for drug demand reduction in the country. There is no drug control master plan.

Deaddiction services are virtually non-existent. There is paucity of civil society responses for drug abuse and HIV prevention. There is a need to build on the government's attempts to introduce life skills education modules especially for high school children and introduce drug prevention.

- **Precursor control:** There are concerns about the country's vulnerability to being used as a site for the channeling of licit precursors to illicit purposes, as well as being used both as a transit point and a point for document conversion. An exclusive precursor control legislation that could meet the current challenges of diversion of precursor chemicals is yet to be established in the country.

- **Drug convention adherence:** UNODC has recently assisted Bhutan to draft the "Prevention and Control of Drug Abuse Act 2005" which is expected to be adopted by the National Assembly in November 2005. Assistance will be required to help draft the necessary subordinate Rules and Regulations to give detailed effect to this new Act.

- **Crime and terrorism convention adherence**: Bhutan is not a party to any of the international crime conventions. It is a party to only six of the 12 universal ant-terrorism instruments.

INDIA

- **National Strategy:** There is currently no drug control master plan or national strategy for the country. A drug control master plan 1994-2000 had been drafted with assistance from UNODC. There is a need to develop a national drug demand reduction strategy and action plan in the country.

- **Diversion of licit opium:** Although an elaborate system of regulatory controls has been established to prevent the diversion of opium, the Government of India admits that an unknown quantity (for which estimates vary) does flow into illicit channels. There is a need to develop capacities by developing signature profiling (see below), reducing the spread of cultivation, increasing the minimum qualifying yield, enhancing training and the provision of state-of-the-art equipment for preventing diversion.

- **Diversion of licit pharmaceuticals and the manufacture of spurious drugs:** While the law requires all drugs with abuse potential to be sold only on prescription, there are reports of continuous diversion of licit pharmaceuticals in violation of the legal provisions. In India, at the moment, injecting drug use is more closely linked to the abuse of licit opiate pharmaceuticals than to illicit drugs. Related to this problem is the issue of the entrance of spurious drugs into the marketplace.

- **Precursors and substitute chemicals:** Considering the relative ease of availability of ATS precursors in India and the growing demand for ATS in the world, especially SE Asia, the control of precursors continues to be a matter of concern. There is an urgent need to develop an improved

cooperation mechanism between India, China and Myanmar as a response to the ever-growing threat of the diversion of ATS precursors in the region and the consequential production of ATS. One recently detected trend has been the use of acetyl chloride as a substitute chemical for acetic anhydride, which is controlled under the NDPS Act. The use of such chemicals will render the location and identification of illicit manufacturers increasingly difficult.

- **Heroin signature analysis:** It is possible that a significant percentage of diverted opium is intended for local consumption of opium addicts in the country. It is also possible that a significant percentage of it is also processed into heroin in makeshift clandestine laboratories. Yet, there is no heroin signature programme in India. This has led to continuous debate over the provenance of the bulk of the heroin which is seized in the country. There is thus a need to upgrade the laboratories of the Government Opium and Alkaloid Works at Neemuch and Ghazipur as well as the Central Revenue Control Laboratories (CRCL) and State Forensic Science Laboratories to enable implementation of signature profile programme.

- **Drug trafficking:** (1) While ATS are smuggled from Myanmar into north-eastern states of India, ephedrine and pseudo-ephedrine (the precursors for their manufacture) are smuggled from India to Myanmar. The problems of interdiction relate*, inter alia*, to logistical difficulties and the uneven level of counterpart contact with the Myanmarese authorities. (2) The movement of drugs across the open Indo-Nepalese border is facilitated by the overall ease of cross-border movement. (3) There have been documented attempts to manufacture ATS within India. Efforts therefore need to continue to address the detection of illicit ATS manufacturing in the country. (4) Authorities in Bangladesh report concern over the volume of pharmaceutical preparations like cough syrups and painkillers which are smuggled into that country from India. (5) 'Brown sugar' heroin enters the north-east states from their internal borders with other Indian states.

- **Money laundering:** Even considering that the majority of drug seizures tend to be for small quantities where no financial investigation and asset forfeiture is possible, the number of financial investigations currently being undertaken remains limited. This may be explained by the fact that (a) many cases are booked by the police who are often not trained in financial investigations and hence there is hesitation in initiating the process and (b) many enforcement officers are not even aware of the provisions for financial investigation and asset forfeiture under the NDPS act and money laundering act. Although the money laundering act has been passed by the Indian parliament, the related administrative guidelines have not been developed and approved.

