Drug policy-making in Sri Lanka 1984-2008: people, politics and power

A Thesis submitted to Middlesex University in partial fulfilment of the requirements for the degree of Doctor of Philosophy

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Author's declaration

I hereby declare that this thesis entitled 'Drug policy-making in Sri Lanka: people, politics and power' represents the results of my own work except where specified in the thesis.

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Abstract.

Policy analysis has not been a part of mainstream Sri Lankan research or academic tradition, and hence there exists a lack of research on policy studies in Sri Lanka. Given also a paucity of research on illicit drug use and contemporary drug policy, this research study generated and analysed a body of evidence about the response to drug misuse and its related policies in Sri Lanka between 1984 and 2008. As the subject of drug policy can be viewed through a variety of perspectives, this thesis adopted a multi-disciplinary approach. It drew on ideas, theories, concepts and research from a variety of social science disciplines such as sociology, political science, international relations, public administration and social policy and included an historical approach to understanding policy development. The study provides an informed narrative describing the rationale for the development of Sri Lanka's drug policies, their course and outcome and the roles of the various actors, institutions, organisations and interest groups already established, or which came into existence to respond to drug misuse. This shows how, and why, particular policies are shaped and influenced by the actors, institutions and organisations, and by particular discourses. The conceptual foundations for this study were epistemic community theory, stakeholder analysis and policy transfer theory; and the thesis will seek to explain policy in changing contexts. Semi-structured key informant interviews and documentary analysis were the main research methods employed. The analysis revealed that external influences, stakeholder dynamics, consensus in policy approaches, and moral frameworks have combined to sustain a criminal justice model to the management of drug problems and to ward off attempts to introduce a system with a stronger focus on treatment and public health. This study demonstrates that the interests of stakeholders and their relative power significantly influenced the legitimisation of consensual knowledge diffused by epistemic communities which underpinned policy outcomes.

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List of abbreviations.

ADIC: Alcohol and Dug Information Centre

AG: Attorney General

AIDS: Acquired Immune Deficiency Syndrome

CMO: Comprehensive Multidisciplinary Outline

CND: Commission on Narcotic Drugs

CPDAP: Colombo Plan Drug Advisory Programme

EMCDDA: European Monitoring Centre for Drugs and Drug Addiction

EU: European Union

FONGOADA: Federation of Non-Government Organisations Against Drug Abuse

GSP: Generalised Scheme of Preferences

HIV: Human Immunodeficiency Virus

INCB: International Narcotics Control Board

IOGT: International Organisation of Good Templers

JHU: Jathika Hela Urumaya

LTTE: Liberation Tigers of Tamil Eelam

NATA: National Authority on Tobacco and Alcohol

NDDCB: National Dangerous Drug Control Board

NGO: Non-Governmental Organisation

NNAC: National Narcotic Advisory Committee

PNB: Police Narcotics Bureau

SAARC: South Asian Association for Regional Cooperation

SLAS: Sri Lanka Administrative Service

SLFP: Sri Lanka Freedom Party

TB: Tuberculosis

UK: United Kingdom

UN: United Nations

UNCND: United Nations Commission on Narcotic Drugs

UNDCP: United Nations Drug Control Programme

UNODC: United Nations Office for Drug Control

UNP: United National Party

UPFA: United People's Freedom Alliance

USA: United States of America

WHO: World Health Organisation

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Chapter One

Introduction.

Literature on health policy analysis in low and middle income countries is limited, diverse, fragmented and descriptive in nature, and is dominated by authors based in western countries (Gilson and Raphaely, 2008). Similarly, health policy analysis has not been part of mainstream research or academic tradition in Sri Lanka[1] and there exists limited research on policy studies, particularly investigating policy change processes that integrate politics, process and power. Given the paucity of research on illicit drug use and contemporary drug policy, this thesis aimed to generate and analyse a body of evidence on the drug problem and its policies in Sri Lanka between 1984 and 2008, a key period in the emergence of the formulation of policy.

The thesis will argue that drug policy has followed a punitive course, with the prevailing response established within the criminal justice system to manage the drug problem, and has not adopted a health or social welfare model. This has been largely consistent over the period studied although there was some limited success in attempts to challenge the criminal justice model and persuade policy-makers to follow an alternative approach. Many economic, political and social factors have combined to sustain the criminal justice model and avert attempts to introduce a stronger health focus. External influences

[1]Sri Lanka is an island located in the South of the Indian subcontinent with an approximate population of 20.9 million (Department of Census and Statistics, 2015). Its location is considered to be of strategic importance from the time of the ancient Silk Road through to World War two. It is home to many different ethnic groups, religions and languages and is known as one of Asia's oldest civilisations. The majority of the people are Sinhala Buddhist and the country has a rich Buddhist heritage. Sri Lanka gained independence from the British colonial rule in 1948 and has been a democracy since. Constitutional changes in the 1970s moved it from a "Westminster" model to one that concentrates power in the hands of an Executive President.

shaped the direction of national drug policy and the recent shift towards including drug rehabilitation can also be attributed to external pressures along with the influence of national policy actors' interaction with international knowledge networks.

Aim of the Thesis.

The aim of the thesis is to provide an informed narrative describing the rationale for the development of Sri Lanka's drug policies (1984-2008), their course and outcome and the roles of the various actors, institutions, organisations and interest groups already established, or which came into existence to respond to the problem of drug misuse. This will show how and why particular accounts are shaped and influenced by the actors, institutions and organisations, and perhaps by particular discourses. The protocol for the thesis detailed the research questions as follows:

1. How was drug policy developed over time, and why?

2. Which organisations and individuals were behind this development, and why?

3. Who was influential in making policy decisions, and why?

4. What was the role of international organisations in the development of drug policies in Sri Lanka?

5. Have there been other agendas, tensions, contradictions and coalitions identified during the development of policies, and if so how were they managed?

The questions were researched utilising a qualitative research design where interviews with policy-makers and people in positions of power were triangulated with documentary sources. These approaches enabled the generation of rich information on the process of policy development over time

and place and uncovered the many meanings attached to drug policies in Sri Lanka.

The following sections provide an overview of: the four key drug policy initiatives that emerged post the British colonial period which ended in 1948; the policy background which provides the rationale for the choice of the study period and introduces some of the factors influencing the direction of policy; major policy initiatives and events which recognises the influence of external as well as internal policy developments; the conceptual framework and the research methodology; and, finally, the structure of the remaining chapters of the thesis.

The Development of Drug Policies During the Period 1984-2008.

For the purpose of this thesis, drug policy is defined as the "system of laws, regulatory measures, courses of action and funding priorities concerning (illicit) psychoactive drugs and promulgated by a governmental entity or its representatives" (EMCDDA, 2014:2) as adapted from Dean Kilpatrick's (2000) definition of public policies.

The research was informed by historical perspectives which Berridge (2001: 611) notes, draw attention to the value of "long-term and contextual perspectives on current health issues", seek to place policy developments in the context of the times in which they emerged, and facilitate a critical narrative of current policy. In short, the historical approach helps to explain and contextualise policy development without adopting an advocacy position or attempting to justify policy choices. More recently, Berridge (2013) analysed the attitudes towards alcohol, tobacco and drugs in the UK as an evolving process situated in the history where the role of the state, economic and professional interest groups, and various other local, national and international stakeholder interests had been influential.

The thesis focuses around four key drug policy initiatives introduced during the period 1984-2008, which will be discussed in detail in subsequent chapters.

First, the amendments made in 1984 to the Poisons, Opium and Dangerous Drugs Ordinance of 1929 require discussion as they solidified and strengthened a penal approach to managing drug problems and gave effect to some of the international drug control conventions that Sri Lanka had become party to in earlier years. Legislative amendments led to the creation of the National Dangerous Drug Control Board (NDDCB) as a formal government entity, charged with the responsibility of devising a national policy on drugs and coordination of all drug control activities in the country. The role, interests and interrelations of the NDDCB as the focal organisation concerning drugs requires examination as it was instrumental in the development and maintenance of drug policy. Further legislative amendments in 1984 resulted in significant changes to the way that criminal justice agencies, government ministries and departments, health and the non-government organisation (NGO) sector responded to the drug problem. Actors came into existence and inter-related with external organisations, influenced and instigated national action, though not always rapidly, and became the instigators for contemporary drug policy development.

Secondly, a decade later, the first national policy on drugs emerged as a cohesive single document in 1994. By this time, illicit heroin had supplied local drug markets and reached epidemic levels. Divergent views existed among professional groups on the drug problem, which resulted in the problem being viewed and framed within different disciplinary perspectives. A multi-agency approach to drug policy implementation within an established and dominant penal approach emerged as the basis of the first national policy on drugs. Treatment and rehabilitation of drug users was endorsed and appeared for the first time in a national policy document alongside supply reduction strategies.

Thirdly, the updated national drug policy in 2006 further strengthened the penal approach and the rehabilitation ideology, which were intertwined with the government's ambition to achieve a drug-free society. Although moral overtones in policy-making existed previously, they peaked after 2005 as the government aspired to moving towards a "righteous society", based upon abstinence. Whilst the multi-agency approach to policy implementation had been re-emphasised, policy continued to be based on the four pillars identified in the first national policy in 1994: enforcement; preventative education and public awareness; treatment, rehabilitation and after-care; and international coordination.

Other areas included were the development of restrictions over precursor chemicals used in illicit drug manufacture and "a requirement for drug dependants to seek treatment" (Updated National Policy for the Prevention and Control of Drug Abuse, 2006:4), a re-wording of the term for compulsory treatment which had been announced in the first national policy on drugs although it had not been implemented by 2006.

Finally, the thesis will discuss the development of the Drug Dependant Persons Treatment and Rehabilitation Act introduced in 2007, which aims to tackle two aspects: the regulation of drug treatment centres, introducing a legal licensing requirement to establish facilities for the purpose of drug treatment and rehabilitation; and the introduction of compulsory drug treatment for drug dependants. This extended the power of the criminal justice system, whereby, following a medical examination, a person could be compelled to have treatment.

The Policy Background.

During the period under investigation, there have been considerable changes to the way in which the problem of drugs was framed and defined, including significant changes to the social policy framework and to the legislative system

which attempted to regulate drug use. The thesis analyses social factors influencing the development of policy, examines the policy-making processes and the wider economic, political and social contexts. The start date of 1984 was selected because this was the year when the Poisons, Opium and Dangerous Drugs Ordinance of 1929 was amended, the death penalty for drug related offences was introduced and the NDDCB was established to co-ordinate all drug related activities. Policies adopted since 1984 ensured that the response to the drug problem was firmly located within the criminal justice system leading to a large number of drug users being imprisoned. Out of the total prison population in the country, nearly 45% of men and women were admitted for narcotic-related offences in 2000, the largest single category (Handbook of Drug Abuse Information, 2002). By 2003, the majority of drug-related prison admissions were for heroin related offences (88%) with the remaining (12%) for cannabis (Handbook of Drug Abuse Information, 2004).

Successive governments strongly condemned drugs and their responses have been directed at either total eradication or reduction in the supply and use of drugs to the barest minimum. Drug policy has been largely uncontested throughout the period under investigation. There was cross-party political support and strong consensus among policy makers on an abstinence-based approach built on stringent law enforcement and rehabilitation. The responsibility for dealing with drug problems comes under the Ministry of Defence. The Presidents have had a keen interest and control over drug policies. The President has additionally been the Minister of Defence from 1984; he is the most powerful politician in the country and is at the core of economic, political and social decision-making. Prominent Buddhist monks have periodically taken an interest in addressing drug problems but the more recent politically active monks have become adept at influencing the development of drug policies.

It is suggested that drug policy is a highly politicised and sensitive research area, particularly in the developing world. Many researchers might not have studied this area due to its political nature, a lack of data on this subject in the

country and difficulties in gaining access to interview powerful policy-makers. The significant influence of politics in the area of drug policy-making in the developing world requires scrutiny and understanding beyond the point at which many drug policy analysts cease their research. The content of drug policy is not separate from the politics of policy-making (Duke, 2002; Lancaster, 2016), questions such as who?, how?, what?, and why? related to drug policy and policy decisions require examination. In this context, there is a need to engage and communicate with those who are in positions of power, those who influence the introduction or maintenance of drug policy, to understand the conflicts, contradictions and coalitions in the policy process. Hence, progressing beyond a content analysis of drug policy documents indicates a need to understand the economic, political and social contexts in which these documents have been produced and used, including if they too had a role in the introduction and maintenance of drug policies in Sri Lanka.

Summary of Initiatives.

The focus is particularly on Sri Lanka, but takes cognisance of some external drug policy or programme initiatives as they have influenced the development of drug policies within Sri Lanka. National, as well as related international policy initiatives, including the national structures created to respond to drug misuse are depicted chronologically in Table1. Significant events that had an impact on drug policy are also included. The range of policies, initiatives and events provides a flavour of how drug policies were embedded in government activities.

Table 1. Policy initiatives, structures and events.

1983	Civil war began in Sri Lanka.
1984	Poisons, Opium and Dangerous Drugs Ordinance of 1929 amended.
1984	The NDDCB was created under the Ministry of Defence.

1985	SAARC members' first summit and the adoption of SAARC Charter.
1985	The NDDCB holds a workshop on medical aspects of drug abuse.
1986	NDDCB Amendment Act No 41 expanded the membership of the Board.
1987	Sri Lanka participates in the UN conference on drug abuse and illicit trafficking convened in Vienna.
1987	UNDCP adopts the CMO of Future Activities in Drug Abuse Control.
1987	Navadiganthaya, the first residential treatment centre for drug users opens.
1987	FONGOADA created as an umbrella organisation to represent all NGO's working in the drugs field.
1987	UNDCP funds the NDDCB to develop drug prevention and treatment.
1987	UNDCP funds the drug abuse monitoring programme.
1988	UN Convention against illicit traffic in narcotic drugs and psychotropic substances adopted.
1988	The SAARC Islamabad Declaration commissioned a regional convention on drug control.
1989	Declared as SAARC Year for Combating Drug Abuse and Drug Trafficking.
1990	SAARC Convention on Narcotic Drugs and Psychotropic Substances.
1990	The NDDCB opens Meth Sevana drug rehabilitation centre.
1991	UNDCP funds phase 1 of drug prevention and treatment programmes.
1991	The NDDCB published the first Handbook of Drug Abuse Information.
1991	The NDDCB opens two more drug rehabilitation centres.
1992	SAARC Drug Offences Monitoring Desk established in Colombo.
1992	President Premadasa appoints a committee to inquire into the need for prevention of alcohol and tobacco use.
1993	UNDCP funds phase 2 of drug prevention and treatment programmes.
1993	The NDDCB takes over Navadiganthaya drug rehabilitation centre.

1993	Colombo Plan seminar on drug rehabilitation takes place.
1994	The first national policy on drugs published.
1995	Memorandum of understanding between SAARC and UNDCP.
1995	Resolution in Parliament to implement capital punishment for drugs and violent crimes.
1997	President Kumaratunga appointed a new committee to draft a national policy on tobacco and alcohol.
1999	Presidential proclamation to implement capital punishment.
2000	UNDCP regional workshop to restrict precursor chemical availability in SAARC countries.
2001	National STD/AIDS control programme launched
2004	JHU Buddhist monks contested Parliamentary elections.
2005	Mahinda Chinthana[2], presidential election manifesto launched.
2005	The JHU joined the UPFA coalition.
2005	The JHU Buddhist monk tables tobacco and alcohol control Bill in Parliament
2006	The National Drug Policy updated.
2006	Tobacco and Alcohol Regulation Act passed.
2006	National Authority on Tobacco and Alcohol created.
2007	Drug dependant Persons Treatment and Rehabilitation Act.
2008	Conventions Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances act No 1 of 2008 introduced in Sri Lanka.

[2] Mahinda Chinthana is President Mahinda Rajapakse's election manifesto published in 2005. He contested the Presidential elections in 2005 from the coalition, the United People's Freedom Alliance. This election manifesto urges people to support his vision of building a new Sri Lanka.

Conceptual Framework for the Analysis of Drug Policy.

To answer the identified research questions, due consideration of the domestic policy-making context is required by reading the relevant policy documents and previous research conducted by the author (Samarasinghe, 2006, unpublished). The development of a theoretical framework for the analysis of drug policy is relevant. The three theories of epistemic communities (Haas, 1992), stakeholder analysis (Varvasovszky and Brugha, 2000) and policy transfer (Dolowitz, 2000) are used to provide the basis for the thesis to describe and analyse the development of drug policies in Sri Lanka. While stakeholder analysis can examine the dynamics of stakeholder action within the policy process, epistemic community and policy transfer will seek to explain policy in changing contexts. The inter-connections of these theories in conjunction with documentary analysis aim to provide a comprehensive account of the development of Sri Lankan drug policies.

Epistemic communities is a term used to describe a network of professionals or expert individuals who come together to share their knowledge and understanding of a complex problem in an unbiased, truthful, impartial, apolitical and neutral manner (Haas, 1992). The intention is to generate solutions for identified problems related to illicit drugs, which may include the formulation of law, policy and practice. A knowledgeable group of experts on drugs can supposedly bring confidence and experience along with learning to address problems existing at national or international levels which may be outside the ability of a local group to resolve or to provide an outside, informed opinion. Epistemic community members can be regarded as stakeholders in the policy process and play a pivotal role in the social construction of reality. Thus, some of the meanings attached to domestic drug policies are constructed by epistemic communities existing at national and international level. However, this theory has not been widely applied to either policy studies on drugs or to those within low to middle income countries. The thesis will identify national and international epistemic communities concerning drugs and discuss their influence on shaping drug policies in Sri Lanka. It is suggested that the epistemic community theory and its features are evident in the establishment of various expert committees and institutions set-up in the country to deal with the

drug problem, and subsequently having an impact on policy outcomes. The theory is not without criticism, as will be evidenced in the thesis. For instance, there may be a blurring of roles among members of epistemic communities that could result in decisions being susceptible to political influence, making impartiality somewhat difficult to maintain.

Stakeholder analysis is complementary to the application of epistemic community theory in that it does not primarily investigate the role of knowledge experts but examines the characteristics of policy actors their dynamics and interrelations. The thesis will employ stakeholder analysis theory to look at policy actors' role in knowledge utilisation, decision-making process and any power, influence, prevailing interests or other characteristics which may affect drug policy outcomes. It suggests that powerful elite individuals and groups can exert significant influence in the development of drug policies in Sri Lanka and that *elite theory (*Laswell,1958) as applied to stakeholder analysis is probably dominant over pluralist (Dhal and Lindblom, 1976), structuralist (Blackburn, 2008) and bounded-pluralist views. However, stakeholders' power and influence is dependent on a number of mediating factors and does not remain static. The thesis considers if power can shift between individual and stakeholder organisations concerning drugs policy and if this is subject to any changing economic, political and social factors.

As with the application of the epistemic community theory, stakeholder analysis requires a context and time period to be identified and explored. It is applied retrospectively here as it lends itself to tracing the development of drug policies between 1984 and 2008. Stakeholder analysis is utilised to identify the influence of institutions and policy actors operating within the country's main drug policy-making institution, the National Dangerous Drug Control Board (NDDCB), government departments and ministries, political and other interest groups and NGOs.

Policy transfer is the final theory utilised in this thesis and is congruent with the application of epistemic community and stakeholder analysis theories in addressing significant social problems. Policy transfer refers to the adoption of a policy used in one area to be used to address a similar problem in another. The theory has gained momentum to inform policy change in various fields and across countries as societies become more alike due to influences of industrialisation, modernity and harmonisation. It has been described through a number of terms: policy convergence, policy diffusion, lesson drawing, policy mimicry, policy learning, policy translation and emulation (Bennett, 1991; Majone, 1991; Rose, 1991; May, 1992; Howlett, 2000; Stone, 2012), However, policy transfer remains the main or umbrella concept in the academic literature. It can be voluntary, negotiated or coerced. Reflecting on the historical developments of drug policy, Sri Lanka has been subject to coerced and negotiated types of policy transfer as applied by the colonial administrations from Portugal, the Netherlands and Great Britain respectively. Following the country's independence in 1948, organisations such as the United Nations, the Colombo Plan[3] and their actors have also engaged in transferring the internationally agreed norms and principles of drug control onto the domestic policy-making context. The diffusion of knowledge and ideas by epistemic communities, their role, interests and influence and the inter-relationships among national stakeholders in contemporary drug policy development in Sri Lanka is worthy of study.

Research Methodology.

The application of the afore mentioned three theories are the conceptual foundations of this qualitative thesis and lend themselves to the use of key informant interviews and documentary analysis to provide an informed and in-depth view of the origins and development of drug policy in Sri Lanka. The objective is not only to test one kind of gathered data, such as documents against another i.e. interviews, but to use them in conjunction with each other.

[3] Colombo Plan and Colombo Plan Drug Advisory Programme are terms used interchangeably throughout this thesis.

The notion of methodological triangulation and how it improves validity of the data collected, methods for recruiting key informants and a reflexive account of the fieldwork is discussed later.

Stakeholders involved in the policy process include individuals who represent the Ministries of Defence, Health and Justice; NDDCB, Police, Customs, political parties, religious groups, and NGOs. Key to this thesis is the understanding of factors and processes which influence these stakeholders' perceptions and experiences in relation to policy development. A qualitative research design is able to demonstrate how and why particular accounts are shaped and influenced by stakeholders, institutions, and perhaps by particular discourses. It is well suited to capture rich descriptions of complex phenomena, both in terms of the policy process and its implementation. A quantitative research design is not being applied since its methods are unlikely to capture the level and depth of data required to answer the research questions. Furthermore, due to the existence of limited data and research on drug policy in Sri Lanka in comparison to western and more developed nations, the adoption of a developmental approach inherent in a qualitative research design enabled the identification of the areas of policy for investigation.

Interviewing elite and powerful individuals generates a unique set of dilemmas and complexities for the researcher (Duke, 2002; Lancaster, 2016). Gaining access to interview influential people, power relations between the interviewer and the interviewee, the researcher's positionality and identity are some of the issues discussed in detail as reflections in the research methodology chapter.