- **Drug abuse awareness/prevention:** There is currently no national drug awareness strategy or policy guidelines in place to drive and channel best practice in terms of drug prevention programmes in schools (as well as for

out of school youth) and in the media generally. There is also a need to develop curricula, modules, training material for drug prevention and link it to ongoing lifeskills efforts in schools. There is a low awareness of the nexus between drug abuse and the spread of HIV. In view of the vibrant industry in the country, there is a need to include responsible corporate citizens in active partnerships for drug use prevention, especially in the workplace.

- **Drug abuse treatment:** The National Survey demonstrates that very few current problem drug users contemplate early treatment for their addiction. Only a small minority are actually seeking help. The available responses suggest that there are certain factors which discourage users from undergoing treatment. Among these are: (a) lack of infrastructure, (b) cost of treatment, (c) lack of facilities and (d) the indifferent attitude of staff. Facilities for women drug users are limited. Though minimum standards have been laid down for treatment and counselling, necessary linkages have not been sufficiently established with the health and other sectors in terms of addressing drug use consequences – either holistically or competently. There is an urgent need to improve coverage, decentralise services to the state and district level to enable and foster decentralised lateral linkages. Services set up by the Ministry of Health and Family Welfare need to be linked with services set up by NGOs funded by the Ministry of Social Justice and Empowerment. There is an urgent need to mainstream substance use concerns in ongoing development programmes that address issues for especially vulnerable populations and empower women to reduce consequences of substance abuse.

- **Prison populations:** Various studies have shown the severity of drug use and vulnerability to consequences of drug use increase among incarcerated populations – especially if there are services in place to address their needs. There is a need to start prevention and treatment programmes in prisons across the country.

- **Drug use and HIV:** An analysis of national policies pertaining to drug use and HIV/AIDS found that there is no signal from government that HIV/AIDS prevention will be established as a central element of drug prevention and treatment programmes. The same analysis also noted that there was also no clear policy on opioid substitution treatment in India. In some quarters there is a view that there is a need for support for substitution treatment and progressive policy reform in India. This needs to be explored. Current surveys – sentinel, behavioural and rapid situation assessments – reveal that injecting drug use is rapidly increasing in 'non-traditional' geographic areas. Synergies with the National AIDS Control Organization (NACO) and the Ministry of Social Justice & Empowerment (MSJE) are currently nascent and need to be fostered in order to address HIV issues among drug-using populations. Policy and programme advocacy towards incorporation of standardised protocols for reducing injecting drug risks need to be linked to sexual risk reduction initiatives. Substance abuse issues also need to be mainstreamed into current HIV intervention settings and involving populations that are vulnerable to both

drugs and HIV, such as truckers, street children, sex workers and their partners, incarcerated populations, migrant workers etc. There is a dearth of trained manpower in NGOs aided by Ministry of Social Justice and Empowerment. The National Centre for Drug Abuse Prevention (NCDAP) and Regional Resource and Training Centres established in the country need strengthening. There is also a need to address the increasing feminisation of the epidemic resulting out of substance abuse.

- **Human trafficking**: In view of the level of trafficking in human beings and especially women and children, there is a need to develop and improve functional databases on routes, structures, and modalities used by traffickers of human beings; to improve law enforcement functions and cooperation; to strengthen criminal justice responses; to heighten awareness within the law enforcement and judicial communities and among the population at large; and to improve the protection and support system for victims and witnesses.

MALDIVES

- **Drug policy coordination:** There is no drug control master plan for the country. The findings of Rapid Situation Assessment highlight the urgent need for development of multi-pronged strategies in the prevention and treatment of drugs users and better liaison and networking between different involved agencies. The rapid situation assessment also drew attention to the fact that injecting drug use is an emerging issue with 8% of the sample having a recent history of injecting.

- **Drug trafficking:** There is a limited ability of law enforcement officials in the Maldives to profile and search air and sea vessels passing through their territory. There is consequently a need to strengthen the capacity of law enforcement agencies on intelligence gathering and interception through training and state of art equipment. There is also a need for stepping up cross-border cooperation for sharing of intelligence, and operational cooperation between countries to prevent trafficking into the country.

- **Drug treatment (including in prisons):** A lack of any therapeutic intervention means that very little is done to motivate drug users to quit their habit. There is an expressed need for a model for therapeutic intervention in prisons.

- **Drugs and HIV:** The rapid situation assessment report of the Maldives drew attention to the increasing vulnerability of young people to drugs and HIV. There is a need to develop a prevention strategy backed by a low-cost model for increased coverage to reduce risk behaviours among adolescents related to drugs and HIV in the country.

- **Precursor chemicals:** The Government has not yet promulgated regulations to include precursor chemicals in the list of dangerous chemicals falling under its special regime. A precursor control law has been drafted with the assistance of the Regional Precursor Control Project and it is hoped that the same would be placed before the parliament in the near future.

- **Crime and terrorism convention adherence**: The Maldives is not a party to any of the international crime conventions. It is a party to only eight of the 12 international terrorism conventions.

NEPAL

- **Injecting drug use and HIV:** The rise in HIV prevalence among IDUs in Nepal in the recent past has highlighted the need for reaching out to a critical mass of IDUs in any city/country in order to provide adequate safer injecting options when an effective mechanism to reach out to IDUs is developed. A situation analysis of HIV/AIDS in Nepal (largely qualitative) has noted not only the increasing number of IDUs in Nepal, but also their vulnerability to high-risk behaviour and the increasing prevalence of HIV among IDUs. The report also noted with concern, inadequacy of initiatives in Nepal which reduce harm to drug users within the context of an overall comprehensive package of services. A clear trend towards IDU was noted among users who smoked heroin or took codeine cough syrup. Cost-effective drug treatment and HIV prevention programmes for IDUs are urgently required. There are provisions in the law for medical practitioners to prescribe oral substitution. There is therefore a need to train medical practitioners in this regard. There is a need to place injecting risk reduction within a continuum of treatment, care and support for drug users. There is a paucity of drug demand reduction facilities in the country, and, currently, no minimum standards have been identified. Linked to IDU risks are the issues of mobility, migration, trafficking in women and children, poverty and HIV consequences. There is an urgent need for cross-border interventions between India and Nepal addressing the above multi-sector issues in a comprehensive manner. While the Ministry of Home is in charge of demand reduction, the Ministry of Health is in charge of promoting risk reduction and STD/AIDS prevention. There needs to be convergence in the responses by the two ministries. The Drug Abuse and Drug Demand Reduction Project (DADRP) run by the Ministry of Home has only a few dedicated inpatient de-addiction facilities in the government sector. There is a need for an active multi-disciplinary board for DADRP. Facilities in the NGO sector are not well coordinated.

- **Drug use and prisons:** One significant problem at present is that drug dependent persons do not receive regular treatment and rehabilitation and no psychiatrists are available in the prisons. The Community Recovery Centre run by the Ministry of Home attends to incarcerated prisoners and needs to be strengthened.

- **Precursor control:** The geographical location of Nepal between India and China – the two largest producers of ephedrine and pseudoephedrine – as well as its proximity to Myanmar, which has a large illicit demand for these two precursors, makes Nepal crucial in any scheme of precursor control in the region. There have also been attempts to use Nepalese territory to divert Indian acetic anhydride to Pakistan. There is no comprehensive law to regulate precursors at present. A precursor control law has been drafted with the assistance of the Regional Precursor Control Project and it is hoped that the same will be placed before the parliament in the near future.

- **Money laundering:** There is no law criminalizing money laundering in Nepal. The multiplicity of agencies, the tendency not to share criminal intelligence, and division

of authority for financial investigation and drug crime investigation between different ministries results in a very low detection rate of money laundering and related crime.

- **Human trafficking:** Nepal is a source country for women and girls who are trafficked into India for work in brothels and as domestic labour. The Human Trafficking Control Act of 1986 is the main piece of legislation currently in place. It criminalizes the trafficking in human beings. The National Plan of Action on human trafficking exists but is not being fully implemented. There is a need to strengthen the capacities of law enforcement officers through training to prevent trafficking. There is also a need to step up cross-border cooperation for intelligence gathering, as well as, developing community-based initiatives that address issues of prevention both at source and destination for victims of trafficking. There is a need to improve the protection and support system for victims and witnesses.

- **Drug convention adherence:** Nepal is still not a party to the 1971 Convention.

- **Crime and terrorism convention adherence:** Nepal is not a party to the international crime protocols. It is a party to only five of the 12 international terrorism conventions.

SRI LANKA

- **Information and programmes on the extent, pattern and trends in crime and small arms trafficking:** With the ongoing peace process there is a risk that individuals with few skills to maintain a sustainable livelihood other than in a military or paramilitary setting may become involved in drug use or trafficking or other criminal activities, often involving small arms trafficking. This would seem to call for an assessment of the nature of the problem and the integration and training of ex-combatants and deserters into civil society. There is no comprehensive crime survey in the country.