Preliminary interviews, also known as initial key informant interviews in this thesis, conducted with a few key informants, were based on purposeful or non-probability sampling. These key informants can be defined as individuals who were all involved in formulating and implementing national drug policies, directly involved in either amending or developing legislation, were members of the National Dangerous Drug Control Board, and occupied powerful positions

to influence and shape policy decisions. The second stage of the interview process involved a snow-ball sample, based on other informants identified through preliminary interviews.

The interview schedules for key informants were devised with the intention of generating data anchored to significant policy events such as the amendments made to the Poisons, Opium and Dangerous Drugs Ordinance of 1929 in 1984, the formulation of the first Sri Lankan national policy on drugs in 1994, the updated national drug policy in 2006 and the creation of the Drug Dependant Person's Treatment and Rehabilitation Act in 2007.

Policy-makers, politicians, public sector administrators, civil servants, legal experts, non-governmental organisations and the public are routinely involved in the production and consumption of written records and documents. However, policy studies conducted by social scientists have largely ignored the systematic use of documents to analyse and enlighten certain public policy events and processes. In social research, documents can go beyond being only a source of data and can be viewed as actors in their own right, recruited into schemes of organised activity and regarded by others as allies, enemies or perhaps instigators of further action (Prior, 2008). Hence, documents are considered to fulfil a dual role as they appear both as sources of content and as active agents in the drug policy-making process. Selected documents for analysis are: legislation related to drugs, national drug policies, election manifestos, Hansards, international drug control conventions, annual reports and handbooks produced by the INCB and NDDCB respectively, national HIV/AIDS policy, minutes of the NDDCB meetings and documents summarising national and international conference proceedings related to drug control. Many of these were able to provide a version of past policy events supplying sufficient material to design preliminary research questions as well as the establishment of some chronological certainty about policy events.

This analysis of drug policy documents shows the social, political and economic contexts in which the above mentioned documents have been produced and used and their attached cultural meanings. It includes a textual analysis of key policy documents regarding them as resources as well as actors extending beyond a silent or non-contributory role. As Atkinson and Coffey (2004:70) argue, “it is part of the facticity of many official and organisational documents that they are not identifiably the work of an individual author and their very anonymity is part of the official production of documentary reality”. However, while consultation lists and acknowledgements recorded in published official documents assisted with the identification of key informants for interview, key informants were able to identify the documents they had written or identify the authors. The key informants’ role in the production of policy documents, influence in the content meaning of inscribed text, and any contradictions or consensus encountered during the document’s production requires further understanding and discussion.

The Structure of the Thesis.

As briefly discussed, external drivers of national policy, policy drivers that had been unique to the national context, the moral frameworks and power and politics involved in the policy-making process are the running leitmotifs of this thesis. They are interwoven and cut across all chapters. The chapters follow a chronological sequence and introduce the key policy initiatives, concepts, literature and documentary sources.

This chapter has provided the rationale for the thesis, briefly introducing the key policies and related initiatives or events, including the main concepts that will run through the thesis. It has also touched briefly on the conceptual framework and research methodology employed to analyse drug policy development in Sri Lanka.

Chapter Two is written with the broad aim of developing a conceptual framework for the analysis of drug policies. It will discuss in more detail the rationale and benefits of utilising the three theories of epistemic communities, stakeholder analysis and policy transfer. The inter-connections of these theories with documentary analysis are also explored with a view to explaining policy development at national level, instigated and influenced by knowledge-based policy experts operating at national and international level. Attention is paid to the human actors inherent within epistemic community theory, the integration of epistemic community theory with stakeholder analysis where power relations can be examined in particular, and the combination of these with policy transfer theory will be elaborated to discuss policy in changing contexts.

Chapter Three discusses the research methodology employed to answer the research questions and exploration of Sri Lankan drug policies. It provides a rationale for utilising a qualitative research design whereby key informant interviews and documentary analysis become the main research methods employed. Adopting a reflexive approach, methods for key informant recruitment, identification of documents for analysis and the fieldwork process are described. It includes challenges encountered and how they were addressed, which contributes towards the literature on fieldwork undertaken with influential people in developing countries.

Chapter Four examines the historical developments and the identification of stakeholders and interest groups concerning drugs prior to 1984. To describe contemporary drug policy without consideration of past policy events fails to appreciate the country's history and misses an opportunity to understand and interpret the processes and influences in the period covered by this thesis. While highlighting the social, political and economic factors that prevailed in the history, this chapter traces the existence of epistemic-like communities, stakeholders and policy transfer in the area of drugs.

Chapter Five provides a comprehensive empirical account, which concentrates on external organisations, actors, policy events, and their influence on shaping drug policies in Sri Lanka. The role of expert knowledge, the diffusion of internationally recognised principles and norms on drug control and how they resulted in policy transfer or translation, including evidence and rationale for non-transfer is explored.

Chapter Six is interwoven with Chapter Five, although the empirical account is primarily focused on national policy actors' involvement in drug policy development. It pays close attention to how national policy actors responded to external influences previously discussed, how the drug problem was framed and defined by local groups, which led to the desired, legitimate policy responses. Consensus, contradictions and coalitions formed amongst national policy actors in the policy-making process are discussed.

Chapter Seven is concerned with the politics and power inherent in the drug policy-making process with specific reference made to national stakeholders and their ideologies operating at the political level and how they influenced policy development. In this context, power structures and their relationship with stakeholders are examined. The overlap between prohibition and the moral underpinning of policy-making amongst politicians and interest groups is discussed.

Chapter Eight will provide a concluding overview of the key findings of the previous chapters and offer some remarks on the nature of drug policy development in Sri Lanka during 1984-2008. In doing so, 'documents as actors' in the policy process and the usefulness of applying the conceptual framework is revisited. The latter part of this chapter will discuss the limitations and contributions of this research, and the course of drug policies after 2008.

This thesis does not include a traditional literature review and as noted at the beginning, there has been little research on drug use in Sri Lanka, no research

on drug policy and limited research on policy analysis in general. Relevant bodies of literature have been used to inform the study design and methods and to provide insight into drug issues discussed. Both primary and secondary sources of information are used.

Chapter Two: Conceptual Framework for the Analysis of Drug Policy.

Introduction.

This chapter is written with the broad aim of developing a conceptual framework for the analysis of drug policy in Sri Lanka. It discusses three main theories; epistemic communities, stakeholder analysis and policy transfer, and how they can be integrated to describe and analyse drug policy development 1984-2008. The three theories seek to explain policy in changing contexts. The interconnections of these theories with documentary analysis and the tenets of a pluralist conceptual framework for the analysis of policy are also examined. While some of the concepts discussed in this chapter favour structural explanation of policy development, others favour agency, the human actors involved in the policy process. It is acknowledged that structure and agency should be integrated to present a broader understanding of policy-making in Sri Lanka.

Epistemic Communities and the Role of Knowledge Experts.

Policy studies have increasingly demonstrated an interest in the role of expert knowledge, values, ideas and technical understanding in shaping policy outcomes, particularly under conditions of complexity and uncertainty. This has led to the introduction of the concept of ‘epistemic community’. “An epistemic community is a network of professionals with recognised expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area” (Haas,1992:3). Thus, epistemic communities are a source of policy innovations and 'expert knowledge' (Stone 1996:87). In international relations and political science, an epistemic community can also be referred to as a global network of knowledge-based professionals in scientific and technological areas that often have an impact on policy decisions. As described by Haas (1992:3), these ‘knowledge experts’ who belong to a variety of professional backgrounds have:

- a shared set of normative and principled beliefs, which provide a value-based rationale for the social action of community members
- shared causal beliefs, which are derived from their analysis of practices leading or contributing to a central set of problems in their domain and which then serve as the basis for elucidating the multiple linkages between possible policy actions and desired outcomes
- shared notions of validity- that is, inter-subjective, internally defined criteria for weighing and validating knowledge in the domain of their expertise
- a common policy enterprise- that is, a set of common practices associated with a set of problems to which their professional competence is directed, presumably out of the conviction that human welfare will be enhanced as a consequence.

Increasing uncertainties and complexities associated with problems of global concern, the growing interdependence between countries, the expansion of communication and globalisation have led policy-makers to turn to epistemic communities for advice and help to understand current issues and anticipated future trends. While policy-makers' goal may be to ameliorate the uncertainty, the specialists called upon for advice impart their interpretations of the knowledge, which are in turn 'based on their causally informed version of reality and their notions of validity' (Haas, 1992:21). Epistemic communities not only provide insights and knowledge, they influence policy-makers by diffusing ideas and play an important role in the social construction of reality. This is possible through the application and diffusion of broad ideas, knowledge and reasoning patterns where policy actors are able to construct the meanings attached to social problems. 'Reality' or 'truth' is then constructed through the interpretation of diffused knowledge and ideas emanating from epistemic communities, the 'cognitive baggage handlers' of constructivist analyses of politics and ideas (Haas, 2001:27).

In addition to uncertainty and the interpretation of knowledge and ideas, the third major dynamic in the causal chain that plays a role in policy change is institutionalisation (Haas, 2001). New ideas and knowledge, shed on social problems and resulting in new frames for understanding policy through their interpretations, can give rise to the creation of new institutional processes and frameworks. As Balch (2009:615) argues, “the extent of the impact of epistemic communities can be observed by the extent to which they can embed their influence in mechanisms that institutionalise the use of expert knowledge”. Once institutions are in place, ideas are likely to prevail as governments and their key actors become socialised to institutionalised regimes and practices, which are generated by the application of new ideas. Eventually, ideas are likely to convert into domestic laws and to be enforced as routine policy and practice (Balch, 2009). “It also becomes politically costly to reverse such practices as new interest groups and policy communities mobilise around them after recognising that material gains are possible from the application of new ideas” (Haas, 2001:11583).

Epistemic Communities- a critical appraisal.

The socially constructed truth tests and shared causal beliefs makes epistemic communities stand out from other types of policy networks and groups active in policy-making (Haas, 2001). They are also different to organised interest groups in that they are bound by the truth tests to which they were socialised, consequently providing information that is politically innocent or unbiased (Haas, 2001). However, it is argued that there may be limits to political innocence (Sebenius, 1992), especially when epistemic community members are located at the core or on the periphery of political parties, interest groups and government decision-making systems. Impartiality may be somewhat difficult to maintain as epistemic community members are required to promote certain ideas and political interests in the policy-making process. Epistemic actors are politically empowered to conduct their activities (Dunlop, 2012) but are unable to exist without links to politicians (Smirnova and Yachin, 2015), which Haas underlined when he coined the theory. Furthermore, there are

criticisms on the definition of the expertise and the manner in which they are called upon for advice (Sugden, 2006). Although epistemic communities generate consensual knowledge, they do not always produce truth (Haas et al., 1993), suggesting that there are distinctions between consensual knowledge and scientific evidence.

From a developing country perspective, the role of knowledge experts in drug policy-making and their links to political parties, interest groups or elite decision-makers is an area that has not been investigated in the academic literature. This thesis will argue that the epistemic community members do not remain static, but change their roles as a result on being appointed into different government departments which are not always related to the subject of drugs. These role changes can be subject to the ideologies and interests shared between successive governments and epistemic actors. For example, some members of the NDDCB are political appointees and alter as a result of change in government and/or leadership. However, some Chairs have continued to be engaged in epistemic activity related to drug control despite moving positions. Other analyses which provide a critical perspective on the concept of 'epistemic community' are found in the literature.

Concepts and theories similar to 'epistemic communities' such as policy communities, policy networks and advocacy coalitions were considered but are not covered in this thesis. Cognate literature suggests that policy communities (Richardson, 1995) explore the common interests and causal beliefs shared by policy makers in policy development; but, the theory falls short of fully developing a causal model and diffusion, unlike the epistemic community theory. Similarly, critics of policy networks argue that cognitive frameworks and beliefs of network members are not elaborated adequately by the model (Atkinson and Coleman, 1992). Analysts of advocacy coalitions note the presence, at different points in time, of people from multiple interest groups and organisations coming together to advocate for a particular policy option. According to Haas (2001) this theory does not address systematically issues of beliefs, nor does it look at the causal role of a kernel of individuals sharing

beliefs and involved in the same policy enterprise over time (Haas, 2001). Although later work by Sabatier and colleagues does address issues of shared belief systems and the processes by which advocacy coalitions attempt to influence policy (Sabatier, 1998; Weible et al., 2009), this theory was not used in the thesis largely because advocacy coalitions generally operate within contexts where there are conflicting views regarding the appropriate nature and direction of policy developments – a situation which did not apply to Sri Lanka where the tendency was towards a high level of consensus. Analysts of epistemic communities primarily focus on agency and the shared beliefs of a community which has a set of common practices or policies associated with a set of social problems; this was more relevant to the Sri Lankan policy context.

Conducting an Epistemic Analysis.

The application of the epistemic community theory into policy analysis is not limited to international relations literature or policy transfer across transnational governments. It has been applied to domestic areas of policy concern where the role of knowledge experts has been examined to describe policy change. For example; security sector reform in the UK (Sugden, 2006), the case of managed migration under the Labour government in the UK (Balch, 2009), inter-organisational learning in the case of biotechnology in France (Stranger and Emmanuel, 2010), and scientific research and the policy agenda in the United States Congress (Chung-Li, 2008). Closer to the area of health policy, Hadii et al., (2011) investigated the nature and scope of the global tobacco control epistemic community. The theory has also been applied to policy studies on drugs at European level where Elvin (2003) analyses the evolution of enforcement-based anti-drugs policies, which demonstrates the increasing importance of epistemic communities or knowledge societies in the formulation of drug policy.

There is no evidence indicating the use of the epistemic community theory within low to middle income countries into the study of drug policy. The logic for

the application of this theory is to study the cognitive perspective of the concept, which assumes that consensual knowledge can influence drug policy and practice. Interviews with key informants identified epistemic and *epistemic like* communities, both national and international. The theory provides a framework that proposes a role for experts in the transformation of drug policy addressing; why, when, how and with what effects the Sri Lankan government turned to expertise. This also involves thinking about why, how and when knowledge experts were involved in the problem definition, agenda-setting, directing and shaping the policy debate, that is, consideration of the preconditions for knowledge utilisation.

Epistemic communities can be identified at national and international levels. The first part of the analysis will be to identify epistemic community members/actors present in government expert committees, Cabinet, Parliament, National Dangerous Drug Control Board, other government and non-governmental departments and international organisations. In order to investigate the use of knowledge by identified community members and to explain the timing and tempo of policy change, it is imperative to pay closer attention to what kinds of principal and causal beliefs were held by knowledge experts and how they may have changed or been maintained overtime. It also involves tracing their activities and demonstrating their influence on decision-makers at various points in time. For example, members from international epistemic communities have had an impact on domestic drug policy decisions at various points in the history. A brief description of this is provided in the chapter on historical developments.

Epistemic community members may well appear on delegation lists at governmental, inter-governmental or transnational meetings and conferences. Some of these individuals are involved in the production of important documents that diffuse knowledge and play a crucial part in shaping public discourses. Identifying the beliefs of epistemic communities calls for an investigation into the study of these documents, the speeches delivered by knowledge elites and the public interviews they have given. Some epistemic

community members may be members of the Parliament or have close relationships with Members of Parliament who have an interest in drug policy. Therefore, an investigation into Hansards will uncover some of the beliefs held by them on the subject of drugs.

Although the epistemic community theory has enjoyed good currency across political and policy studies, it is not without its critics. While Balch (2009) argues that disaggregating the role of ideas from those of interests is somewhat problematic, Sugden (2006) states that unequal dynamics and differences among members of an epistemic community can influence the direction of the community. The latter is possible through the existence of a dominant member who may pose a threat. The consensual aspect of the theory also put forward an impression of homogeneity within the community. Dunlop (2009:289) states that the variety of roles and levels of influence epistemic communities have over decision-maker learning are not fully captured by the framework and argues that "variety is best captured by differentiating the control enjoyed by decision-makers and epistemic communities over the production of substantive knowledge that informs policy from the policy objectives to which that knowledge is directed".

Stakeholder Analysis.

The concept of 'power' and 'influence' exercised by interest groups and policy actors in the policy-making process has been central to many policy studies. Stakeholder analysis as a tool for policy analysis has its origins in political and policy sciences and the organisational and management literature in the 1970s and 1980s, which primarily investigated the distribution of power amongst actors and interest groups in the policy process (Brugha and Varvasovszky, 2000). The model has the potential to generate knowledge about individual's, groups' and organisations' behaviour that may have an impact on the decision-making process. Power and influence to facilitate or impede policy reform of course depends on stakeholders' interests, influence and the resources they bring to the policy process (Varvasovszky and Brugha, 2000; Walt, 2006).

Stakeholder analysis considers not only the power relations; it also has the potential to illustrate the characteristics of stakeholders and their interrelations overtime.

With regards to drug policy analysis, recent work has focused on the emergence, interests, influence and dynamics of stakeholders in opioid substitute treatment policy in six European countries (Thom et al., 2013), and stakeholders' debates around methadone maintenance and the negotiation for a recovery orientated drug treatment system in Britain (Duke et al., 2013). Furthermore, a comparative analysis of the shifting roles of medical stakeholders in opioid substitution treatment in Denmark and UK had been examined from the point of medical stakeholders' expertise in the field of drugs and their influence on the policy processes (Bjerge et al., 2015).

First, it is useful to have a general understanding of who stakeholders are. From a policy perspective, Walt (2006:177) states that stakeholders are those "individuals and groups with an interest in an issue or policy, those who might be affected by a policy, and those who may play a role in relation to making or implementing policy". Thus, actors (persons or organisations) who have a vested interest in a policy that is being promoted, or, in some cases discouraged, can be considered as stakeholders. They are usually grouped into categories such as; international actors (e.g. donors, international and transnational organisations, knowledge networks), national or political actors (e.g. legislators, politicians, political parties), public sector agencies (e.g. ministries and government departments or people representing these), interest groups (e.g. unions, medical associations), non-profit organisations (non-governmental organisations), civil society members, and users/consumers. Epistemic communities in considering the knowledge they bring onto the policy agenda, also have a 'stake' in policy. Stakeholder analysis, while including epistemic communities, embraces a much broader approach to policy analysis than just limiting the analysis of drug policy to the role of expert knowledge in policy development.

Although individuals, groups and organisations may have a ‘stake’ in a given policy or issue area, some may be more powerful than others and may have varying degrees of influence in the decision-making process.

Stakeholders and Power Relations.

While macro theories of the policy process analyse power in political systems reached through consensus or conflict, micro theories focus more on mechanisms and administrative routines of policy-making (Walt, 2006). In both theoretical levels the determining factor is the influence that stakeholders may have on the policy process and decision-making: there are 'pluralist', 'elitist', 'structuralist' and 'bounded pluralist' views of influence in the policy process (Hill, 1997) and the below section will consider each of these theories briefly.

Dahl (1958), the main proponent of the pluralist view, advanced the theory of representative democracy where he argued that power is diffused through society and there is no dominating group to suppress others' opinion. As a result of such a policy process the policy outputs are ‘wise' and represent public interests (Walt, 2006). However, even in most countries with long traditions of democracy, though power is held by different societies and groups, in practice these groups are not equally active and there exist imbalances in their influence on policy. Furthermore, conflicts of interests amongst stakeholders mean there will be different approaches to resolve policy issues.

An important alternative to pluralism is *elite theory*. The elitist view (or Marxist theory) suggests that policy choice and change is determined by certain social classes/institutions, which are represented in policy-making positions, and the state ensures the continuing dominance of those classes/institutions. Elites could achieve their position through: i) revolutionary defeat; ii) military invasion; iii) control of key economic resources; iv) developing large-scale organisations/institutions in different areas of life which support their existence (Hill, 1997). Institutions are the sources of power for the elite (Mills, 1956). This

theoretical perspective is very much relevant to Sri Lanka where power is concentrated amongst relatively few organisations and actors, especially in relation to the subject of drugs where relatively few organisations and individuals are involved. In general, these stakeholders also bring resources (expert knowledge and monetary) into the policy-making arena where they have an advantage over other stakeholders who may not enjoy these resources and status.

As with elite theory, structuralist theory sees political action being determined by powerful forces which are not human resources but those beyond individual human control. The theory suggests that political choice is predetermined by demographic, social and economic factors that are powerful constraints over human action, which should be addressed to achieve fundamental change (Hill, 1997). This theory elaborates on the relationship between structure and action, but fails to consider the conditions essential for supporting the actions to initiate social change.

Bounded pluralism suggests that issues of high policies (e.g. economic, national security issues) are decided through the elite, whereas low policy issues (e.g. domestic, social issues) are decided through pluralism. This view presents the government as open to legitimate influence. Though health policies are considered to be low policies, due to interventions from various groups they could become high policies (Walt, 2006). To this extent, the level of importance given to a policy can be seen as a fluid concept. In order to not 'lose' their influence and 'weaken' their positions, policy makers should 'keep their hand on the pulse' of events and constantly exert their power. As the stakeholders who deal with unimportant issues are appointed by stakeholders in higher positions dealing with important issues (to 'please' those who 'trusted' them), 'a chain' which serves the same goal is established. However, even low policies have their elites who determine the direction of policy development. In most cases this elite (stakeholder) is highly dependent in its decisions on the elite (stakeholder) making high policies, especially as the high policy-making elite decides on resource allocation. Drug policy development in Sri Lanka falls

under the Ministry of Defence, a Ministry that is involved in policies concerning national security. In general, the President of Sri Lanka additionally held the portfolio of Minister of Defence and had vested interests in the appointment of members to the NDDCB.

As discussed, stakeholders' power and influence is dependent on a number of mediating factors. However, it is also important to recognise that the notion of power is not a static concept and should be seen as fluid, moving from one organisation/actor to another. This is dependent on the changing economic, political, and social landscape where stakeholders' positionality and interests change. The level of stakeholder support or opposition to a policy or programme is somewhat determined by the above mentioned mediating factors.

Conducting a Stakeholder Analysis.

Varvasovszky and Brugha (2000) identified three preliminary questions to address prior to conducting a stakeholder analysis. They were; what is the aim and time dimension of the analysis? What is the context? And at what level will the analysis take place?

Similar to applying the epistemic community concept, it is imperative that researchers define the area under investigation and identify a time dimension for the analysis of stakeholders. Policy studies utilising the stakeholder theory for analysis can have a past, present and/or future time dimension. "Its scope can range from broad with a strong retrospective dimension, with the aim of understanding the roles of stakeholders in the evolution of the policy context and processes, to prospectively outlining more long-term and also broadly-focused policy directions" (Varvasovszky and Brugha, 2000:338). As stated earlier, this thesis looks at the history of drug policy development 1984-2008 and has a retrospective time dimension. It will identify stakeholders who contributed towards the development of drug policies at different times and

consider the changing socio-political landscape of policy-making. The initial identification of stakeholders is based upon secondary literature and documents published concerning the drug problem in Sri Lanka. This approach enables the identification of the 'initial key informants' who are able to provide an overview of past policy events. The aim is to communicate with these individuals and uncover how drug policies evolved overtime, identify influential stakeholders in the decision-making process, the rationale for their involvement and influence, trace the existence of epistemic communities, their inter-relationships and the impact upon policy outcomes.

A recent development in stakeholder theory research has been the concept of the stakeholder network that considers how a focal organisation exists within a network of inter-dependent stakeholder organisations (Rowley, 2006; Neville and Mengue, 2006). The influence of individual stakeholders on a policy or an issue can be identified by social network analysis and the concept of the stakeholder network provides a useful framework for stakeholder analysis as the relationships and alliances between stakeholders within a network are likely to influence the behaviour of stakeholders, the demand they place on a focal organisation and, in turn, the way in which the focal organisation behaves towards them. Stakeholders do not behave or make decisions as individuals outside a social context. Their behaviour, decisions, and actions are embedded in ongoing systems of social relations. It is within the scope of this thesis to investigate how the NDDCB, the main drug policy-making organisation was afforded its role as the focal organisation and the relationships it has had with stakeholders in the creation of policy. For example, there is a need to explore the links and inter-relationships the NDDCB has had with government and non-government organisations, the medical and legal professions, civil servants, politicians, religious leaders and other stakeholders.

Negotiating access to interview stakeholders and the ongoing relationship a researcher has with a stakeholder, according to Varvasovszky and Brugha (2000), should be based on a thorough understanding of the cultural context in which the thesis is undertaken. "In many developing countries, essentially,

ethnic and cultural affiliations may make demands on politicians and national policy makers to maintain channels of communication, and be accessible to potentially influential individuals and groups, which are not envisaged in the official positions they occupy" (Varvasovszky and Brugha, 2000:340). Stakeholders dealing with 'unimportant' issues may act as gatekeepers to stakeholders who deal with 'important' issues who have resources to mobilise. Understanding the wider cultural context and how actors are positioned within social networks, assists researchers to understand the process of gaining access to influential stakeholders and securing their support. Sometimes access may be easier through a personal contact of the researcher. Although the personal contact may not have any involvement in the drugs field, due to his/her status and influence in a related field, identified stakeholders may be more willing to communicate with a researcher than when being introduced by an 'unimportant stakeholder' in the drugs field. Researchers may need to use their street sense when dealing with these issues. A snow-balling technique to identify stakeholders is discussed in the research methodology chapter where issues such as access and sponsorship are elaborated in detail.

Due to practical reasons, policy analysis in this thesis is limited to national level where stakeholders can be reached and interviewed individually. At the same time, the thesis will explore the role of stakeholders identified at international level. These external stakeholders are geographically dispersed with limitations on their access. However, stakeholders identified at domestic level will be in a position to provide an account of the role and extent of influence of stakeholders identified at international level.

One of the main limitations of the thesis is that it relies heavily on qualitative data generated through interviews. Selection bias is another area of concern where important stakeholders can be overlooked or omitted. For this reason and to minimise bias, careful selection of key informants and triangulation of data is pivotal. Furthermore, during the period under investigation a civil war was occurring which produced an unsettled society and an unstable political landscape with policies subject to sudden change. Consequently, stakeholder

interests, action, positions, alliances and influence could also be subject to change. Ensuring a thorough understanding of these factors is critical when selecting stakeholders for interview.

Policy Transfer- a critical appraisal.

An increasing globalised economic system, internationalisation of politics, the growth of supra-national institutions and improvements in technology, transport and communication have influenced domestic public organisations to look outside to other governments or non-governmental organisations for answers concerning public issues (Jones and Newburn, 2007). Policy transfer or the conscious adoption of a policy from another jurisdiction is one way of tackling a public problem or a potential problem identified at domestic level. Dolowitz (2000:344) defines policy transfer as “the process by which knowledge of policies, administrative arrangements, institutions and ideas in one political system (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political system”. Within this background, epistemic communities are able to transfer policies from one area to another.

In recent years, especially as an analytical tool to explain policy change, the policy transfer concept has gained momentum across political science, international relations, sociology, public policy and other related fields. Considering its multidisciplinary involvement and the multi-organisational setting in which policy transfer tends to take place, there is a flurry of terminology related to policy transfer appearing in the academic literature. This can be confusing when attempting to deepen our understanding of the concept and sharpen the research questions that need to be posed for this study. For example, terms such as; policy convergence (Bennett, 1991), policy diffusion (Majone, 1991), lesson drawing (Rose, 1991), policy learning (May, 1992), and emulation (Howlett, 2000) refer to different forms of policy transfer. Although ‘policy transfer’ has been treated as the chief concept or the umbrella term in the academic literature, there are some distinctions between the above terms.

This section will provide an overview of policy transfer research and related concepts, writing with the broad aim of developing a framework within which some specific developments in drug policy can be explored in later chapters.

In the context of industrialisation, modernity and harmonising macro-economic forces, policy convergence is defined as 'the tendency of societies to grow more alike, to develop similarities in structures, processes and performances' (Kerr, 1983:3). It involves a process in which policies in two or more countries become more alike over time (Knill, 2005). A simple definition of policy diffusion views it as a process through which policy choices in one country affect those made in a second country (Braun and Gilardi, 2006). While Rogers (1995:11) defines policy diffusion as 'the process by which innovation is communicated through certain channels over time among the members of a social system', Ikenberry (1990), along the same lines, states that policy diffusion is a type of social learning which involves the dissemination of new information with which governments make policy choices. Although these two concepts may appear to be akin, policy convergence assumes that similar policies emerge independently of policy made elsewhere, while policy diffusion assumes the active dissemination of policies and ideas by a number of human agents. Therefore, it suggests policy convergence to have a passive role for state actors whereas policy diffusion presupposes pro-activity by a range of actors with an interest in ensuring the spread of a particular policy' (Common, 2001:12). Here, the argument is that policy convergence may occur unintentionally without the involvement of any human agents, whereas, 'intentionality' may be the precondition for policy diffusion and transfer from one jurisdiction to another (Evans, 2009).

Policy diffusion literature suggests that expert-knowledge, ideas, policy goals and content may be spread from one area to another. However, for policy transfer to occur, they must be adopted and implemented. Once an adopted idea or model becomes institutionalised, diffusion cannot be explained by theorisation but by the demands of organisational routines and by being promoted by self-interested actors (Strang and Meyer, 1993). A wide variety of

actors from different fields may be at work at different points in the policy transfer process and they include; politicians, civil servants, pressure groups, academics, international organisations, non-governmental organisations, supra-national institutions, think tanks, policy entrepreneurs, global financial institutions and other experts (Evans, 2009; Dolowitz and Marsh, 2000). In other words, policies can be diffused without their actual adoption and implementation, but, policy transfer literature is concerned about the implementation of new policies via institutional frameworks. Therefore, structure and agency explain the difference between convergence, diffusion and transfer. While convergence literature tends to favour structural explanation, the diffusion and transfer literature places more emphasis on agency.

The study of policy transfer is better understood when social and political action is placed within the structured context in which it takes place (Evans and Davies, 1999). Giddens' (1984) 'structuration theory' suggests that all human action is performed within the context of a pre-existing social structure that is governed by a set of norms and rules which are distinct from those of other social structures. Accordingly, all human action is at least partly predetermined based on the varying contextual rules under which it occurs. In this context, policy actors (agents) cannot be separated from the structure (organisations) where the latter may either constrain or facilitate agents' actions. For example, within the international arena, organisations such as the United Nations, World Bank and the South Asian Association for Regional Cooperation (SAARC), through their coordinated efforts, have increased opportunity structures for actors to engage in policy transfer in the south Asian region. It is important to note that agents who work for these organisations are also involved in interpreting those structures, and in acting, change or translate them according to their perceived needs and desires. The argument here is that in the investigation of policy transfer, one needs to acknowledge that the relationship between structure and agency is dialectical, that is interactive and iterative (Evans and Davies, 1999).

In addition, although the last two decades focused on policy transfer, the notion of policy translation has gained traction more recently. This is in response to the criticisms levelled at policy transfer ideas, whereby policies (and practices) cannot be transferred directly from one context to another but must be adapted and modified to be relevant to the particular cultural, economic, political and social context into which it is being transferred – in other words, the policy has to be translated (Stone, 2004). As Hulme (2005: 423) argues, policies and practices are not easily 'transferrable' since they have evolved from legal, social and educational settings unique to their host-states and are neither ideologically nor culturally proximate.

Unlike western studies on policy transfer where the emphasis has been on investigating already established international organisations and on how they were involved in diffusing knowledge and ideas across affluent societies, developing countries have been somewhat behind in coming into contact with various international and transnational structures and their actors. Similarly, at national level, some organisations and institutions concerning drug control may have been established far more recently in comparison to the western world. Relationships in newly established institutions with external organisation might still be in their infancy. In view of the developmental approach adopted in this thesis and the phases of drug policy development between 1984 and 2008 in Sri Lanka, domestic, and international structures and agencies, need to be described in terms of how they have evolved, changed and influenced policy outcomes.

Policy Transfer Processes.

Policy transfer analysts refer to three different processes of transfer. They include voluntary transfer or lesson-drawing, negotiated transfer and direct coercive transfer (Dolowitz and Marsh, 1996; Evans, 2009). It is helpful to consider voluntary and coercive transfer on a continuum, with lesson-drawing as a rational action-orientated approach to dealing with public problems at one end (completely voluntary) and the direct imposition (completely coerced) of

constitutional reforms, social and political changes and other policies against the will of a government at the other end (Dolowitz and Marsh, 1996). Within this continuum, there are concepts such as policy learning, mimicry, competition, and coercion identified as mechanisms of policy diffusion and transfer. Although these mechanisms receive varying degrees of attention in the diffusion and transfer literature, 'learning' is the chief mechanism identified in the transfer literature and other mechanisms receive more attention in the diffusion literature (Marsh and Sharman, 2009). The next section will look at this continuum, exploring the four afore mentioned mechanisms identified in the academic literature and discuss how some of these terms are complementary of each other.

Lesson-drawing or policy learning implies a rational decision by governments to emulate foreign institutions and practices to tackle public problems identified at domestic level (Rose, 1991). For Rose, the object of policy learning is to find a suitable program that is acceptable while Bennett (1991) states that the central characteristic of emulation is the use of evidence of a programme or programmes from overseas and drawing lessons from that experience. In the context of a growing drug problem in Sri Lanka, the government may have looked for models of good practice and evidence to deal with the problem as incentives might be high to utilise a program from elsewhere as a ready-made solution. "Learning can lead to complete or partial policy transfer and may take place on a strictly bilateral basis, or through transnational problem solving in international policy networks or epistemic communities" (Marsh and Sharman, 2009:271). Rational learning can be contested when considering the cognitive obstacles to learning. Cognitive obstacles refer to the process by which public policy problems are recognised and defined in the pre-decision phase, the breadth and detail of the search conducted for ideas, the receptivity of existing policy actors and systems to policy alternatives and the complexity of choosing an alternative (Evans, 2009). Additionally, the prevailing organisational culture and ideology, domestic public opinion, the absence of effective cognitive and elite mobilisation strategies deployed by agents of policy transfer, and technology and resource limitations may inhibit successful policy orientated learning. To this extent, Weyland (2005) has emphasised the importance of

bounded rationality and cognitive heuristics in learning, which may lead to patterns of diffusion distinct from fully rational learning.

Policy 'mimicry', also known as 'copying' in the literature, may involve copying attractive foreign social and political standards in terms of symbolic and normative factors. According to Rose (1993:30) copying is to enact 'more or less intact a program already in effect in another jurisdiction'. During the 1980s, within the Asia Pacific region, countries such as Malaysia, India, Bangladesh, Pakistan, Singapore, Taiwan, Thailand, Indonesia and Sri Lanka introduced the death penalty for drug related offences. The rapid spread of this populist policy option across the Asia Pacific region may be the result of a process whereby government elites copied the social commitments made by other governments, considering them to be advanced, progressive and morally praiseworthy. It can be argued that governments may know that the policy in question is technically ineffective, but, nevertheless, place a greater value on the social pay-offs among domestic and foreign audiences. The importation of the death penalty as a policy option to tackle the drug problem at domestic level requires examination in terms of its adoption and context in Sri Lanka.

Policy transfer is not independent from the agents of transfer where learning is negotiated largely on the interpersonal relationships between bureaucrats and politicians operating within inter-organisational settings. These agents share common values and beliefs expressed through culture, and it is important to emphasise in analysing the structure of decision-making through which policy transfer takes place, the relationships between agents of transfer and their dependencies. Rose (1993) demonstrates the importance of who has relationships with whom and how these relationships have an impact on policy-making. However, while Rose's approach is useful for understanding the nature of the policy transfer process, it is limited in its tendency to explain why transfer takes place in the first place. This is due to the limited reflection on the role of exogenous forces in lesson-drawing (Evans, 2009). Additionally, the pre-occupation of researchers with the voluntary processes of transfer between developed countries has given less prominence to the study of lesson-drawing

in developing countries. Lesson-drawing within developing countries may be subject to various forces operating at international level. On some occasions it is beyond the control of developing nations where lesson-drawing can potentially become a coerced activity informed by developed countries and their representatives working for international organisations.

Negotiated policy transfer involves varying degrees of coercion and is more common in developing countries. It takes place in the context of affluent donor countries, global financial institutions, transnational and international organisations, and other influential institutions which introduce (coerce) policy change in order for the dependent government to secure loans, grants or other forms of aid and investment (Evans, 2009). It is acknowledged that confining drug policy analysis to the borders of Sri Lanka gives a highly skewed picture. As Walt (2006:122) argues, "developing country policies are sometimes decided by external institutions such as the World Bank, the International Monetary Fund and the huge empire of United Nations' institutions". Furthermore, countries such as India, Japan, China, the United States, Russia and regional organisations such as the Colombo Plan are major funding donors to Sri Lanka. Some may argue that foreign aid to Sri Lanka comes at a price where domestic bureaucrats and politicians are coerced to change legislation and social policy, particularly in the economic and security interests of developed nations. Sri Lankan drug policy is not an exception here.

Direct coercive policy transfer is the 'imposition of a policy on a country by either another country or a transnational actor and is usually executed against the will of a government or the will of its people' (Common, 2001:18; Evans, 2009). It can arise from international law or conventions that countries are signatory to, which will impose penalties on countries that break the law. For example, Sri Lanka is a signatory to all three United Nations Conventions on drug control. This prompted changes within domestic legislation and the operating framework for drug control activities. Once a country is a signatory to international drug control convention, it is expected that nation states conform to the conventions/law, and coercion is most likely where relatively few

powerful international actors operate within a global system such as the United Nations.

Direct coercive policy transfer was also “widespread in periods of formal imperialism and its implications can still be seen today in contemporary Mexico, Kenya, India, Pakistan, Sri Lanka, Zimbabwe and South Africa” (Evans, 2009:245). Drug policy development during the British colonial period is explored in Chapter Four, Historical Context of Drug Policy-making in Sri Lanka, where coercive elements of policy change and the birth of local interest groups on the subject of drugs will be investigated. Demonstrating these historical aspects of coercive policy transfer during the colonial period will help understand if contemporary policy development has also been subject to coercion.

Policy Transfer Analysis.

Dolowitz and Marsh (1996) identify a five step framework to analyse the nature and extent of policy transfer. The framework is a useful starting point for the consideration of policy transfer in the arena of drug policy in Sri Lanka and helps inform the development of an analytical framework for this thesis:

1) The subject of analysis

It is imperative that the subject under investigation is clear at the outset and, specifically, whether the thesis has a prospective timeline facilitating policy transfer, exploring policy transfer as it is occurring, or when making a claim that transfer has taken place in the past (Evans, 2009). The methodological approaches for a retrospective study are further discussed in the chapter on research methodology.

2) Who/what are the agent(s) of transfer? Who wants it? What do they want from it? How are they going about effecting it? To whose benefit? And why?

This thesis will identify the agents of transfer who operated at domestic, international and transnational levels, and explore why they have engaged in policy transfer, to whose benefit and how they went about it. As discussed earlier, structure and agency will be considered as dialectical and the wider social and political contexts in which transfer took place will be identified. It is also worth exploring the factors that enabled or hindered transfer. This includes the identification of voluntary and coercive forms of policy transfer. While some of the agents of policy transfer can be identified within international organisations, others may be stakeholders or epistemic community members operating at domestic level.

3) Is there evidence of non-transfer?

'Non-transfers' will include elements of an idea or programme that have been taken from domestic antecedents or which are genuinely innovative (Jones and Newburn, 2007: 30; Dolowitz and Marsh, 1996). Parts of an original idea or programme discarded or filtered out by the subject/agent are also non-transfers. Robust comparison of identified drug policies during the period under investigation against both domestic and original settings is considered as essential to demonstrate the real extent of policy transfer. Although, this comparison may not be between Sri Lanka and another neighbouring country, a comparison between domestic drug policy and the policies adopted or promoted by transnational and international organisations can explain the true extent of policy transfer from one jurisdiction to another. Evidence for non-transfer can be established within identified documents for analysis and the transcripts of interviews held with policy actors.

4) What is the evidence offered to support the claim of policy transfer and how good is it?

The scrutiny of data from documents and interviews will be able to demonstrate the evidence of policy transfer in this thesis. To demonstrate whether an idea or

a perception has been transferred, published documents will be examined where more concrete 'physical' evidence of policy content in different jurisdictions can be verified. The section on documentary analysis in the research methodology section will further elaborate the search for evidence to support the claim of policy transfer.

5) What conclusions can be drawn from the nature/extent of policy transfer?

This includes an overall examination of the extent to which ideas and programmes have been culturally and organisationally assimilated in the domestic context and if policy transfer has been successful or not. As suggested by Evans and Davies (1999), distinctions will be identified between 'soft' transfers (including ideas, concepts and attitudes) and 'hard' transfers (including actual policy programmes and implementation), which have been either imported voluntarily or coerced by foreign organisations and governments.

Conclusion.

As discussed, there are a number of similarities between epistemic communities, stakeholder analysis and policy transfer. Stakeholder analysis is considered as a general concept as applied to this thesis. However, epistemic community members and actors involved in policy transfer can equally be identified as stakeholders. They are also involved in the production and consumption of policy documents and when these concepts are integrated, a broader and rich understanding of policy-making can be presented that reflects different policies under shifting circumstances.

As argued by Marsh and Sharman (2009), the thesis will acknowledge that policy transfer and diffusion are complementary and that five key issues that cut across both literatures should be considered in a thorough analysis of policy

transfer (Marsh and Sharman, 2009). They include; a greater focus on the interaction between actors engaged in policy diffusion and transfer; the adoption of an approach which recognises the dialectic relationship between diffusion (structure) and transfer (agency); the integration of pattern-finding and process-tracing inherent in diffusion and transfer literature; application of these concepts into developing countries due to the present case studies being limited to developed countries; and finally if diffusion/transfer is likely to be successful or not.

The focus on human actors in epistemic community theory, the integration of epistemic community theory with stakeholder analysis wherein stakeholder interests, inter-relations and power can be examined, and the theory of policy transfer will lend to a thorough analysis of drug policy development in Sri Lanka.

Chapter Three: Research Methodology and Methods

Introduction.

This chapter describes the rationale for the chosen research design and discuss its strengths and limitations. In keeping with a qualitative research design, the methods employed by this thesis are key informant interviews and a documentary analysis. It is concerned with 'human action and interaction' and with 'imperative power, meaning and illumination, and not with 'generalisation and prediction' (Usher, 1997:5). Adopting a reflexive approach, the method of key informant recruitment, identification of documents for analysis, the manner of undertaking the fieldwork, the challenges encountered during the research process and how they were overcome are discussed. The latter part of this chapter explores the process of data analysis in order to understand how the study findings were reached and the ethical issues that arose during the field work.

Study Aims.

The aim of the study is to provide an informed narrative describing the rationale for the development of Sri Lanka's drug policies, their course and outcome and the roles of the various institutions, organisations and interest groups already established, or coming in to existence to respond to drug misuse. This will show how and why particular accounts are shaped and influenced by the individuals, institutions and organisations, and perhaps by particular discourses. As discussed previously, the reader is reminded about the research questions for investigation so as to justify the research design and methods employed in answering the research questions in subsequent sections of this chapter.

1. How was drug policy developed over time, and why?

2. Which organisations and individuals were behind this development, and why?

3. Who was influential in making policy decisions, and why?

4. What was the role of international organisations in the development of drug policies in Sri Lanka?

5. Have there been other agendas, tensions, contradictions and coalitions identified during the development of policies, and if so how were they managed?

Research Design.

In order to answer the research questions, it is necessary to understand the complexity of factors and processes influencing drug policy-making in Sri Lanka. Fundamental to this is the need to identify stakeholders who are in powerful positions or who make decisions about national policy. They include individuals who represent the Ministries of Defence, Health and Justice, the NDDCB, Police, Customs, politicians and political parties, religious groups, international and non-governmental organisations. These individuals need to be identified and then interviewed in order to obtain access to their decision-making domain and their experience and to ascertain their prevailing influences in the drug-policy process. The role of knowledge experts and epistemic communities concerning the subject of drug control and their influence on national drug policy can also be revealing. For this reason a qualitative research design is selected, as it is well suited to capture rich descriptions of complex phenomena, both in terms of the policy process and of its implementation. In short, qualitative research methods are capable of: providing rich descriptions of complex phenomena; tracking unique or unexpected events; illuminating the experience and interpretation of events by actors with widely differing stakes and roles; and giving voice to those whose views are rarely heard (Sofaer, 1999).