- **Precursor control:** At present there is no comprehensive precursor control legislation in the country and precursors are regulated under the customs laws and procedures. There is a need to develop strong monitoring procedures to ensure that precursors are not diverted for illicit purposes after their import into the country. The NDDCB has, meanwhile, expressed the view that the Government of Sri Lanka would like to establish an exclusive precursor control legislation in the near future and may need UNODC's assistance in doing so.

- **Data on drug abuse:** There have been no large-scale surveys or Rapid Situation Assessments of drug users conducted in Sri Lanka in recent years. Alcohol and cannabis abuse (especially among plantation workers), a proliferating entertainment industry and the easy availability of other drugs, point to the necessity of mounting evidence-based interventions that address drug use and its consequences, including HIV.

- **Drug use in prisons:** Although a successful prison diversion programme for convicts is in place, there is a need for a structured therapeutic programme. There is a need for de-addiction programmes for incarcerated remand prisoners. An institutional framework should be created for treatment and rehabilitation of drug users in the

prisons. Any available resources for this purpose should be identified and used. Community mobilization in this connection is necessary. Aftercare for released drug dependent prisoners is required. Technical experts and resource persons should be exchanged within the region.

- **Drugs and HIV**: There is no stated concern over the need for prevention of HIV in the demand reduction policy/programmes run by NDDCB, although there is informal exchange between the National STD/AIDS Control programme and NDDCB.

- **North and East of Sri Lanka:** Due to the prolonged civil conflict, the infrastructure for drug control is skeletal in the North and East. Therefore a preliminary needs assessment for drug control activities in the Northern and Eastern Provinces is required.

SUMMARY OF REGIONAL PRIORITIES

1. **To provide the means for key stakeholders to prevent the spread of drug abuse and related drug-abuse-driven HIV in South Asia, especially among vulnerable populations.**
   a. Develop and implement replicable models of effective drug prevention approaches in India.
   b. Establish a replicable model for school-based prevention and community awareness in South Asia.
   c. Test and validate peer-based interventions to reduce drug-related risk behaviour.
   d. Develop and implement peer-outreach programmes, low-cost community-based care and support, safer practices and oral substitution treatment where legislation permits, especially among vulnerable populations such as IDUs, incarcerated populations, street children, sex workers and migrant workers.
   e. Share intervention protocols within the region and advocate for their up-scaling.
   f. Increase the coverage and quality of interventions.
   g. Scale-up outreach to current drug users.
   h. Promote treatment before injecting occurs.
   i. Mainstream HIV concerns into ongoing drug demand reduction initiatives.
   j. Mainstream drug issues and concerns into ongoing HIV programmes.
   k. Raise awareness on the connection between drugs and HIV among religious leaders, local government, and community-based organizations.

2. **To assist governments of the region to reduce the supply of illicit drugs, licit (diverted) drugs and precursors.**
   a. Increase controls over licit pharmaceutical drugs in selected countries.
   b. Strengthen precursor control measures and mechanisms.
   c. Improve technical capacities for effective drug law enforcement, including in border control.
   d. Improve controls over licit opium supply to prevent diversion.

3. **To build the capacity of governments and civil society to reduce the number of people trafficked within and from the region, and its consequences.**
   a. Raise awareness of the extent, nature and pattern of human trafficking in South Asia and contribute towards policies and action to halt it.
   b. Provide greater support and rehabilitation for trafficked victims.
   c. Train law enforcement officers in measures to counter human trafficking.
   d. Strengthen or help establish states-NGO task forces in source states to ground counter-trafficking interventions.

4. To assist governments to strengthen normative frameworks and improve the knowledge base on drugs, crime and terrorism.

a. Promote adherence by the governments of the region to the drug, crime and terrorism conventions and protocols.
b. Improve the knowledge base on drug/crime problems and enhance capacity for evidence-based policy development.
c. Provide training programme on international cooperation mechanisms, especially mutual legal assistance.
d. Provide legal assistance to selected countries.
e. Develop and support a national master plan process in selected countries.
f. Undertake a rapid assessment of drugs and crime issues in selected countries.
g. Support the establishment of mechanisms to prevent money laundering in India.
h. Advocate for evidence-based policies and programmes based on solid research and accurate epidemiology.

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