Use of qualitative research designs in policy research is not new. Academic scholars and policy analysts have for some years been venturing out into the field as ethnographers or participant-observers, to study first-hand the experiences of legislators, policy implementers, agency clients, community members and other policy relevant stakeholders (Yanow, 2007). Based upon the view that reality is socially constructed and negotiated, qualitative research aims to uncover the situated, contextual, and changing nature of reality as a socially constructed experience. The qualitative research design attempts to understand policy action, or in some cases, inaction, as socially organised and influenced by different social, cultural, political and economic factors**.** A quantitative research design is not being used since this method is unlikely to capture the level and depth of data required to answer the research questions. As Pollitt et al (1992) argue, positivistic research models are of limited use in the investigation of contemporary policy whilst qualitative approaches offer distinct advantages. Furthermore, Ramazanoglu and Holland (2006:155) state that "quantitative methods offer limited access to accounts of experiences, nuances of meaning, the nature of social relationships, and their shifts and contradictions". Key to this study is the understanding of factors and processes which influence policy makers' perceptions and experiences within a particular and fluid social context. This includes conducting an examination of both consensus and disagreement on major issues between, and within, government departments, political parties, knowledge networks, various professional and interest groups and international organisations.

Some researchers argue that quantitative methods are based on reliable and valid measurement tools which are informed by prior knowledge and understanding of the area under investigation (Babbie, 1998). Considering the limited amount of data and research about drug policy in Sri Lanka, it was more beneficial to approach data collection as an evolving process that reduced the uncertainty of missing issues that needed to be addressed in this study. The adoption of a developmental approach, a key feature of a qualitative research design, enabled the consideration of what might be the policy issues for investigation, the right questions to ask from key informants and how they should be framed to capture meaningful answers. Against this background, it is

difficult to test a pre-determined hypothesis through the use of a survey questionnaire or any other quantitative measurement tool. Some preparation is required to discover the appropriate research questions and ensure that the subsequent documentary analysis and key informant interviews are mutually supportive so as to capture a version of past policy events and lead to finding more refined investigative questions.

The analysis has not been limited to one particular shift in policy, but includes a series of policy decisions extending over a period of twenty-four years. During this period, there have been remarkable changes in how drug control activities were co-ordinated in Sri Lanka, including the involvement, or omission, of different stakeholders from multi-disciplinary backgrounds. As well as identifying these changes, the thesis will study key policy changes that took place such as; the introduction of legislation to amend the Poisons Opium and Dangerous Drugs Act in 1984, the initiation of the death penalty for drug related offences, creation of the first National Drug Policy in 1994, emergence of rehabilitation and its underpinning ideology in the 1990s, the updated national drug policy in 2006, and the introduction of the Drug Dependant Persons Treatment and Rehabilitation Act in 2007 whereby compulsory treatment was introduced.

A qualitative research design was best suited to the above developmental approach adopted in this study. It allowed sufficient flexibility during data collection, especially during the design and administration of interview schedules with key informants and the identification of documents for analysis. Different interview schedules had to be developed for those informants who represented a particular period or policy event where rich, descriptive information unfolded. The flexibility in the design permitted the expansion of data collection efforts to new key informants and new documents. Where issues had to be further clarified or when unexpected events transpired, re-interviews of the same informants over time also proved illuminating.

Qualitative research also plays an important part in clarifying the values, language, and meanings attributed to key actors who play different roles at different times in transnational, government and non-governmental organisations. Interviewing the actors allows them to give their own views and accounts, rather than conforming to categories and terms imposed on them by others. This style of data gathering has the advantage of probing beyond the official line of inquiry (Duke, 2002; McDonald et al., 2005) or getting inside the 'black box' of decision-making process where hidden agendas and politics can be uncovered. This was particularly useful in generating insights into the sensitive areas of drug policy.

Although a qualitative research design brings advantages to policy studies, it is not without limitations. Due to the in-depth nature of inquiry occurring in qualitative methods and the analysis of data from a small sample, it may be argued that knowledge produced might not be generalised to other settings. There are a small number of policy actors or key senior personnel working in drug control, enforcement and treatment in Sri Lanka. Interviewing policy actors who are restricted to a particular background may result in findings that are biased. In general, it can be argued that the findings may be unique to a relatively few people included in the study and cannot be taken as being representative of a particular group or organisation. However, Becker and Bryman (2004) state that qualitative research is not necessarily dependent on a representative sample and the aim of qualitative research is to gather rich, descriptive accounts of information from the respondents. Similarly, Blaikie (2000:73) states that "the methods used to conduct exploratory research need to be flexible and do not need to be as rigorous as those used to pursue other objectives. The researcher may need to be creative and resourceful in gaining access to the information required". Furthermore, samples in qualitative research studies are selected purposefully to build theory rather than to be representative.

In the following sections, the researcher will look in more detail at the two main methods used in the thesis: documentary analysis and interviews.

Methods.

Documentary Analysis.

Over the last twenty years, policy studies conducted by social scientists have largely ignored the systematic use of documents to analyse and enlighten certain public policy events and processes. Interviews, questionnaires and direct observation have become the basic tools of social research, while documents were of marginal utility. Many social scientists continue to produce ethnographic accounts of complex, literate social worlds as if they were entirely without writing or texts (Atkinson and Coffey, 2004). In relation to policy studies, policy-makers, politicians, public sector administrators, civil servants, legal experts, interest groups and, in some instances, the public are routinely involved in the production and consumption of written records and documents. These documents may function as props, allies, rule-makers, calculators, decision-makers, experts and illustrators, and are considered to be of significant value in policy studies. In brief, they appear as what might be justifiably called 'hybrids' (Prior, 2008), aimed at achieving a particular government or interest group objective or goal. In social research, documents can go beyond being only a source of data and can be viewed as actors in their own right, recruited into schemes of organised activity and regarded by others as allies, enemies or perhaps instigators of further action (Prior, 2008). In this process, documents may be part of the methods organisations might use to identify and publicise themselves, compete with others in the same marketplace or justify themselves to the public and other interested parties (Atkinson and Coffey, 2004). They may be useful in the instigation, maintenance or change of public policies.

From an international perspective, there are few studies that examine in-depth the role of documentary sources in social research. The most significant is John Scott's book *A Matter of Record,* (Scott, 1990). He looked at the use of documents in relation to specific problems in social and historical research and defined a document as "an artefact which has as its central feature an inscribed

text" (Scott, 1990:5). While Scott's work primarily focused on administrative papers produced by government and private agencies, work carried out by Plummer (2001) explored the analysis of personal documents. Similarly, Steedman (2001) has conducted an in-depth analysis of archives, the single largest class of documents available to social researchers, which contain a great deal of material directly related to administration and policy. Prior's (2003) work on documents in social research treats documents in more general terms and looks at the theoretical basis of document analysis.

Hence, documents are considered to fulfil a dual role as they appear both as sources of content and as active agents in their spheres of action. However, most research on document analysis has tended to stress the content role, concentrating upon content analysis. Documents as inert carriers of content are well reflected in standard textbook statements on the place and position of documents in social research (Bryman, 2004**;** Hodder, 2000). Content analysis is often associated with the idea that documents and humans exist in entirely separate realms. Scott (1990), however, argues that documents serve only as sources of social scientific evidence and the key issues in the research process concern matters of document authenticity, credibility and the degree to which a document is representative of a genre and the meaning of its content. This thesis's analysis of drug policy and related documents will aim to show the social, political and economic contexts in which drug policy or related documents have been produced and used and their attached cultural meanings. It includes a textual analysis of key documents, which regards documents as resources as well as actors extending beyond a silent or non-contributory role.

There are a number of reasons why documentary analysis contributes towards a study of drug policy in Sri Lanka. In the absence of research on contemporary drug policy, documents offer material for study and provide a version of past policy events and processes. Landmark policy documents on drugs or in a related field are a useful method to sketch significant policy developments over time and consequently divide the period under investigation into manageable

phases of policy development. Documentary analysis offers sufficient material to map discourses and design preliminary research questions without the need to interview policy actors. Additionally, ethical issues are far less frequent with documentary analysis and there are few problems of privacy, anonymity and confidentiality to be negotiated (Rapley, 2007; Abbott et al., 2004; Hodder, 2000). A vast amount of documentary material is available in the public domain, either in print or electronic form on the World Wide Web and offers a non-intrusive method of data collection in comparison to the often lengthy process of obtaining consent to recruit and interview busy professionals.

Although there are a number of advantages with documentary analysis, the assumption that documents are reliable data sources requires discussion. Documents may contain only a limited amount of detail and debate and certain texts may be carefully crafted as mere political rhetoric that is of populist appeal. Therefore, documents represent only a partial or superficial account of the reality they purport to describe (Atkinson and Coffey, 2004). For example, the balance between the stated intentions of a policy document and hard information such as ‘policy at ground level’ or the actual implementation of it may be skewed. There are also limitations to the study of opposing views, power struggles, changing agendas and policy priorities through the analysis of textual information as these may have been consciously deleted in the text under investigation. Furthermore, Atkinson and Coffey (2004) argue that documents are not transparent representations of organisational routines and decision-making processes. Indeed, documents which embody plans for the future represent aspirations to a possible future reality rather than one that actually exists, and it is usually difficult to test the realism of such aspirations by documentary analysis alone (Abbott et al., 2004). The approach to documentary analysis within this thesis will attempt to bring documents and their creators together in order to explore the content meaning of inscribed text and identify any contradictions or consensus encountered from those who produced or contributed towards their formulation. It is not surprising that policies are often under-defined as a way of accommodating the tensions between various policy actors operating at domestic and international level.

Documentary analysis and semi-structured key informant interviews with policy actors exemplify the broader notion of triangulation and methodological pluralism inherent in the study design. The interconnection of these methods and their value was also elaborated by Duke (2002) who examined the role and influence of policy networks in the development of prison drugs policy in the United Kingdom. More recently, Duke and Thom (2014) integrated these research methods to examine opioid substitute treatment policy in England.

Bringing documents and their creators together, generates a host of problems as a majority of official documents are devoid of named individual authorship. In general, national and international institutions imply authorship of key policy documents, on some occasions identifying a consultation list of those who contributed to the formulation of policy documents and/or names of individuals as acknowledgements. As Atkinson and Coffey (2004:70) argue, “it is part of the facticity of many official and organisational documents that they are not identifiably the work of an individual author and their very anonymity is part of the official production of documentary reality”. However, while consultation lists and acknowledgements identified in national and international documents related to the drugs field assisted with identification of the key policy actors for interview, these actors were able to identify the documents they have, or someone else had, authored or edited. Their role in the production of policy documents is described, how they influence the content meaning of inscribed text and identify any contradictions or consensus encountered during its production. These interrelationships are explored in more detail in the section on semi-structured key informant interviews.

In relation to this study, a number of public documents published by government, non-governmental and international organisations are included. They are largely official documents of public nature developed around the subject of drugs. They represent the government’s approach to dealing with drug control, enforcement, treatment and rehabilitation. Selected documents for analysis included: national drug policies, election manifestos, Hansards, international drug control conventions, annual reports produced by the INCB,

UNODC and the NDDCB, National HIV/AIDS Policy, Poisons, Opium and Dangerous Drugs Ordinance and amendments, Drug Dependant Persons Treatment and Rehabilitation Act 2007, available minutes of NDDCB meetings and documents summarising conference and workshop proceedings. The majority of these documents were printed hardcopies. Modern methods to documentary research in the twenty-first century involve accessing documents via the World Wide Web: some online documents were also included for analysis. They originated from institutional websites held by the Sri Lankan Parliament, NDDCB, PNB, Ministry of Planning and Implementation, the Department of Census and Statistics, INCB and the UNODC.

The analysis of key policy documents will enable the investigation of the links that arise between documents and people, documents and concepts, and documents with each other. It will also endeavour to discover how and why documents were produced, how they were consumed and received or their use for a wide variety of purposes. Furthermore, the analysis will highlight if documents provided potent evidence of continuity and change in beliefs, ideologies and in practices, including how the drug problem was framed over time. Content analysis of documents published between international and national levels will also provide evidence for policy transfer, policy translation or non-transfer. The rationale for including some of the above mentioned types of documents is discussed below.

Hansard, the transcript of Parliamentary debates, indicates directions in future policy and reviews contemporary debates and data on various social problems. Similarly, political parties and presidents in Sri Lanka prepare electoral manifestos setting out aspirations, strategic plans, and prospective legislation should sufficient support be won in an election to serve in government. This thesis was interested in identifying specific discourses occurring in key Parliamentary debates on drug policy and also in political manifestos such as Mahinda Chinthana (Mahinda's vision) 2005. Mahinda Chinthana outlines the strategic plans to tackle drugs, alcohol and tobacco problems in Sri Lanka, in which a section has been dedicated under the title of 'Mathata Thitha' or 'full

stop to intoxicants'. As Hansard documents past and current policy, and indicates potential changes in drug policy, it is worth looking for any sign of cross political party conflict or consensus on major changes to drug policy in the history of Sri Lanka.

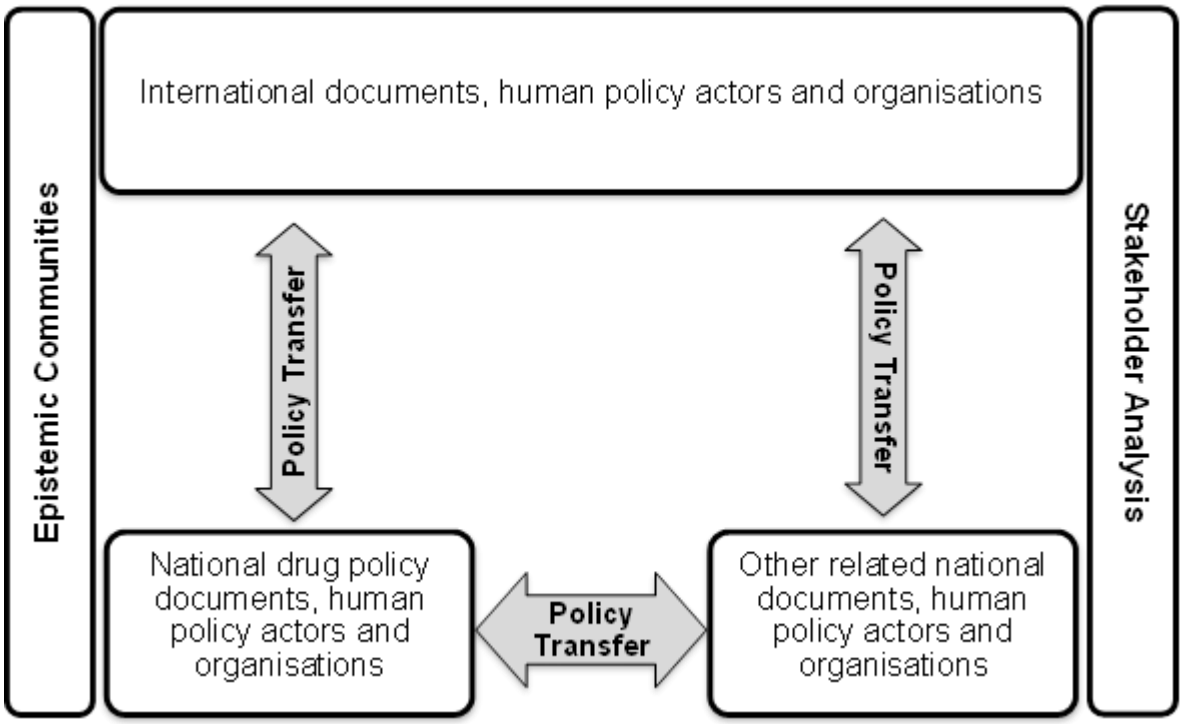
Annual reports produced by the UNODC, INCB and the NDDCB provide information on the prevalence of drug use, amount of drug seizures, price and purity, drug related arrests, drug related prison admissions, treatment admissions, and reported HIV and AIDS cases. The Department of Census and Statistics produces documents on social conditions in addition to reports of health surveys which include sections about drug misuse and HIV/AIDS-related information. Surveys and reports produce graphs, charts and statistics that attempt to describe various drug trends. Such projections have an impact on future policy and practice and this thesis attempts to look at the meanings attached to official statistics and to explore if any indicators prompt changes in policy direction.

International relations literature on networks expanded with the notion of 'epistemic communities' developed by Haas in 1992. In relation to drug policy, Sri Lanka interacts with a number of epistemic community members who represent organisations such as the INCB, UNODC, Colombo Plan, WHO and the SAARC. Epistemic community members are also present within domestic organisations and have links with their counterparts overseas. They are involved in the production and diffusion of drug policy and other related documents into the policy-making domain. The embedding or exchange of these policy ideas, beliefs and concepts into different cultural and geographical contexts is an area which has not been well investigated in documentary analysis literature. National drug policy documents often have links with other documents, particularly international documents and suggest that national policy documents do not operate in isolation. The relationship between documents or text has been referred to as 'intertextuality' (Atkinson and Coffey, 2004). With this in mind, this thesis will explore whether Sri Lankan drug policy documents are a response to internationally published guidelines and

conventions. It is therefore logical to compare and analyse the content and text between national and international documents and to ascertain what has been the Sri Lankan government's response.

Below preliminary model (figure 1) will attempt to illustrate the influence and intertextuality between national and international documents, including national and international structures/organisations and their human actors involved in policy development. Stakeholders operating within international policy transfer networks, epistemic communities in addition to national policy actors are involved in the production, diffusion and consumption of policy and other related documents. Documents may provide potent evidence of policy transfer from one jurisdiction to another. Documentary analysis, combined with interviews with policy actors is well placed to uncover the rationale behind similarities and differences between text and the meanings attached to the language inscribed in drug policy documents. It also enables the identification of different processes of policy transfer: lesson-drawing, negotiated transfer and direct coercive transfer.

Figure 1: National policy documents, human policy actors and organisations



Gaining access to documents is not without problems and difficulties. At the time of the data collection, there was no *Freedom of Information A*ct in Sri Lanka so there was no statutory right or a guarantee to obtain information held by the government. Identified documents had to be accessed via people who worked in various different government departments. They included librarians, research officers and information personnel. These individuals had to speak to someone else in their department, usually a person in a position of authority to release documents to a member of the public. Due to practical limitations, including the limited time available for fieldwork, people in positions of authority were approached via the researcher's personal contacts to obtain these documents. However, it still involved having to travel to various different institutions, building a rapport with key people controlling access to documents and sometimes waiting for long hours for the material to arrive.

There were some shortcomings with documents in terms of their completeness and gaining access. For example, transcripts of some external meetings on drug control prior to 1990 were on occasions illegible or not available. Pages of Hansards dating back to the British colonial period were also missing or not numbered, making it difficult on occasions to follow a logical sequence of ideas. Additionally, according to the NDDCB library, the Handbooks of Drug Abuse Information published prior to 1995 were not available. The researcher was also unable to obtain copies of the NDDCB board minutes pertaining to the discussions held on the key policy events previously mentioned in Chapter One apart from some on the Drug Dependant Persons Treatment and Rehabilitation Act.

Semi-structured Interviews.

Historically, social scientists have researched hidden population groups or those marginalised in society such as drug users, sex workers, those living with HIV and offenders. However, as Berridge (2000) argues, the real hidden populations are the policy-makers, the civil servants, and the members of organisations and interest groups who influence drug policy and decision-

making. According to Berridge, they too should be included within the qualitative investigation. As this thesis is concerned with policy development, it was considered appropriate to communicate with those who are/were in powerful positions to influence and implement drug policy in Sri Lanka. Semi-structured interviews with key policy actors are considered to be the most appropriate medium of communication to generate insights and insider perspectives of national policy development and decision-making.

Semi-structured interviews have been referred to as conversations with a view to generating purposeful information (Burgess, 1984). They are capable of eliciting key informants' views, opinions, values, attitudes and experiences, and are considered a useful technique to generate rich, descriptive data that cannot be easily captured through survey questionnaires or fully structured/standardised interviews (Arksey and Knight, 1999). The choice of semi-structured interview rather than a survey has been employed as it offers sufficient flexibility to approach respondents differently while still covering the same areas of data collection. For example, given the novelty of policy issues being discussed (initially, when it was not clear to the researcher what would be the most important questions to ask) and the need to ensure that the views of the most important policy actors were obtained, the flexibility of semi-structured interviews greatly outweighed the limitations on statistical analysis that would result from using a survey. Semi-structured interviews enable the modification or adjustment of interview guides with different stakeholders such as civil servants, politicians, policy-makers, doctors and lawyers, and NGO representatives who have been involved in policy-making. In fact, flexibility in designing and refining the interview guides and conducting the interviews is probably the key to success in using this technique (Horton et al, 2004). Semi-structured interviews were chosen to allow the key informants a degree of freedom to explain their thoughts, to highlight past policy events and their subsequent experiences, as well as returning to some responses for further clarification e.g. to elicit and resolve apparent contradictions, where conflict seemed to have arisen between stakeholders on the topic of drug misuse.

Key Informant Interviews.

Crabtree and Miller (1999) define key informants as individuals who possess special knowledge, status, or communication skills, who are willing to share their knowledge and skills with the researcher, and who have access to perspectives or observations denied the researcher through other means. The key informants included in this study can be defined as individuals who: were involved in formulating and implementing national drug policies, have extensive knowledge and experience on the subject of drugs, were directly involved in either amending, formulating or implementing legislation, and were in powerful positions to influence and shape policy decisions. Preliminary interviews were conducted with five key informants. They had extensive knowledge and experience on the subject under investigation and had represented either government or non-government sectors.

As information comes directly from knowledgeable people, the five initial key-informants provided data and insights that cannot be obtained from the use of other research methods. The selected five key-informants were a valuable resource to offer insights into the reasons for any changes in policy direction over time and offer inside-perspectives on policy decisions occurring during their time served as members of the NDDCB. They also enabled the identification of a list of priority stakeholders along with: perceptions of their vested interests, their knowledge in the area of drug control, the inter-relationships and alliances they have had with government and non-government organisations. The initial key informants were able to comment upon cultural meanings attached to drug policies, some of the drug policy documents and the role of stakeholders in the creation and implementation of drug policy. They were also in a position to identify their own relationships with national and international organisations concerning drugs as well as others who had close relationships with such organisations.

The selected initial five key informants were in privileged positions in Sri Lankan society due to their knowledge, expertise and the positions they have

held. Some had worked directly with presidents, ministers and other powerful individuals and organisations who had been influential in drug policy-making. This invested them with authority, whereby they were able to identify and provide access to other informants whom they thought would be beneficial for this study. Additionally, key informants were able to provide access to other important information such as national and international policy documents, some of which were either authored or edited by these individuals. For example, during interviews, some key informants said “have you seen the report I edited on.....?” or “you can speak to Mr..... He was the author of .....”

The good working relationship the researcher had with some of the initial five key informants enabled them to provide a guiding role for the researcher on data collection. As discussed in the previous section, documentary analysis and semi-structured interviews are interconnected and this approach to triangulation helps in the identification of individual authors of national policy documents. Direct quotations and information extracted from key informant interviews are labelled throughout this thesis. Where the same data is provided by two or more key informants, the label ‘Interview data’ is given to denote the multiple sources of the information.

Designing Interview Questionnaires.

Nievaard (1996) suggests a four step model for the qualitative interview, which requires the use of literature review, the development of an interview schedule, exploratory or piloted interviewing and more direct interviewing. This study followed this four step model in the development of semi-structured interview schedules by a process of drafting and amendment, following consultation with project supervisors. Interview schedules were developed in two stages. The first stage involved the development of interview schedules for pilot interviews with identified key informants. Here, the primary aim was to sketch major

changes to drug policy and legislation in Sri Lanka during the study period and was informed by a literature review and documentary analysis.

The interview schedules for key informants were devised on the premise of investigating the following identified areas:

1. Amendments made to the Poisons, Opium and Dangerous Drugs Ordinance of 1929 in 1984

This seeks to establish the rationale for amending the law in relation to drugs in 1984 and to identify both national and international forces behind these amendments. It is interesting to discover the nature and extent of the drug problem prior to these amendments, and how they were perceived by both the stakeholders representing the NDDCB and those outside it. The 1984 amendments led to the establishment of the NDDCB so it was considered necessary to look at the rationale for the setting-up of the board, its original membership and the nature of its work. This involved investigation into decision-making processes to understand who had the authority and power to influence policy and why. These initial insights into the work of the first board enable a description of how the NDDCB has evolved and serve to identify any changes to its governance structure, membership and its relationships with other stakeholders. This was revealed in subsequent interviews with key informants, who commented on any marked contrasts or similarities in the way the NDDCB has operated since its inception. Appendix A depicts the interview schedule for this area.

2. The first Sri Lankan National Policy for the Prevention and Control of Drug Abuse (1994) (see appendix B)

Here, the rationale behind the creation of a national policy on drugs in 1994 and the identification of national and international influences is explored. The

interview schedule was drafted so respondents were able to describe prevailing economic, political, social and cultural contexts, identify any tensions or coalitions between policy makers and organisations in the creation of this policy. It was within the remit of this thesis to recognise any prevailing discourses during the policy design stage and identify how these had an impact on the resulting policy. Appendix C depicts the interview schedule for this area.

3. The role of different stakeholders in policy formulation

Within the context of incremental changes towards drug policy, it is useful to see who is behind drug policy development, their roles and responsibilities and the overarching governance framework they have operated within. Professional groups who represent the NDDCB include: police officers, medical doctors, lawyers, civil servants, and Buddhist monks. These individuals who have a 'stake' in drug policy interact with each other and have links to other people in similar public policy arenas. Whilst multi-disciplinary involvement is appreciated as being beneficial in bringing a wide variety of opinion from a variety of disciplines and backgrounds, it is interesting to explore whether policy-making was restricted to a singular professional opinion, and if so why? The interview schedule to explore the role of different stakeholders is depicted in Appendix D. Additionally, a further interview schedule was developed for a Member of Parliament, to explore the rationale for introducing the 'Mathata Thitha' or full stop to intoxicants concept. See Appendix E for this interview schedule.

4. The updated drug policy in 2006

The first drug policy published in 1994 was not revised until a decade later. It was prudent to identify the rationale and the drivers for updating this policy, including the identification of the prevailing economic, political and social contexts and how they may have shaped policy outcomes identified in the updated policy in 2006. There was also a need to study the stakeholders

behind this policy development and if there had been any conflicts or contradictions. See Appendix D for the interview schedule.

5. Drug Dependant Persons Treatment and Rehabilitation Act 2007.

The rationale for introducing compulsory drug treatment and the regulation of drug treatment centres, which are covered by this legislation required examination. It involved looking at national as well as international drivers for policy action and the various actors and agencies involved in introducing compulsory drug treatment. Again, the broader economic, political and social climates in which this legislation emerged needed to be understood in order to have an in-depth understanding of the meaning attached to this policy development. See Appendix F for the relevant interview schedule.

Access to Policy Actors.

The majority of key informants interviewed can be considered as elites, those possessing power and authority as opposed to those who may be more obviously disempowered, such as drug users. These elites belonged to a higher social stratum in Sri Lankan society and are from privileged backgrounds where education and status had both been forthcoming. It is frequently argued that elite groups are more difficult to penetrate than other groups as they are better equipped to protect themselves from scrutiny and resist the intrusiveness of social research (Duke, 2002; England, 2002; Desmond, 2004). Obtaining consent from elite individuals, defining the nature of access once agreement is obtained and maintaining this negotiated access during data gathering was considered to be a critical part of the interview process.

A number of different strategies were used to gain access to the key informants and this process can be separated into two stages:

1. The first stage involved negotiating access. As discussed earlier, the researcher had already come across or interviewed some national drug policy actors in earlier research (Samarasinghe, 2006). Sponsorship to gain access to, and interview, newly identified key informants (initial key informant interviews) was sought from some of these 'known elite individuals'. Additionally, personal contacts of the researcher were employed to approach identified potential key informants, or the researcher contacted them directly stating that the researcher's personal contact (stating the name) suggested speaking to them. While negotiating access to face-to-face interviews, the internet was routinely used to find potential key informants' current contact details, and then send them an e-mail informing them of the researcher's interest in their current or past work, stating that the researcher would telephone them in the next few days to discuss the possibility of an interview. Attached to the e-mail was a standard letter outlining the purpose of the research, promising the anonymity of respondents and informing about the researcher's professional status. This was a successful technique for giving the key informant advance notice of the researcher's interest and reduced the chance of them refusing the telephone request, a format much less easy to ignore than an e-mail or a letter alone. The subsequent telephone conversations took place either while the researcher was in the United Kingdom or during visits to Sri Lanka and were particularly useful in terms of allowing flexibility in arranging interviews with busy people in influential positions.

2. The second stage involved snowballing. Snowballing started from the initial interviews with five key informants during which they were asked to identify additional key informants for interview. This generated a further number of key informants, where the process was repeated until either no new informants were suggested or no new data emerged. A contact list was created from talking to the initial key informants and was continuously updated as subsequent key informants were identified through the snowball method. Initial key informants provided contact details for some of the new key informants they identified and on occasions where this was not available, the researcher found their contact details through personal contacts, searching the hard copies

of the Sri Lanka telephone directory and via the internet. Details of the contact list included information on work, home and mobile telephone numbers and email addresses. Where they were not available, work telephone number and the email addresses were noted for the secretaries or the personal assistants of potential new key informants.

As the five initial key informants were from widely different backgrounds with varying roles in relation to policy formulation and implementation, they were able to identify other informants who did not belong to the same network of policy actors. Whilst this minimises a bias effect of using informants from the same setting, key informants are not homogeneous and some drawn from one group may not accurately represent the views of another group. To further minimise problems with validity, the key informants were asked to identify other informants who both share, and do not share, their views. This enabled gathering a range of different views and perspectives from people coming from different backgrounds. In no particular order, a brief summary of all those interviewed is depicted in Table 2.

Table 2. Interviews with key informants.

Interview number	Role of person interviewed	Date of interview
Interview 1	NGO Director	2009
Interview 2	Policy-maker	2009
Interview 3	Policy-maker	2009
Interview 4	Psychiatrist	2009
Interview 5	NGO Director	2009
Interview 6	Civil Servant	2010
Interview 7	Policy-maker	2010
Interview 8	Policy-maker	2011
Interview 9	Civil Servant	2011
Interview 10	Police Officer	2011

Interview 11	Civil Servant	2011
Interview 12	Civil Servant	2012
Interview 13	Member of Parliament	2012
Interview 14	Police Officer	2012

The below table provides the background of interviewees, the positions they held within government and non-government organisations as well as their connections or links to international organisations. As depicted, the typical profile of policy-makers/epistemic actors is variable, whereby one can represent many different organisations simultaneously, consecutively or following being appointed into an international organisation after retirement.

Table 3: Types of people interviewed

Role	**Background**	**National Positions held**	**Links to government and non-government organisations and key people**	**Links to international organisations**
NGO Director	Lawyer Drug education and prevention	Member of FONGOADA.	Ministry of Justice. Ministry of Health. Customs. PNB.	Colombo Plan.
Policy-maker	Prisons	Member of the NDDCB.	Ministry of Justice. AG Department.	Colombo Plan SAARC
Policy-maker	Customs	Member of the NDDCB	Ministry of Foreign Affairs.	SAARC
Psychiatrist	Medical Doctor	Member of the NDDCB. Professor at Colombo University.	Ministry of Health.	WHO Mental Health Committee South Asia
NGO Director	Buddhist Monk Drug and offender rehabilitation	Secretary to the Ministry of Finance. Member of NDDCB Member of FONGOADA	Ministry of Justice. Dharmavijaya Foundation. Swarna Hansa Foundation. President.	Colombo Plan UNODC SAARC
Civil Servant	Civil service	Ex-officio Member of	Ministry of Justice.	Colombo Plan SAARC

		NDDCB. Lecturer at Colombo University.	AG Department. Ministry of Justice. Ministry of Health. Customs. PNB.	Employed by CPDP following retirement UNODC
Policy-maker	Prisons	Commissioner of Prisons. Chair of NDDCB.	Ministry of Justice. AG Department. Ministry of Foreign Affairs. Police Department. Prisons. President.	Colombo Plan
Policy-maker	Medical Doctor	Chair of NDDCB. Member of ADIC. Member of FONGOADA. Member of National Authority on Tobacco and Alcohol.	Ministry of Justice. AG Department. Ministry of Foreign Affairs. Ministry of Health. Swarna Hansa Foundation. Dharmavijaya Foundation. Police Department. President.	Colombo Plan SAARC WHO
Civil Servant	Civil Service	Member of the NNAC. Ex-officio member of the NDDCB. Secretary to Ministry of Foreign Affairs.	Ministry of Justice. AG Department. Ministry of Foreign Affairs. Police Department. President.	UN Colombo Plan
Police Officer	Police Officer	Head of PNB. Member of NNAC. Deputy Inspector General of Police. Chair of NDDCB.	Ministry of Justice. AG Department. Ministry of Foreign Affairs. Police Department. President.	SAARC Employed by CPDP following retirement
Civil Servant	Civil service	Secretary to the Ministry of Defence. Presidential Advisor. Senior	Ministry of Justice. AG Department. Ministry of Foreign Affairs. Ministry of	SAARC UNODC Commonwealth Secretariat.

		Presidential Advisor. Ex-officio member of the NDDCB.	Defence. Police Department. President. Dharmavijaya Foundation.	
Civil Servant	Lawyer Civil service Diplomat	Ex-officio member of the NDDCB Secretary to Ministry of Foreign Affairs Secretary to Ministry of Justice	Ministry of Foreign Affairs. President. Ministry of Justice. AG Department.	SAARC UN Commonwealth Secretariat EU
Member of Parliament	Politician	Minister of Foreign Affairs. Various Cabinet Portfolios. Adviser to President.	All government ministries and departments. Parliament. Dharmavijaya Foundation. President.	SAARC UN Commonwealth Secretariat. EU
Police Officer	Senior Superintendent of Police. PNB.	Ex-officio member of the NDDCB. Head of PNB.	Ministry of Justice. Customs. Prisons.	SAARC

Interview Process and Procedures.

While the majority of interviews were held in the respondent's departmental office at an agreed convenient time, some interviews were held in the respondent's home. It became common practice for interviews to be held at home for those who were either retired or with those who no longer held an official position in the drugs field. Prior to each interview, the 'information sheet for research participants' (see appendix G) was introduced, along with the 'research consent form' (see appendix H). The interviewee was then given an opportunity to ask any questions about the study and clarify any issues prior to signing the consent form and conducting the actual interview. Twelve interviews were conducted in English and two were conducted in Sinhalese. Prior to conducting the Sinhalese interviews, the interview schedules were translated into Sinhalese.

All interviews were face-to-face, lasted between forty five and ninety minutes and were tape recorded with the key informant's consent. On all occasions, the researcher made detailed reflections shortly after the end of the interview and departure from the interview site. In most instances this occurred either in a car or nearby café. The researcher's reflections were tape recorded to minimise problems with recall. They have proved invaluable in looking back on the interview data and have been particularly helpful in reflecting the atmosphere of the interview and the feelings which were engendered at the time. It became an iterative process whereby the researcher was able to learn and adapt the interview style and approach in general with subsequent interviews. Two key informants were re-interviewed via the telephone as information arising from their initial interviews required further exploration.

Reflections: power and elite interviewing.

From the start, it was important to acknowledge and recognise the researcher's knowledge in the area as a study had been undertaken as part of a master's dissertation on "Drug policy-makers' perceptions on harm reduction in Sri Lanka". Although the focus of this thesis is broader, it was important to recognise how prior knowledge and experience might bias this research and not adhere to a previously held theory, or respond to intuition of the prevailing policy process. Rather, the intention is to pursue and investigate the history and development of drug policies in Sri Lanka.

Interviewing elite or powerful individuals is not free from problems and a unique set of issues can arise for the researcher (Duke, 2002). As Pile (1991) argues, classic approaches to the interviewer-interviewee relationship tend to reveal the researcher as the one in the position of relative power. However, when the informant is an elite or a powerful individual, some researchers argue that there is a shift in the dynamic of power, usually leaning towards the "powerful interviewee" (Bradshaw, 2001; Desmond, 2004). It is assumed that the power associated with people through their professional positions will transfer directly onto the interview space (Smith, 2006). While this was true to some extent

during interviews, power relations are context specific and are dependent on a number of mediating factors.

Throughout the fieldwork, the researcher was employed as a manager in the National Health Service in the United Kingdom. This ‘international status’, including how participants perceived the interviewer as a ‘western researcher’, was considered as an advantage, they were both a measure of status and a descriptor of professionalism. However, it cannot be confirmed whether this aided or detracted the ability to gain access to elite respondents. Some of the respondents commented on the researcher’s occupational position and role in the National Health Service and the fact that Sri Lanka might benefit from adopting some of the drug policies and programmes existing in Britain. The ‘international status’ of this research and the researcher’s involvement with the British academia and the National Health Service placed the researcher in a position, or at least the researcher was perceived, as having relative power as opposed to the researcher's relationship with some of the elite interviewees. For example, some respondents questioned the researcher’s experience in the drugs field and appeared to show a level of concern that they may not have a broad knowledge base (in comparison to the researcher’s) to comment on how Sri Lanka should respond to a growing drug problem. Where these comments were made, the researcher made the respondents aware that this is about a study of the policy-making process and that they were instrumental in developing and implementing some of the national policies and programmes, and occupy a unique position to comment on these. The researcher also stated that their personal views on how policies and programmes should look would be equally valuable to this study.

Some key informants also perceived the researcher as a potential ‘international funding source’ and were curious to find information on the process of seeking funds to develop drug treatment and rehabilitation services in Sri Lanka. Although, these elites were in powerful positions, the researcher was made to feel that he had some kind of authority and influence over international funding decisions. In these situations, the researcher clearly stated that he lacked any

influence over ‘foreign funds’. However, when this was brought up, contact details for potential international donors were provided at a later stage. These experiences during interviews reminded the researcher to be vigilant of power relations, particularly being perceived as a ‘western researcher with potential funding influence’ and the need to implement techniques to minimise and compensate for it in subsequent interviews.

In contrast, there were occasions when key informants demonstrated their authority and the elevated position and status they occupied. During these instances, the ‘power relationship’ commenced on the route between identifying a potential key informant and beginning the interview. Although personal contacts were used to gain access to some of the potential key informants, the researcher had to overcome a number of obstacles, including having to deal with gatekeepers who controlled access to some of the informants. This involved having to go through a third party such as a secretary or a personal assistant who managed the diary of the potential key informant. One secretary said:

“You are calling from UK. Call us again when you come to Sri Lanka. Mr..... is very busy these days... You won’t be able to speak to him today and I don’t book appointments in advance for him”.

Gate keeping also involved being processed via a security office and being searched prior to entering the key informant’s office or the building in which their office was situated. Security was paramount during the time of key informant interviews, especially in the context of the war in the north and east of the country and the risk of suicide bombers targeting government offices and their staff in Colombo. The respondents’ status, the powerful institutions they represented, the security provided to them, and their access via a secretary or a security officer, highlighted their important position and initial authority relationships.

During interviews, key informants emphasised their expertise in a number of ways: an extensive level of knowledge and expertise in the drugs or related field; the international conventions, conferences and workshops attended; reports and documents authored or edited; whom they are connected to across national and international organisations, and whether they were appointed by the president or any other influential person or entity. This was not always unexpected since background work had been undertaken to uncover as much relevant information as possible on key informants. However, some mentioned their expertise and appointment to their current position possibly due to a desire to demonstrate their power and authority. As more research interview experience unfolded with key informants interviews, the researcher brought up in conversation the speeches delivered, articles published in national newspapers and scientific journals, the prestigious positions held and the interests of key informants identified through secondary information sources. This technique proved to be useful in breaking the ice and acknowledging the authority of the key informant, which enabled their willingness to disclose information.

Some key informant interviews were conducted during a period when there was mounting international pressure on the Sri Lankan government to withdraw their military offensive against the Liberation Tamil Tigers of Tamil Eelam[4] (LTTE) in the north and east. This was a period where there was high morale and an increased sense of nationalism, which was particularly prevalent in southern Sri Lanka as the LTTE were on the point of defeat following a war that

[4] The Liberation Tigers of Tamil Eelam was a militant organisation based in the North of Sri Lanka. It conducted a secessionist nationalist insurgency to create an independent state in the North and East of Sri Lanka for Tamil people. This campaign led to the Sri Lankan Civil War, which ran from 1983 until 2009, when the LTTE was defeated by the Sri Lankan Military during the presidency of Mahinda Rajapaksa. During the height of LTTE's military power, it assassinated several high profile politicians in India and in Sri Lanka, including the assassination of two world leaders, former Indian Prime Minister Rajiv Gandhi in 1991 and Sri Lankan President Ranasinghe Premadasa in 1993. The LTTE is also well known for inventing the suicide belt and in pioneering the use of women for suicide attacks in the world. It is proscribed as a terrorist organisation by a number of countries. Historical inter-ethnic imbalances between majority Sinhalese and minority Tamil populations are alleged to have created the background for the origin of the LTTE (LTTE. In *Wikipedia*, Accessed on 14 May 2015 from https://en.wikipedia.org/wiki/Liberation_Tigers_of_Tamil_Eelam.

lasted for almost three decades. There was a growing sense of distrust and suspicion of international organisations, including those which had hopes to carry out research in Sri Lanka. Although the researcher is unable to comment if any of these views entered the interview space, it was important to be aware of the prevailing sensitivities and keep abreast with the local political and security situation. This involved reading national newspapers online whilst in the UK and speaking to friends and family both in the UK and Sri Lanka about significant problems. This increased understanding and awareness was of benefit in dealing with key informants, particularly with those who were working under the supervision of the Ministry of Defence.

Henry (2003) argues that the researcher's identity has an impact on the research process and has different meanings in different contexts. The researcher was born and brought up in Sri Lanka until age 18 and subsequently lived in the UK for the following two decades. The researcher made frequent visits to Sri Lanka, keeping in regular touch with friends and family and keeping abreast of news and events. Some friends who remained in Sri Lanka made periodic comments, stating that the researcher seem to be more abreast with developments in Sri Lanka than local residents. Although this may be accurate in relation to friendships, an opposing view was communicated during some key informant interviews, making the researcher feel as if he were a non-native individual attempting to investigate local problems and their related responses without any first-hand experience in Sri Lanka. This led to the researcher feeling that he was not being identified as a Sri Lankan during some interviews. For example, some questions directed at the researcher included; "How long have you lived away from Sri Lanka?", "how often do you visit Sri Lanka?", "so.. can you still speak Sinhalese?" etc. However, as more interviews unfolded, the researcher used techniques such as speaking in a typical Sri Lankan accent, introducing Sinhalese words and sentences into English interviews and subsequently engaging in conversations unrelated to the research, such as cricket, to convey having topical and local knowledge. These tactics proved useful and helped the research process.

Data Management and Analysis.

According to Dey (1993: 30), data analysis is “a process of resolving data into constituent components to reveal its characteristic elements and structure” in order to “know how and why as well as what”. Furthermore, “data analysis is a related process of describing phenomena, classifying it, and seeing how our concepts interconnect” (Dey, 1993:30). In general, the purpose of qualitative analysis is to discover patterns in data and ideas which help to explain their existence (Lee and Fielding, 2004). The data collected on the subject of drugs in Sri Lanka were pieces of messages or communications and their transfer into information can be achieved through data analysis by organising it into categories. This is a process of bringing order, structure and meaning to the mass of data collected (Marshall and Rossman, 1995). Siedel (2010) suggested three parts of the qualitative data analysis: noticing things, collecting instances of these things, and thinking about these things. The thesis employed thematic analysis of interview transcripts and documents, although content analysis was also performed on the latter.

Data Coding.

The texts for analysis (documents and interview transcripts) were coded manually and utilising Microsoft Word software. Coding is a process of data conceptualisation through the use of an abbreviation or symbol applied to a segment of words (sentence or paragraph) to classify and clarify segments into meaningful and relevant categories (Miles and Huberman, 1994; Pope and Mays, 2000). Basit (2003) further states that indexing/coding is the application of the codes to the text during which the data is broken down, conceptualised and assembled together in a new way, helping to build theories from the data. Using an editing style, the text was read, re-read, observations made during a systematic reading, and then these observations were organised into codes, which were then re-read further for interpretations as described by Glaser and Strauss (1967). A separate electronic file was created for each code, containing information to link coded text with similar codes in other documents. Coded text

was then connected and corroborated by sectioning related text together. An immersion/crystallization organising style (Crabtree and Miller, 1999) was then used to identify themes within those text sections.

Thematic Analysis.

Thematic analysis was conducted using the framework described in the literature by (Bryman and Burgess, 1994) and Silverman (2000).

Interview and interview reflection tapes were listened to; documents, transcripts and field notes were read initially to familiarise with the material in order to gain an overview of the richness, depth and diversity of the data. These enabled the drawing out of general ideas and began the process of abstraction and conceptualisation.

The material was re-read to support the identification of a thematic framework. Key issues and policy events were identified, concepts and themes by which data can be examined and referenced were established and sub-headings and division into thematic categories were noted.

The aims and research questions of the thesis were reviewed prior to this exercise. Based on the main research questions, the codes for each theme were developed. Subsequently, indexing of the thematic framework for systematic application of the data in textual form was performed with breaking into paragraphs, cutting into phrases and coding. On each transcript the appropriate code was inserted into the text.

Related text was lifted from its original context and re-arranged according to the appropriate thematic references through chopping, extraction, categorization, placing in headings and subheadings, quantification and clipping. The indexed paragraphs were extracted from transcripts and a separate file was created for

each theme, expressing the general ideas and explanations. Finally, mapping and interpretation of the data set was performed by putting together the main characteristics of the data so associations between themes were examined with a view to providing explanations for findings. Again, it was performed bearing in mind the original aims and research questions of the thesis as well as the themes that emerged from the data.

Ethical Considerations.

Attempts to cordon-off elite research as demanding a different type of ethical framework from other types of research are problematic for a variety of reasons, not least because this is dependent on the researcher's ability to define who does and who does not exercise power (Smith, 2006). As Bradshaw (2001) points out, it is impossible to work with two different ethical codes, one for researching up and one for researching down. This research adheres to the "Statement of Ethical Practice for the British Sociological Association" (2002) and those of Middlesex University. Ethical issues and dilemmas in social research were approached from a position of expertise, which included the management of issues concerning consent and confidentiality. The research was driven by accepting that maintenance of high ethical standards go hand in hand with the assurance of good quality social research, and these considerations were central to this study. Factors of data protection, access, informed consent and confidentiality were considered as important areas and will be discussed further.

Prior to the interview, participants were informed of the purpose of the study (both verbally and in writing) and stated that their participation was entirely voluntary and they could withdraw at any time without needing to provide any reason. Confidentiality was guaranteed and participants were reassured that information they supplied would not identify them, their position, or the organisation they currently or previously represented. This was particularly important when seeking the views of influential and powerful informants as obtaining inside knowledge might be considered politically sensitive.

Additionally, those who are involved in formulating and implementing national drug, alcohol and tobacco policies are an extremely small group of individuals, and might be identified if data was attributed. However, some key informants were happy to be identified, even in the context of revealing sensitive information. They were known to the public for the views they held on the drug problem and their disclosure of information was seen as being helpful for this thesis and in influencing policy change or further development, particularly as they were known as distinguished elites in Sri Lankan society. It was more common with key informants who served as members of the NDDCB but no longer do so. However, the researcher has not identified any key informant in this thesis on the basis of safeguarding key informants from potential harm.

All participants registered their understanding and consent to participate in the study by signing the consent form. The consent form was then counter-signed by the researcher and a copy of it was handed over to the respondent along with the Information Sheet for Research Participants (Appendix G). None refused to have their interviews tape-recorded. The hand-held digital voice recorder was capable of recording and storing all the conducted interviews and only the researcher had access to this device. Audio interviews were transferred onto the researcher's personal computer and all transcripts, including paper records relating to the interviews were stored in a lockable filing Cabinet. The study was reviewed by Middlesex University ethical committee to ensure that it complies with the appropriate standards and was approved.

Conclusion

This chapter has described the research methodologies used to investigate the identified research questions and justify the rationale for employing a qualitative research design to answer the 'how' and 'why' questions related to the origins and course of contemporary drug policy development in Sri Lanka between 1984-2008. The methodology utilised has been reflexive in order to allow for the emergent research findings to inform the thematic framework for analysing contemporary drug policy. Ethical considerations are particularly relevant when interviewing subjects for research, especially those regarded as elite individuals

who occupy prominent positions and are involved in drug policy-making. Although this latter group were small in number they could be identified if data is attributed.

The next chapter will discuss the historical context in which drug policies evolved prior to 1984, the chosen start date of this study.

Chapter Four: Historical Context of Drug Policy-making in Sri Lanka.

Introduction.

To describe contemporary drug policy without consideration of past policy events fails to appreciate the country's history and misses an opportunity to understand and interpret the processes and influences in the period covered by this thesis. Examination of the past enables the identification of policy actors and stakeholders concerning drugs, the commencement, continuity and cessation of policies and any ideologies specific to the culture in which drugs had been used.

Sri Lanka has a known history of drug use dating back to the sixteenth century (Uragoda, 1983). In this chapter, significant landmarks will be highlighted in the establishment of drug policies from the early nineteenth century to the middle of the twentieth century, when Sri Lanka or Ceylon as it was previously named, was a colony under British administration. Details of any previously existing drug policies or more detailed information about drug problems are limited. The latter part of this chapter will focus on drug policy development post-independence and identify the key stakeholders and other actors present in the policy process. Throughout, specific attention will be paid to the dynamics underlying legislative action taken to regulate the use of drugs, highlighting the interaction of social, cultural, economic, medical and political factors. This chapter is based on a literature review and the analysis of available documents.

Drug Policies during the British Colonial Period (1796-1948).

From the sixteenth century until the middle of the twentieth century, Sri Lanka was under the administrations of the Portuguese, the Dutch and the British respectively. All three administrations regulated the use of opium primarily as a revenue-earning measure (Jayasuriya, 1995). When the British took over in 1796 a system was already partially in force to raise revenue through the

lucrative trade of opium. Initially, the British government was keen to promote cultivation of certain agricultural products, including opium (Uragoda, 1983). Consequently in 1829, imported tools and machinery for the purpose of agriculture were given to locals free of tax as a way of encouraging cultivation of opium. In addition, it was agreed that land already set aside for opium growing would not be claimed or used for other purposes by the government for a twelve year period (Jayasuriya, 1978). However, there are no reports or evidence of any opium cultivation in Sri Lanka soon after 1796 and this is probably due to the poor climate conditions. Opium is known to have grown better in India and it is reported that commercial quantities of opium were imported into Sri Lanka via the British East India Company (Kandiah, 1994). Other items traded by this company were cotton, silk, indigo dye, saltpetre and tea. The British East India Company was an early English joint-stock company, the first modern multi-national corporation in the world; it was formed initially for pursuing trade with the East Indies, but ended up trading with the Indian subcontinent and China. It had a significant impact on domestic and regional economies and may have had an impact on international relations, globalisation and policy transfer in many different areas.

The first legislation concerning opium under British administration appeared much later in 1867 when a law, or ordinance (the term in usage in Sri Lanka) was enacted to restrict the use and sale of opium and bhang[5]. This limited the use and sale of opium and bhang to people who had obtained government licences (Uragoda, 1983), probably marking the first demand reduction measure implemented by the British administration. According to the 1867 ordinance, it was an offence for any person to possess any quantity beyond two pounds weight or to sell opium or bhang without a license. The legislative change was aimed at establishing control over the sale of opium and bhang, but might not have had any significant impact on habitual users who required less than two pounds of opium to sustain a daily opium habit. There were no reports of any arrests or imprisonment of users with large quantities of opium

[5] Bhang is an edible preparation of cannabis commonly used in the history in the Indian subcontinent as part of tradition and custom.

during this era even though statutory powers were given to police officers and municipal inspectors to arrest any persons suspected of being involved in the possession or sale of opium and bhang without a license.

A novel feature in the history of opium distribution in Sri Lanka was the introduction of government-licensed ‘opium shops’. They were subject to several regulations; for example, the hours of business were restricted to opening between 6am and 8pm, and the maximum quantity sold to an individual was 180 grains (Uragoda, 1983). The sale of opium was forbidden to women and to children under the age of fifteen. Following the opening of these shops, the use of opium and bhang smoking was allowed on their premises, which were known as ‘opium dens’. The smokers paid a monthly rental of less than one rupee to the shop owner to consume opium or bhang in the dens (Uragoda, 1983). The main objective of the ordinance was to restrict the use of opium and bhang to opium shops which allowed the police to keep the premises and customers under observation. It can be argued that opium dens, more commonly known as drug consumption rooms today in some western countries, had then existed in Sri Lanka with the intention of restricting and containing drug use. The government’s assumption was that the system of surveillance would restrict and reduce the rapid spread of opium in Sri Lanka. There is no mention of any opium being injected at this time and it was mainly smoked in hookah pipes or else mixed with tobacco and smoked (Uragoda, 1983).

In 1878, another ordinance, which amended the law regulating the possession and sale increased the license fee for the sale of opium or bhang from rupees 30 to 250 and the license fee to possess opium from rupees 10 to 50 (Jayasuriya, 1978). In introducing this law, the queen’s advocate stated that:

“There was no doubt that among the least objectionable sources of revenue was the taxation of such articles as opium and bhang thereby discouraging their use” (Hansard, 9 October, 1878).

This ordinance did not prevent any medical practitioner or chemist from selling opium or bhang for medical purposes, a practice which had existed among the ayurvedic or native practitioners, known as *vedalaras,* for many centuries. In addition to increasing license fees, the 1878 ordinance reduced the quantity of opium which a person may possess without a license from two pounds to one pound in weight. It also prohibited any medical practitioner or chemist from possessing more than five pounds weight of opium at a time without a government license. This was the first time *vedalaras* had restrictions placed on their authority to use opium for medical purposes.

These increases in taxes, adoption of a licensing system, and other restrictions on imports after 1878 were considered excessive, eventually resulting in an increase in opium smuggling into the country. The governor at the time participated in an opium taxation debate and pointed out the risk of illicit opium being available in the country. He stated:

"With regard to the duty, I would remind the legislative council[6] *that by putting on a too high a duty on opium the risk of illicit introducing of it will be very considerable"* (Hansard, 25 October 1893).

Uragoda (1983) argues that authorities viewed smuggling as a loss of revenue rather than of any danger to the public and overlooked any considerations and views expressed by Sri Lankans about any moral decay resulting from opium use.

[6] The legislative council was the legislative body established in Sri Lanka by the British colonial administration. It is claimed to be the first form of representative government in the country and consisted of sixteen members including the Governor. The Governor, who was a British national presided over the council and appointed five members of the Executive Council (the Colonial Secretary, the Officer commanding the Military Forces, the Attorney General, the Auditor General and the Treasurer). Four other official members included the Government Agents of the western and central Provinces. Government agents were Sri Lankan civil servants of the Sri Lanka Administrative Service (SLAS). In addition, six unofficial members were nominated by the Governor, three represented the Europeans (British residents in Sri Lanka) and three represented Sri Lankans. The nominated unofficial members had no right to initiate legislation; they could only contribute to discussion.

Further changes to the licensing system were made in 1889, whereby opium could be sold at public auction, and a licence to possess and sell could be issued to the highest bidder (Uragoda, 1983). Over the succeeding years, the number of opium users grew steadily and it was estimated that by 1908 approximately 19,847 habitual opium users existed in the country (Uragoda, 1983). This may be an under-report considering the established illicit opium trade and the number of users without a license.

Promotion of opium use was a controversial and sensitive issue in a predominantly Buddhist society where Buddhists condemned the use of opium (Uragoda, 1983). Additionally, the views of the local Sinhala and Tamil people were not considered by the British administration. There is no evidence to indicate that any request was made by the majority Sinhalese Buddhists or the minority Tamils to participate in any part of the promotion of opium. There was agitation against the government's opium policy on cultural and religious grounds. This was occurring at a time when the majority of the Sri Lankan population were demanding increased representation in the legislative council (Jayasuriya, 1995).

Buddhists comprised over seventy percent of the population and resented the relegated status given to their religion under an alien government (Uragoda, 1983). This gradually developed into a movement for the revival of Buddhism and had strong nationalist undertones. One of the five precepts of Buddhism is abstinence from intoxicants. Although the use of opium is not specifically denied to Buddhists, it became evident that a substance imported by the British with a profit-making motive was beginning to be more vilified than alcohol. Consequently, and in parallel with the Buddhist revival movement, a temperance movement aimed at government opium policy began to develop. This attitude was later shared by other religions, and the agitation against opium found common support among all other ethnicities in the country (Jayasuriya, 1995).

Against this background, a member of the legislative council submitted a petition which was signed by approximately 27,000 Sri Lankans in 1893, urging the British administration to take remedial action to prevent the promotion of opium in a predominantly Buddhist society (Jayasuriya, 1995). The petition was submitted following a public meeting in Colombo and was addressed by Sri Lankan members of the legislative council and prominent Buddhist monks. The involvement of Buddhist monks in influencing drug policy might have started here. They could be considered as activists and became a significant pressure group in later years.

Between 1893 and 1907, various Bills were introduced to increase taxes on opium, mainly through the introduction of import duty. In 1897, the importation of bhang was prohibited although its use was not banned. This was an insufficient response for those who had campaigned for a complete prohibition on bhang. In 1897, a select committee was appointed to investigate the conditions under which opium was imported, sold and consumed in Sri Lanka. It concluded that there was insufficient evidence to indicate that there was a major opium problem. However, the committee recommended that the existing practice of permitting people to consume opium where it was purchased be discontinued (Jayasuriya, 1978).

The profit-making motive of the opium trade was periodically criticised by Sri Lankan members of the legislative council. It was in the hands of private tradesmen, whose main interest was to increase its sale and consumption. There are reports where a member of the legislative council called for the adoption of a system similar to that existing in the Philippines, whereby sale was undertaken by salaried government officials rather than private tradesmen. In a hard hitting speech this member stated that:

“The obstacles are official conservatism and British veneration of freedom. Any departure from the old lines, from the familiar grooves, is abhorrent to the official mind, especially if there is a suspicion that the revenue might suffer.

Here I am free to say that the revenue will suffer by reform, but infinitesimally as compared with the vast moral gain that will follow. People shout for proof that opium tends to crime, as if violence is the only expression of criminality. Is there a higher crime than to bring ruin on one's own family? To bring destitution on wife and children? To ruin one's own body and soul?" (Hansard, 6 February 1907).

It is evident from the above quote, that by the beginning of the twentieth century, people were questioning the meaning of moral values and good citizenship in society. Drug use was seen as immoral, and those who use drugs were seen as social outcasts. No significant evidence was available at the time to suggest high levels of criminal behaviour among opium users, apart from the perceived 'crime of immorality' arising out of drug use. This was a perception shared by the general public and certainly the previously mentioned religious groups who had an interest in drug policy at the time.

Although opium is not grown in Sri Lanka, the incidence of opium use was rapidly spreading across the country. In May 1907, a resolution was debated in the legislative council, seeking to close all licensed opium-selling shops from January 1908 and limiting the issue of opium to licensed apothecaries and government dispensaries (Hansard, 1 May 1907). However, the resolution was defeated, but the strength of feeling left no doubt in the minds of British administrators that there was a growing agitation for a new policy on opium.

Developments in 1908 were encouraging to those who had been seeking a change in policy for several years. The then colonial secretary introduced a Bill to change the law on importation, sale and distribution. Under the proposed new Bill, the government would secure a monopoly on importation and maintain complete control over distribution within the country. This would mark the end of licensed opium shops. Habitual opium users would have to register themselves in order to receive opium and the aim was to gradually wean users off opium, with the end goal being abstinence. The colonial secretary stated:

"All persons who are habitual consumers of opium will register themselves, and will receive a certificate vouched for by their headman or by some other person of standing, and the certificate will also state what quantity of opium he habitually consumes. Clause 14(f) enables the governor in executive council to fix the date after which the daily allowance of opium specified in the certificate of registered consumers shall be reduced each month by an amount equal to five per cent of the original allowance, the object being that the reduction should go on progressively from month to month until such time as even the licensed consumer, who is entitled to the largest quantity, will be unable to obtain any further supply" (Hansard, 28 October, 1908).

Today this can be recognised as a gradual form of detoxification, although, the initiation of such an approach did not form part of any medical treatment or a response from *vedarala*s.

The proposed Bill was not passed until 1910 due to a disagreement on the absence of statutory provision enabling *vederalas* to prescribe opium in the treatment of diseases. At the time they were involved in treating nearly seventy per cent of the population (Jayasuriya, 1986). The proposed Bill was referred to a sub-committee to make recommendations to consider the appropriateness of opium prescribing by *vedalaras*. One of the main concerns was the absence of a regulating body overseeing their work. The colonial secretary feared that in the absence of any regulation, untrained individuals calling themselves *vedalaras* might not be suitable to be trusted with opium prescribing for therapeutic purposes. Towards the end of 1909, a commission chaired by the Attorney General recommended a system for registering *vedalaras*. Under this, provincial boards (similar to local councils in the United Kingdom) were to register *vedalaras* who, in the opinion of the board, had undertaken sufficient training and were of good character. Upon registration, they were allowed eight ounces of opium annually, an amount the commission believed sufficient to meet their prescribing needs (Jayasuriya, 1986).

Opium was generally used by *vedalaras* in the treatment of diseases such as dysentery, diarrhoea, cholera, rheumatism, and diabetes and in general pain management of individuals. However, there was no provision made for *vedalaras* to supply opium, for non-therapeutic purposes, to individuals for chewing or smoking i.e. for any purpose other than in the treatment of diseases. Furthermore, the opium supplied was only in the form of a medicinal preparation and only three days' supply could be prescribed at a time. There is no mention or documented evidence of opium being prescribed by *vedalara*s in the treatment of drug addiction.

The Bill, the Opium Ordinance of 1910 was designed with an end goal of eliminating non-therapeutic opium use. However, the new system had financial repercussions on many areas of public administration. Financial losses were felt by many areas of the administration: the government, municipalities, local boards and sanitary boards, all of whom had relied on opium revenue, to carry out the various activities of local and central administration (Jayasuriya, 1986). In response to this crisis, the governor proposed a new excise policy aimed at generating revenue. The Excise Ordinance of 1912 applied to intoxicating drugs such as cocaine, bhang and every preparation containing, or prepared from, any part of the hemp plant. This law prohibited the hemp and coca plants from being sold without a license from a government agent. At the time, existing laws prevented *vedalaras* from possessing or prescribing bhang for medical purposes. In 1915, attempts were made to debate the hardships these practitioners were experiencing as a result of the new law. The chief medical officer opposed any move to allow bhang to be sold, distributed or prescribed in a similar manner as opium. This was later supported by the colonial secretary, stating that it is not safe for *vedaralas* to use bhang in the treatment of diseases (Jayasuriya, 1986). In 1920, the *vedalaras* tried to pass a resolution calling for the appointment of a committee to consider whether provision should be made for the prescription of bhang and other preparations from cannabis for medical purposes (Uragoda, 1983). In response, the principal civil medical officer who was also the government's chief spokesman on health stated that:

"It will be seen that for the Ceylon government to refrain from imposing restrictions, or to give facilities for the use of what appears to be regarded as a more or less 'universal panacea' or cure-all is to deliberately sanction the establishment of a dangerous drug habit, to be followed by the mental, moral and physical ruin of a large number of persons seeking medical aid from practitioners who, with the best intentions, perhaps, may set up a horrible vice. I maintain that to sanction the medical use of this intoxicant would be to encourage the establishment of a dangerous drug habit amongst a large population. The drug grows wild in some parts of the country. Excise restrictions would be ignored. The native practitioners would be looked upon as officially sanctioned purveyors of the intoxicant. They would or could realise a rich harvest by disguising the drug as decoctions, extracts, pills or powders and so on. The more the drug comes into use as a remedy for disease, the more would it be in demand as a cheap intoxicant, and a habitual craving established among all classes all over the country" (Hansard, 28 June, 1920).

On this occasion, cannabis had been seen as an intoxicant that compromised the country's moral values if it were to be made available to the public via ayurvedic transaction. Suspicions were raised over its potential for misuse subsequently leading to the establishment of a drug habit if it were to become more widely available. There were emerging fears that cannabis use would lead to a growth in violent crime, which was not a major concern in debates around opium policy in the past. Following a review on the toxicology of bhang, the civil medical officer stated in 1915 that:

"We have at present a great number of crimes of violence in Ceylon and I am of the opinion that a drug should not be allowed which has proved such deleterious effects, and to which so little beneficial properties can be ascribed" (Hansard, 6 August, 1915).

This statement from the government's civil medical officer, in conjunction with the toxicological review and concurrent moral panic fuelled by the government

and public, may have been sufficient to justify the policy stance on bhang taken by the British colonial administrators. The international policy climate on drug control which the British administrators operated within Sri Lanka was also changing as increased sanctions and regulation of drugs were becoming more internationally recognised and established.

Between 1912 and 1931 some international conventions concerning the regulation of opium had come into effect. For example,

1. The International Opium Convention (1912);
2. The Agreement Concerning the Suppression of the Manufacture of Internal Trade in, and Use of Prepared Opium (1925);
3. Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs (1931); and
4. The Agreement Concerning the Suppression of Opium Smoking (1931).

Considering this international policy climate, the British Secretary of State for the colonies, in his despatch of 12 June 1925 to the governor in Sri Lanka, prompted him to take action to enact legislation to give effect to international drug control conventions. In 1927, a Bill to amend and consolidate the law relating to poisons, opium and dangerous drugs was tabled in the legislative council. This proposal occurred at a time when the internal drug legislation was in a confused state. For example, some of the dangerous drugs were controlled by the excise commission, others were controlled by the medical and sanitary services, and the whole system is further complicated by large numbers of excise notifications notified in gazettes, making it extremely difficult to understand the extent of the drug laws (Jayasuriya, 1986).

The Poisons, Opium, and Dangerous Drugs Ordinance was passed in 1929, but was not enacted until 1935. Section 47 stated that dangerous drugs should only be imported into the country under the direction of the director of medical

and sanitary services. Previous regulations enabled the importation of dangerous drugs by parties outside government under a license obtained from this directorate. This change was found to be inconvenient for the government and to non-government organisations. An amendment was made in 1935, where non-government agencies were allowed to import drugs under a government license, thus reverting back to the old importation system. Earlier laws on poisons and opium control were repealed by this new ordinance. Under the new law, illicit drug possession, consumption and manufacture became criminal acts. In detail, it became an offence to sell, give, obtain, procure, store, administer, transport, send, deliver, distribute, traffic, import or export such (illicit) drugs and aid or abet in the commission of such offences (NDDCB, 2005).

However, it is important to note that *vederalas* were legally able to use opium and its preparations in therapeutic medical treatment but were forbidden to use bhang or any cannabis preparation. The Medical Ordinance of 1927 deals with the registration of medical practitioners, dentists, pharmacists, midwives and nurses. At first, there had been some opposition in relation to medical personnel being allowed to prescribe dangerous drugs. One member of the legislative council stated that:

"Because haphazard legislation with regard to wording might afterwards work a difficulty and might put fees in the pockets of the wicked tribe who live on the troubles of other people" (Hansard, 4 July, 1929).

However, the Bill was passed by the legislative council. There is no documented evidence to suggest that the medical profession had a strong influence in policy decisions or had any interest in the prescribing of opium or cannabis at the time.

Since 1935, the Poisons, Opium, and Dangerous Drugs Ordinance has been through many amendments, most recently in 1984 (Act No.13) and remains the

principal statutory enactment regulating illicit drugs in Sri Lanka. The 1984 amendments and changes brought forward as a result will be discussed in the proceeding chapters as it is within the period for contemporary drug policy analysis (1984-2008) for this thesis.

After Independence and the New Wave of Nationalism (1948-1972).

Sri Lanka gained independence from Britain in 1948. Between 1948 and 1960, few amendments were made to The Poisons, Opium and Dangerous Drugs Ordinance of 1929. Since independence, the Sri Lankan government has been more concerned with regaining a cultural identity in society and as a result a resurgence of a new wave of nationalism was born. The government has been more concerned and preoccupied with moral values in society and less concerned with promoting individual liberties. Moral values have been almost entirely drawn from Buddhism, a philosophy followed by over seventy per cent of the population (Deegalle, 2006).

The general elections held in 1956 marked the era of the 'common man'. Certain groups, which had at one time in the country's long history occupied a position of eminence and influence in society but had subsequently languished for the want of patronage by the elitist groups and recognition by those in power, came into the social and political limelight almost overnight (Jayasuriya, 1986). One such group was Ayurvedic physicians. There was a sudden awareness at all levels of society of the needs, aims and aspirations of these groups. To ignore their demands would have resulted in political disaster (Jayasuriya, 1986). Besides, the majority of Ayurvedic practitioners were Buddhists, including some prominent Buddhist monks practising Ayurveda at the time. This group of people made explicit demands on the government to elevate their status in society. One of their arguments was the relegated status given to the profession when the British were promoting western medicine, channelling all resources to the development of a western medical system.

The drafting of an ayurveda law was delayed due to political unrest after 1956, arising from communal disturbances and the assassination of the Prime Minister SWRD Bandaranaike in 1959. The law was not enacted until 1961, although it addressed the arguments raised by ayurveda practitioners, for example, resolving difficulties in obtaining opium and bhang for the manufacture of medicinal preparations (Jayasuriya, 1986). It was introduced at a time when there had been less pressure from international bodies attempting to control and shape drug policies in many countries. It is worth mentioning that the Single Convention on Narcotic Drugs came into effect in 1961; this endorsed the use of cannabis for medical and scientific purposes, bringing Sri Lanka in line with international law. There was no other significant drug legislation in this period.

Application of Global Drug Policies to Sri Lanka (1973- 1983).

The international policy climate on drug control 1973-1983, the various actors and organisations involved in domestic policy-making and how these actor networks have an impact on policy outcomes, require examination. Particular emphasis will be given to the role of the United Nations Commission on Narcotic Drugs and their strong ally, the Colombo Plan, in sensitising and diffusing international principles, norms and policies on drug control into the domestic context. Available evidence on the drug scene during this period, and how this was framed and defined, needs to be analysed. Ideas discussed are predominantly drawn from a comprehensive report compiled following the first ever narcotics and drug abuse seminar held in Sri Lanka on 18th and 19th of October 1973. The proceedings were tape recorded and this report contains a summary of the discussions (Colombo Plan Meeting on Narcotics and Drug Abuse Problems, 1974). As a documentary record, this is probably the only comprehensive report that traces policy ideas and proposals to deal with the drug problem in great detail in the 1970s. Additionally literature was drawn on where it was available.

With the changing international climate on drug law enforcement, Sri Lanka has been compliant in adopting new international drug control conventions. Prior to the 1970s, Sri Lanka was already a signatory to the United Nations Single Convention on Narcotic Drugs when the International Narcotics Control Board (INCB) was set-up by the United Nations in 1961. In 1971, Sri Lanka participated in the United Nations Convention on Psychotropic Substances, and became a signatory to the protocol in 1972. Policy transfer and harmonisation across intergovernmental organisations and co-operation between countries was a key priority for the United Nations. Confining drug policy analysis to the borders of Sri Lanka gives a highly skewed picture, as "developing country policies were, and are, being decided externally by financial institutions such as the World Bank and the huge empire of United Nations' institutions" (Walt, 2006:122., Bernstein and Cashore, 2000). Moreover, as previously discussed, external influence on drug policy during the British administration had also been traced in the origins of drug policies in Sri Lanka.

During the early 1970s, the need for policy change was periodically highlighted by both external and internal parties. The majority of these changes were proposed by the Colombo Plan Drug Advisory Programme (CPDAP), an international organisation established under the Colombo Plan in 1973 to address drug problems in the Asia-Pacific region. This programme assisted member states in organising national and regional seminars, conferences and discussions on various aspects of drug abuse prevention and control. It also advised and assisted in updating drug legislation and promoting drug law enforcement action. At the time, member states of the Colombo Plan included: United States of America, Thailand, Singapore, Philippines, Pakistan, New Zealand, Nepal, Myanmar, Maldives, Malaysia, Laos, South Korea, Bangladesh, Fiji, Japan, Iran, Indonesia, India, Australia, Afghanistan as well as Sri Lanka. Since its inception in 1973, the head-quarters of CPDAP has been based in Sri Lanka and might have benefited the local bureau in terms of policy application on many different fronts through its dealings with domestic actors. The majority of funds received by the Colombo Plan were from the United States and, arguably, policy decisions taken by the Colombo Plan might have been shaped by the US government.

The first Sri Lankan narcotics and drug abuse seminar in 1973 was jointly sponsored by the Colombo Plan and the Sri Lanka police narcotics bureau. It was also assisted by the United Nations Representative in Sri Lanka and the United Nations Commission on Narcotic Drugs. The seminar was timed to coincide with the visit of the United Nations Commission on Narcotics A*d Hoc* Committee on Illicit Traffic in the Far East Region. It was attended by over forty participants, representing government ministries, corporations, universities and various international, professional and voluntary organisations. While the director for Colombo Plan, Mr. I.K McGregor, delivered the welcome address, Mr. J.C O'Connor, the Chairman of the United Nations Commission on Narcotic Drugs *Ad Hoc* Committee on Illicit Drug Traffic, delivered a speech prior to the opening of this seminar (Colombo Plan Meeting on Narcotics and Drug Abuse Problems, 1974).

One of the main objectives of the seminar was to exchange knowledge and information, and suggest measures for improving law enforcement, drug treatment and rehabilitation. These objectives were not entirely different from the key priorities set out by the United Nations. During the seminar, drug abuse was presented as a global problem affecting both the developed and developing countries. As the Chairman of the UNCND stated:

"This is a problem which is not local to Sri Lanka. It is worldwide, one which should be looked at, we think, in that context. Our charter concerns international liaison and co-operation to combat the illicit traffic in narcotic drugs" (J.C O'Conner, 1973, Colombo Plan Meeting on Narcotics and Drug Abuse Problems, 1974: 13).

The importance of international co-operation to curb the illicit trade in narcotic drugs and cannabis was allotted a high priority. It was particularly aimed at politicians and influential people who participated in the Colombo Plan seminar and used as an opportunity to diffuse the United Nations' principles, norms and policies related to drug control into the domestic policy-making arena.

There was a considerable amount of pressure and coercion from the international community, particularly the UNCND, for Sri Lanka to bring its law into line with international drug control conventions (Jayasuriya, 1986). The seminar was perhaps utilised as an opportunity to spearhead the implementation of some of the international drug control policies by Asian-pacific member states. The UNCND, through their regional representative bodies and other bodies such as the Colombo Plan exerted influence on the Sri Lankan government to respond to the global problem of drugs at a local level. This occurred against the backdrop of Sri Lanka being a signatory to the 1961 UN convention; although a high acquittal rate for narcotic related offences existed in the absence of any domestic legislation to give effect to the UN convention.

According to Bennett (1991), the notion of policy penetration involves a significant element of coercion. It is via this route that nation states are forced to conform to particular policy developments driven by other nations or external organisations, in this case, the United Nations and its ally, the Colombo Plan.

There were a number of significant organisational structures established in Sri Lanka in response to these international influences. The year 1973 marked the establishment of a National Narcotic Advisory Committee (NNAC). It was set-up administratively almost overnight, under the instructions of the Colombo Plan, to coincide with a United Nations mission that visited Sri Lanka (Jayasuriya, 1986). The Board's primary function was to advise the government on drug-related issues and advocate on policy options. The Deputy Minister for Defence and Foreign Affairs became the chairman of this Board and appointed members drawn from the Ministries of Defence and Foreign Affairs, Health, Education and the Departments of Police, Customs and Excise, and the Attorney General. Although not provided with a legal mandate, the Board marked the start of a multi-agency approach to drug policy development and thinking.

International interest in domestic drug policies gave rise to an epistemic-like community, the members of the NNAC. They hoped to address the drug problem in many different ways: law enforcement, treatment, rehabilitation and prevention. Those who represented the NNAC were loosely knit and comprised of a small group of powerful elites in government office. Representatives from non-governmental organisations were not included on the board and hence were not within this network. Considering the make-up of this Committee, the members shared one characteristic that they all belonged to higher social strata in Sri Lankan society. They also shared the belief that drug use is an obstacle to socio-economic development and prohibition must be the primary policy response (Colombo Plan Meeting on Narcotics and Drug Abuse Problems, 1974).

The involvement of the Deputy Minister of Defence and the Superintendent of police, led to the Committee having a strong focus on law enforcement. This was a domestic priority, but still an expectation of the international drug control conventions to which Sri Lanka was becoming a part. Although opium was not grown domestically, the Committee's emphasis was to focus on illicit trafficking of narcotic drugs particularly opium, into Sri Lanka from India. At the time, India was the world's largest supplier of legal opium for medicinal and scientific purposes. Opium had always been a major item in the overall two-way illicit traffic between southern India and Sri Lanka and this pattern of trade remained much the same during this period (Colombo Plan Meeting on Narcotics and Drug Abuse Problems, 1974). According to the World Opium Survey (1972), it was estimated that five tons of opium was illicitly imported into Sri Lanka annually from India by large scale drug traders. Considering that figures for local consumption were far less than illicit importation figures, there were growing concerns around the illicit traffic of opium to other parts of the world, particularly the west. The island's popularity as an onward-shipment point for narcotics from India grew from the early 1970s. Against this backdrop, the United Nations was keen on providing assistance to stem this trade.

The United Nations narcotics division provided training in law enforcement in the form of scholarships to member states. Whilst Sri Lanka had recently made its own start in police narcotic control, some police officers were sent for training to the United Nations narcotics division in Geneva. These training programmes were designed to unite senior law enforcement officers from various parts of the world, to establish informal friendship networks, discuss professional problems and find solutions domestically, regionally and internationally on illicit trafficking operations and generally to make officers realise that illicit trafficking is very much an international undertaking (Tufnell, 1973). This certainly became a platform for exchanging knowledge and ideas and for policy transfer.

In contrast to opium cultivation, cannabis sativa or the Indian hemp plant, grew easily under the varying climatic conditions prevalent in Sri Lanka. According to aerial surveys conducted by the police and air-force in the early 1970s, there were about 2,000 acres where cannabis was grown, namely along the south-east coast of Sri Lanka (Colombo Plan Meeting on Narcotics and Drug Abuse Problems, 1974). Ganja was a cash crop and the illicit cultivation of ganja involved approximately 3,000 workmen in the ‘ganja belt’ region. According to police intelligence, it was roughly estimated that 200 pounds of ganja arrived in Colombo on a daily basis for local consumption (Colombo Plan Meeting on Narcotics and Drug Abuse Problems, 1974) and there were several ‘ganja dens’ situated in Colombo and its suburbs; ganja cigar-smoking was a habit among local groups. In view of this large-scale illicit cultivation, one pound of ganja, which was worth rupees 300 in the early 1960s, had reportedly dropped to rupees 30, a tenfold price reduction within a decade (Colombo Plan Meeting on Narcotics and drug abuse problems, 1974). Law enforcement authorities used this information to demonstrate there was a substantial domestic illicit ganja trade, a problem needing attention from law enforcement agencies and the Ministry of Agriculture. Ganja growing was seen as a threat to the local agrarian economy especially in the wake of a concurrent food crisis. The Deputy Minister for Defence and Foreign Affairs, Mr Lakshman Jayakody in his inaugural address at the Colombo Plan Meeting on Narcotics and Drug Abuse problems stated:

"I am very happy that we have decided to have the meeting on narcotics and drug abuse problems in Sri Lanka and that this meeting is being held in Colombo today at a time when we are fighting a food war, because indeed it is important that we should also consider the growing of ganja in Sri Lanka as one of the problems facing the country" (Lakshman Jayakody, Colombo Plan Meeting on Narcotics and Drug Abuse Problems, 1974: 11).

The need to cultivate as many crops, food crops as well as other produce, to replace more expensive imported food and raw materials was highlighted from time to time. The country's economy was regulated by a socialist government and inevitably a food rationing system was in place. The emphasis was to promote and increase the production of domestic agricultural products, and the flourishing cannabis plantation was perceived as a threat by the Deputy Minister for Defence and Foreign Affairs.

Another significant landmark in 1973 was the establishment of the Police Narcotics Bureau. Its operational head was the detective superintendent of police for crimes division, Mr. R. Sundaralingam, who was also the secretary of the newly formed National Narcotics Advisory Committee. He was a leading figure in terms of driving the drug law enforcement agenda forward. He facilitated a discussion titled "Illicit traffic in narcotic drugs and cannabis in relation to Sri Lanka" at the first national seminar in 1973. It is reported that he was conducting training for local police officers in drug law enforcement. Initially, the Police Narcotics Bureau was involved in data collection and training activities but the role later changed to include law enforcement, steering drug users into treatment and some demand-reduction activities such as drug education programmes for schools.

Looking at the drug scene during the 1970s, there was no evidence to suggest that heroin had infiltrated the market in Sri Lanka. Although the accurate number of opium users was not known during this period, an approximate number of between 10,000 and 15,000 was quoted based on quantities of

opium that arrived in Colombo (Colombo Plan Meeting on Narcotics and Drug Abuse Problems, 1974). The majority of opium users were a cohort of an older generation who had habitually used opium for many decades. They were essentially a non-injecting population and belonged to the low-income earning group (Colombo Plan Meeting on Narcotics and Drug Abuse Problems, 1974). In 1978 the Narcotic Advisory Board coordinated the first systematic field investigation of drug abuse in the country which showed that opium, cannabis and barbiturates were the most commonly misused substances. The use of heroin was virtually unknown in Sri Lanka prior to the early 1980s apart from a few locals who had migrated outside Sri Lanka and some tourists who visited Sri Lanka (NDDCB, 2005). In 1981, Colombo Plan experts from Australia and Malaysia estimated a much higher figure of drug users, stating that 34,450 to 58,800 people used opium, whilst 133,060 to 164,940 people used cannabis in Sri Lanka (Spencer and Navarathnam, 1981).

A Christian priest, delivering a speech on 'the role of the citizen' at the same seminar on drug abuse control stated that drug addiction should be seen as a social problem and as a product of inequality in society. He went on to say that drug addicts should be treated as human beings and not as criminals:

"The problem of addiction has to be viewed with the primary objective of helping the drug addict. If a husband takes ganja, the wife does not consider the husband as a criminal. If a son takes ganja, the parents do not consider the son as a criminal. But in the eyes of the police and of the public, both the husband and the son are criminals" (Rev. Kurukulasuriya, Colombo Plan Meeting on Narcotics and Drug Abuse Problems, 1974::123).

This was a response to the prevailing societal attitudes towards drug use and the moral underpinning of policy-making which then existed. The focus had been to arrest and punish drug users as opposed to providing any help to overcome their addiction.

There were limited treatment facilities or institutions available for the treatment and rehabilitation of drug problems at the time. According to Rev. Kurukulasuriya, the only place to which an addict could be referred at that time was the police. However, a humane response was not to be expected from a law enforcement agency, but rather a more punitive one. But it appears that most Sri Lankan doctors in hospitals were also unable to understand the psycho-social factors associated with drug addiction. This was possibly due to the profession's emergence out of the educated and affluent middle and upper middle classes in Sri Lankan society and a lack of interest in the area of drug treatment. Commenting on this and on the question as to why the country had suddenly become alive to the problem of drugs, Rev. Kurukulasuriya stated:

"As far as the present day society is concerned, doctors tend to take a narrow view about their role. For the past several years we have been having addicts in our society but it is only now that people are getting worried. The reason is that it is only now that the middle class people are being affected. That explains why there is so much 'hoo-ha'. All this while poor people were already affected and their welfare was not the concern of anyone at all. Now that the middle class society does not want any of the people in their group identified as addicts or thrown away or cornered by society everybody is getting highly worried about the drug addiction problem. That is how the people with whom I have been moving around and I myself think about it. We are in fact happy that in one way at least those people are getting involved with us so that at least some attention will now be paid to the plight of the lower classes. As far as the middle class is concerned, drug addiction spreads through the pop music groups. So, when pop groups take to ganja even the Colombo seven (people from middle class live in this area) folk will take up drugs" (Rev. Kurukulasuriya, Colombo Plan Meeting on Narcotics and Drug Abuse Problems 1974:123).

The drug problem in Sri Lanka in the 1970s exemplifies how the social profile of drug users influenced the evolution of national policies (Jayasuriya, 1995). Until the early 1970s, it was widely believed that drug problems largely remained among the poor and socially disadvantaged in society. This perception resulted

in the problem being ignored, a topic which did not form part of any public agenda or require a policy response. Although there had been discussions by the NNAC concerning measuring the nature and extent of drug problems and provision of treatment facilities, the official lack of interest and investment in this area continued.

Following the first drug seminar, a recommendation was made to establish treatment for drug-dependent individuals. As a result, the Police Narcotics Bureau announced through the media that it was prepared to grant an amnesty to encourage drug users who were willing to submit themselves voluntarily to hospital treatment. The response to this was encouraging as several hundred people sought help from the police. A large majority of them came from socially disadvantaged backgrounds (Jayasuriya, 1986). Those who had adequate financial resources appear to have sought help from private medical practitioners.

Some international researchers believe drug usage became a real problem in the 1970s with approximately 3,000 persons reporting to various treatment facilities in Sri Lanka between 1975 and 1979 (Ray, 1998). Treatment was generally provided via acute hospitals whereby symptomatic prescribing of non-opioid drugs became the norm to alleviate opioid withdrawal symptoms. Considering the fact that these services were not widely available, and that available treatment facilities were possibly not known to a majority of drug users, suggests that physical, psychological and social problems arising out of habitual cannabis, opium or barbiturate use may have pre-dated the early 1970s. It was only when people were encouraged by the police to seek help that drug users started to come forward. Additionally, the concept of treatment, as opposed to punishment, was explained via the media and the Police Narcotics Bureau as a means to inform both the public and drug users (Jayasuriya, 1986).

At the end of the 1970s, it is reported that opium users were treated free of charge in some state hospitals with methadone prescribed twice a day to suppress withdrawal symptoms. This usually lasted for ten days and was generally in the form of a gradual daily reducing dosage or detoxification (Satkunanayagam, 1979). Only a few doctors were interested in helping drug users and in providing treatment. This response was directed at achieving abstinence, facilitated by a short term medical detoxification programme. Methadone or any other substitute maintenance programmes were unknown at the time. There was also a lack of evidence to denote that, before the late 1970s, residential rehabilitation centres were available or that a concept of rehabilitation was fully developed.

Conclusion.

Sri Lanka has been a country subject to colonial administration for many centuries and its adoption of domestic drug policies from the sixteenth to the twentieth century has been influenced by the shifting priorities of these administrations. Stakeholders in the policy process identified during British administration are; the legislative council, British East India Company, Ayurvedic physicians, the chief medical officer, Buddhist monks and the local public. Influence over policy decisions were clearly in the hands of the British dominated legislative council. The agitation against the government policy on opium gave rise to interest groups such as Ayurvedic physicians and Buddhist monks, who progressively lobbied against the promotion of opium for revenue purposes.

After Sri Lanka gained independence from Britain in 1948, there were few legislative or policy innovations at first. Later, international organisations such as the United Nations and the Colombo Plan exerted influence on Sri Lanka to bring domestic law into line with the United Nations drug control conventions. External influence prompted the creation of a small network of policy actors who represented the Ministries of Defence and Foreign Affairs, Health, Education and the Departments of Police, Customs and Excise, and the

Attorney General. The use of knowledge experts to support policy decisions during British administration and after independence has been observed. Examining these historical developments, the identification of interest groups and actors present in the policy process, and the recognition of policy transfer in the history, provides a solid platform for the analysis of contemporary drug policy in Sri Lanka.

Chapter Five: External Influences

Introduction.

"There was an obligation on Sri Lanka to come in line with international drug control conventions. The drug control board, in a way, was obliged to move things as the UN was trying to get all countries, through their regional offices, to get the legislation and policies in line with drug control conventions. That was all about it, rather than some great national movers taking it up and delivering" (Policy-maker, Interview 8).

International co-operation to fight against the so-called drug menace has become a distinctive characteristic of contemporary drug policymaking and international relations (Bewley-Taylor, 2012). In this effort, external organisations such as the United Nations, South Asian Association for Regional Cooperation (SAARC) and the Colombo Plan were initially formed to address a wide variety of problems existing both within and beyond national boundaries. These organisations subsequently also became prominent vehicles to tackle and shape the drug policy landscape in member countries, including Sri Lanka. Their roles included harmonisation of policies in member states and the transfer of principles and norms on matters related to drug control from one jurisdiction to another.

This chapter aims to provide a comprehensive empirical account of external events, organisations, actors and their influence on shaping drug policies in Sri Lanka. It will elaborate on the role of expert knowledge, the diffusion of internationally accepted principles and norms on drug control through various forms of transnational policy-making and their impact on national policy. Attention will be paid to both continuities and shifts in drug policies, taking into account the prevailing economic, political and social contexts. It is argued that external influences instigated national action, though not always rapidly, and became a preamble to contemporary drug policy development.

Transferring Global Principles, Norms and Policies on Drug Control.

As described in Chapter Four, the origins of the Colombo Plan date back to the Commonwealth Foreign Ministers' Conference in 1950 where the Sri Lankan former Minister of Finance, J.R Jayawardena and the former Australian Foreign Minister, Sir Percy Spencer, proposed the establishment of a committee to prepare a 10-year plan for the socio-economic development of countries in South-East Asia through international collaboration (Colombo Plan Secretariat, 2001). Subsequently, the Colombo Plan was established as an intergovernmental organisation in 1951 and Sri Lanka hosted its activities for over six decades. The right-wing government led by the late President J. R Jayawardena from 1977-1989 continued having a close relationship with the Colombo Plan where, at macro level, some normative and principled beliefs were shared by key policy actors. It is reported that the Colombo Plan had been supportive of member states to ensure that there were fewer opportunities for communism in mainstream society and to promote instead a neo-liberal market economy (Adeleke, 2003; Lowe, 2010). It also appears that due to the physical presence of the Colombo Plan, the headquarters being based in Colombo itself, Colombo Plan may have had a significant impact in shaping national policies such as transport, education, trade and agriculture (Colombo Plan Secretariat, 2001).

Some of the aid provided to the Sri Lankan government via Colombo Plan in the 1950s was directed towards the renowned Gal Oya project, which aimed at expanding agriculture, river valley development, supply of electricity and livelihoods for the residents in the Gal Oya and adjacent areas. A total investment of US $ 67.2 million was collaboratively allocated between the US and the Colombo Plan for this project. By mid-1960s, Canada, as part of infrastructure development, donated diesel-electric locomotives and provided financial assistance via the Colombo Plan to expand the main airport in Katunayake. Later, the double curvature arch Victoria Dam was built with a grant of £113 million from the UK government under the Colombo Plan. This was commissioned by Margaret Thatcher, the late Prime Minister in the UK and

the late Sri Lankan President J R Jayawardena in 1985. The above information is based on a speech delivered by the Secretary-General of the Colombo Plan on 23rd November 2007 in an address to a gathering organised by the United Nations Friendship organisation on the theme of Colombo Plan's involvement in the eradication of poverty on the Asia Pacific region, including Sri Lanka (Yoon-Moi Chia, 2007).

However, the Colombo Plan was not merely an aid programme as it was linked to the strategic interests of the west, especially in the background of promoting social and economic stability in the newly independent Commonwealth countries, making them less likely to embrace communism (Rizvi, 2009). Another common criticism of the Colombo Plan is that it became an extended arm of British imperialism where it offered economic solutions almost exclusively for problems which were political and social (Lowe, 2010). Nevertheless, by the early 1980s, the Colombo Plan had become widely accepted by the Sri Lankan government as a credible organisation that harnessed social and economic stability, institutionalising a stake in influencing government policy decisions due to its previous relations with the government and to providing financial aid. It is within the context of the Colombo Plan maintaining its international membership and outlook, success with securing multi-million finance, acquisition of a reputation for good-judgement and respect, and its subsequent experience in providing technical advice and in developing social and economic projects within its member countries that any perspectives on contemporary drug policy analysis should be viewed.

The Drug Advisory Programme of the Colombo Plan (CPDAP) was not established until 1973, and can be viewed as an epistemic community whereby its actors shared a causal belief in drug use being a major obstacle to the eradication of poverty and development within its member states. By this time, the principle of prohibiting the use and trafficking of illicit drugs was internationalised and formalised through the 1961 and 1971 UN conventions. Nadelmann (1990) argues that the global drug prohibition regime was exceptionally influenced by American protagonists who advocated a penal

approach to manage the supply and demand of psychoactive substances. This gave a mandate and a prominent role to national law enforcement agencies to spearhead drug law enforcement activities with a focus on attempts to counter production and distribution of illicit drugs at national and international level, the latter being strongly associated with the transnational dimension inherent in drug trafficking.

Initially, Colombo Plan's policy responses, practices and advice to member states originated from the principle of prohibition. According to interview data, they were primarily directed towards supporting initiatives to: increase public awareness of the dangers of drug abuse and trafficking, rehabilitate drug users, assist member states to adopt new legislation for the punishment of drug related offences, and secure conformity to international drug control conventions. Although these actions were aimed at addressing the problems caused by producers, traffickers and users, their emphasis was heavily weighted towards law enforcement rather than inclusive of treatment and rehabilitation as well (Policy-maker, Interview 8). This was possibly driven by a clear set of international obligations set out in the 1961 and 1971 UN conventions, underpinned presumably by the conviction that human welfare will be enhanced as a result of law enforcement. However, there appears to be a shift in Colombo Plan's emphasis and response from supply reduction measures to include demand reduction programmes from the 1990s and this will be discussed later in the chapter.

During the early 1980s, the drug problem within Sri Lanka was framed as an emerging issue with focus upon the infiltration of diverted, trafficked heroin into the country's drug market. Although opium was not grown locally, Sri Lanka's popularity for heroin as a major trans-shipment point to Europe, the United States and Canada had been growing and was concerning to organisations such as the Colombo Plan and the United Nations (Police Officer, Interview 10). This period coincided with the emergence of evidence that traffickers were recognising western Europe as a growth market for heroin (Ruggiero and South, 1995). Locally, people were also taking up heroin use. This was a

practice unknown to the Sri Lankan society and the newness of a heroin scene was thought to be more prevalent among the middle classes where affordability was perceived as a chief factor for initiation (Civil Servant, Interview 9). However, the absence of any scientific evidence, and limited knowledge and confidence in managing an emerging heroin problem, including trafficking, magnified the uncertainties and complexities around how the problem should be approached and tackled. A police officer, who was a member of the NNAC at the time stated:

"During the 1970s, the main problem that we had was cannabis and opium. At that time we knew how big the problem was and the types of users. But when heroin hit the scene in the early 1980s we knew very little about drug users. So, if we were to say that there's a massive drug problem and if people ask us what these people used and about their features and how we are going to respond, we knew nothing at that time. All we knew was that heroin was affordable among middle classes and trafficked via Sri Lanka to countries in the west" (Police officer, Interview 10).

These factors along with official uncertainty within the government gave rise to a stronger role for policy actors beyond the nation state. By this time, epistemic community actors from the Colombo Plan and the UNCND had already established informal working relationships with local policy actors, who were mainly representing the Foreign Ministry, the Ministry of Defence, Police Narcotics Bureau and the NNAC. As discussed in Chapter Four, the historical beginnings of these networks goes back to the 1970s when a NNAC was established almost overnight in 1973, following advice from the Colombo Plan to coincide with the UN delegation who visited Sri Lanka.

At first, members of the NNAC and some civil servants believed that trafficking of heroin was an issue that extended beyond the control of Sri Lankan authorities as opium was grown and trafficked from some of the neighbouring member states of the Colombo Plan. This was seen as an attempt to leave the

ownership of the trafficking problem outside Sri Lanka, to the opium producing countries:

"International organisations like the UN and the Colombo Plan were of course concerned about drug trafficking at first. We are not producing opium and we know that it arrives here from neighbouring countries like India and Pakistan. We don't have a coastguard system in place. The powerful neighbours should take care of things from that end as they have a lot of producers in those countries" (Civil Servant, Interview 6).

The Drug Advisor and other experts of the Colombo Plan, together with the UNCND representatives for the region, helped re-shape this debate by highlighting the problem as an issue that needs to be tackled through bi-lateral and multi-lateral co-ordination where collaborative interventions would be more useful and effective in an interdependent world. The international response in the early 1980s had been marked by rigorous attempts to generalise principles of combating drug trafficking problems by establishing and revising national and international institutional arrangements, enacting domestic legislation and harmonising drug control policies across the south Asian region (Civil Servant, Interview 9). It was within the remit of the CPDAP to work in close collaboration with organisations of the United Nations, governments of Colombo Plan member states and other regional and international organisations in pursuing activities and diffusing ideas in line with UN policies for drug control. These both gave information and confidence to, but also required a response from, the Sri Lankan government. The Colombo Plan and the UNCND were mutually supportive of each other in their efforts to establish consensus with the Sri Lankan government in finding acceptable policy options to manage the trafficking problem at regional level.

By the mid-1980s, there was growing concern among law enforcement personnel about the steady increase in interceptions and confiscation of heroin at the Katunayaka international airport and off the coastline of Sri Lanka (Police

Officer, Interview 10). These domestic-level enforcement measures at national borders were not considered as sufficient trafficking controls by the UNCND (Civil Servant, Interview, 9). Their expectations were to include other strategies such as international co-operation with Interpol, and international law enforcement agencies both in other South East Asian countries and further afield. By mid-1980s, consensus was reached between national and international policy actors on the idea that inter-regional co-operation and co-ordination is a more effective option to deal with trafficking problems. As a report produced by the NDDCB states:

"The international community has already launched comprehensive counter attacks against illicit drug trafficking and abuse and stronger political commitments are being made at the highest levels of Governments. New initiatives regularly taken to promote effective and co-ordinated action and improving inter-regional co-operation, particularly at the operational level, are leading to a measure of success. The joint counter actions all proceed from the common conviction that effective and lasting progress can be made in any one affected country only if all countries co-operate" (Report on Illicit Drug Trafficking and Drug Abuse in Sri Lanka, NDDCB, 1986:1).

Leakage of heroin into the local drug market also increased the level of threat whereby law enforcement personnel from the NNAC turned to the UNCND and Colombo Plan to employ international norms as devices to assert legitimacy of enforcement action they wish to take at national level. Although Sri Lanka had been a signatory to the 1961 and 1971 UN conventions by 1983, no domestic legislation had been introduced to reflect the content of the conventions. Legal structures were not in place to give effect to the conventions and the courts continued to apply a more lenient system for drug offences resulting in a higher acquittal rate than would have occurred if adhering to the conventions. This was of concern to the United States who was contributing substantial funds for drug control activities across the Colombo Plan and the United Nations. The Sri Lankan government was constantly reminded by the US about its international

obligations and the need to bring the laws in line with UN conventions. A civil servant who was interviewed, reflecting this period stated:

"There was pressure particularly from the US that we needed to strengthen the law in relation to narcotic drugs. At that time, the acquittal rate was extremely high in Sri Lanka and the convictions for drug offences were few and far between. Although we were a signatory to the conventions, we have not amended the law accordingly. In one sense, although we were able to expand our knowledge in the drugs field with the help of the Colombo Plan and the UN, our legislations and practice did not reflect what was required by the international community. This was something the US wanted to address" (Civil Servant, Interview 9).

External pressure to introduce legislation gave the impression to members representing the drug control board that the desired response in relation to the drug problem at national level was largely a legal one, involving legal and law enforcement agencies and did not require involvement from other groups such as health and social services. This perception led to a requirement from only legal experts representing the Ministry of Justice, the Attorney General's Department and the Police Narcotic Bureau to formulate a response to both the problems of supply and demand reduction.

Diffusion of internationally recognised norms and principles, in this case UNCND principles of drug control, into the Sri Lankan context was possible through national policy actors attending drug control conferences, workshops, seminars and educational tours (epistemic activities) organised and funded by the Colombo Plan. According to interview data, this started soon after 1973 and places were offered to members of the National Narcotics Advisory Committee, civil servants and most individuals recommended by the National Narcotics Advisory Committee. Events organised by the Colombo Plan were predominantly held in Asian countries such as Malaysia, India and Sri Lanka and those organised by the United Nations were held in Geneva, Vienna and

the United States. Attendees from Sri Lanka were predominantly from law enforcement backgrounds and topics covered on the educational tours included regional cooperation on trafficking, police narcotics training and law enforcement. As a result, there had been improvements in bi-lateral and multi-lateral communications across law enforcement agencies and other policy actors with the notion of interdependency and the need to harmonise law enforcement policies becoming agreeable. However, a decade after becoming a signatory to the two UN Conventions and with exposure to new ideas and policies, domestic drug policy-making was still not institutionalised. Ideas had not been converted into domestic laws and not enforced as routine policy and practice.

By 1984 amendments to the Poisons, Opium and Dangerous Drugs Ordinance of 1929 were already underway. This was a response to the afore mentioned pressure exerted by external parties. The UNCND and the Colombo Plan's Drug Advisory Programme had both been persuasive in encouraging the existing policy actors representing the National Narcotics Advisory Committee to introduce and establish a legal and procedural framework for drug policy-making. This was planned to bring domestic law in line with UN Conventions where the government of Sri Lanka was prompted to consider institutionalisation of drug policy-making processes. The outcome was the formation of the National Dangerous Drug Control Board in 1984 as per the National Dangerous Drug Control Board Act No11:

"At that time, we set up the National Narcotics Advisory Committee administratively and then later on you decide if this should be given legal recognition and consider the pros and cons of doing that. By giving legal status it was then possible to get funds allocated by the Parliament, because the Defence Ministry's budget had to cover the activities of the NDDCB. That's how they were able to have their own premises and employ some staff members. That was an important step in policy-making to institutionalise and provide a legal framework. I suppose we were encouraged to do so by the UN and

Colombo Plan. We received some funding from them to set it up as well" (Civil Servant, Interview 09).

At first, and in consideration of international obligations, the priority for the Sri Lankan government had been to establish a national institution, responsible for the formulation and review of a national policy on drugs. The NDDCB, at its inception, primarily focused on law enforcement matters with little emphasis on the health and social needs of actual drug users. The membership of the first Board, its areas of interests, functions and relationships with other stakeholders will be further explored in the following chapters.

The South Asian Association for Regional Co-operation (SAARC).

The SAARC was begun in 1985 and consisted of India, Nepal, Bangladesh, Pakistan, Bhutan, Sri Lanka and Maldives. It was established with the aim of regional cooperation for the economic and social development of people in south Asia, and in the belief that adoption of common public policies and approaches to shared problems in the region would be beneficial and advantageous (SAARC Charter, 1985). The exchange of ideas, knowledge, experience and technical cooperation between its member states was considered fundamental to the goal of promoting collective self-reliance and shared benefits (SAARC Bangalore Declaration, 1986). The SAARC also sought to adhere to the United Nations Charter and cooperate with international and regional organisations with similar aims and aspirations (SAARC Charter, 1985). For example, in relation to matters concerning drug control, SAARC had a memorandum of understanding with the United Nations Drug Control Programme (UNDCP), later known as UNODC, and the Colombo Plan CPDAP.

From the inauguration of SAARC in 1985, the subject of drugs attracted the attention of heads of state in member countries. Concerns were raised on the established links between illicit drug trafficking and organised crime and the threat they pose to development, stability, security and sovereignty. Peace and

stability were considered as essential prerequisites for the realisation of economic and social development (SAARC Dhaka Declaration, 1985) and the notion of an increased threat from illicit drugs had been a significant legitimising principle for supporting the introduction of a wide array of law enforcement policies and programmes. Similar to the Colombo Plan, the SAARC also shared the belief that drug use is a major cause of poverty, and an obstacle to the eradication of poverty and economic development within its member states. As one civil servant stated:

"When SAARC was formed it looked at non-sensitive areas for development such as telecommunication, poverty alleviation, agriculture etc. But at the end of the first SAARC summit itself, Sri Lanka raised the question of terrorism. That was the most controversial area and there were a lot of misgivings. But we managed to put it on the agenda because we had a very difficult time due to terrorism. Within one year, the SAARC convention on suppression of terrorism emerged where it was led by the Sri Lankan delegation. We presented the negotiating text on the terrorism convention as we were the host country to formulate this convention. It was felt that it is logical to deal with crimes connected with terrorism as there was obvious linkage between drug trafficking and fund raising for terrorism. We had the political support to introduce or amend existing legislation in member states and there were no questions as to why we shouldn't be stringent with the law" (Civil Servant, Interview 12).

After the first summit in 1985, the heads of its member states issued a joint press release stating that the SAARC standing committee should set-up two study groups, later to be known as technical committees, consisting of experts from each member state to examine the problem of terrorism and drug trafficking and abuse (Joint press release issued at the conclusion of the first SAARC Summit, 1985). This can be seen as a response to how the problem of drugs was framed by the Sri Lankan delegation, especially in the milieu of the beginnings of a domestic armed conflict in the North and East of Sri Lanka. It was perceived and represented as a major security concern and a crisis for the Sri Lankan government, including as a threat to its own sovereignty and socio-

economic development (Civil Servant, Interview 12). To this extent, concerns raised by the Sri Lankan delegation were in harmony with the SAARC charter, conceivably a driver for gaining consensus across member states on the need to understand the problem more fully.

The two technical committees established to examine the problems of terrorism and drug trafficking and abuse were largely drawn from legal, law enforcement, diplomatic and civil service backgrounds. Some representatives, particularly the legal, diplomatic and law enforcement experts who represented Sri Lanka were members of both committees. There was growing recognition that terrorism and drug trafficking were inter-related problems and any response proposed should address the connections. From Sri Lanka, legal experts from the Foreign Ministry and Attorney General's Department, representatives from the NDDCB and the Police Narcotic Bureau attended the drug technical committee. This committee, which included experts from other member countries, could be said to have the essential characteristics of an emerging epistemic community, whereby responses on prohibiting the supply and demand of illicit drugs and causes of domestic drug use were shared by its members. Undoubtedly, these responses and beliefs may have been influenced by the prevailing political will and commitment declared by heads of states at SAARC's launch. Nonetheless, the drug technical committee's priority had been to develop regional cooperation in order to find solutions to the drug trafficking problem and to introduce measures derived from UN drug control conventions. Later, the committee was provided with a mandate to explore the possibility of formulating a regional convention on drug control as a policy response:

"The Heads of State of Government expressed grave concern over the growing magnitude and the serious effects of drug abuse, particularly among young people, and drug trafficking. They recognised the need for urgent and effective measures to eradicate this evil and decided to declare the year 1989 as the 'SAARC Year for Combating Drug Abuse and Drug Trafficking'. They agreed to launch a concerted campaign, as suited to the situation in their respective countries, to significantly augment SAARC efforts to eliminate drug abuse and

drug trafficking. These included closer cooperation in creating a greater awareness of the hazards of drug abuse, exchange of expertise, sharing of intelligence information, stringent measures to stop trafficking in drugs and introduction of more effective laws. They directed that the technical committee concerned should examine the possibility of a Regional Convention on Drug Control" (SAARC, Islamabad Declaration, 1988:2).

The above developments were underpinned by the contention that drug trafficking and abuse are 'evil' activities, a fear that was placed second only to terrorism on the international scale of threats to society (Civil Servant, Interview 12). The aims of total elimination of illicit drugs and robust, active law enforcement measures taken against drug traffickers were equally regarded and acquired unquestioned political legitimacy. The committee was tasked with formulating the regional convention on drug control with both these aims included. Initially, their activities brought improvement in diplomatic working relations and established a framework through which drug problems existing in member states could be more easily identified and discussed. However, again, the desired policy response was largely a legal one, involving both legal and law enforcement agencies and did not contain involvement from other groups such as health and social services. Thus, the initial examination of drug problems was solely fixated on law enforcement concerns and any discussions of drugs took place in that circumscribed context:

"We were mandated by the SAARC council of Ministers and the standing committee of foreign secretaries and as an ad hoc body we negotiated the treaty. We had a delegation which was multi-departmental or agency and consisted people from Ministry of Foreign Affairs, Attorney General's Department, the NDDCB as the lead agency and also the Police Narcotic Bureau. SAARC member states also sent their delegation of experts. Once again, what we did was prepare the negotiating text for this convention as we were the host country. The negotiating text was broadly based on the 1988 UN convention. At that time it had just come out. So we wanted to look at it as well

as supplementing the universal framework on drug control introduced by the UN" (Civil servant, Interview 12).

Sri Lanka was seemingly able to influence the SAARC convention on narcotic drugs in 1990. Although it was not ratified by all member states until 1993, the convention can be seen as an extended arm of, and complementary to, the UN drug control conventions. The need to enact and harmonise stringent legislation around drugs in the south Asian region appears to have been reinforced by the link established between drug trafficking and fund raising for terrorism (Civil Servant, Interview 12). Additionally, the drafting of the United Nations Convention against illicit traffic in narcotic and psychotropic substances in 1988 was also timely in supporting the SAARC predetermined policy stand on prohibition and law enforcement. Consequently, it can be argued that the principle of prohibiting the use and trafficking of illicit drugs was regionalised and formalised with the introduction of the SAARC convention on narcotic drugs and psychotropic substances (see appendix I). It echoed what the UNCND attempted to achieve when the 1961 and 1971 UN drug control conventions were introduced.

Based on meeting minutes, the SAARC workings brought representatives from legal and law enforcement backgrounds of its member states closer together and developed a regional group of experts who appear to have had regular meetings in the early 1990s:

- SAARC meeting of drug law enforcement agencies towards making exchange of information more effective, 25-27 March 1991, Colombo.
- 6th Meeting of the SAARC technical committee on the prevention of drug trafficking and drug abuse, 10-11 June 1991, Colombo.
- 7th Meeting of the SAARC technical committee on the prevention of drug trafficking and drug abuse, 15-17 June 1992, Colombo.

These led to the establishment of a SAARC Drug Offences Monitoring Desk in Colombo in 1992 under the purview of the Sri Lankan Police Narcotics Bureau. It was to boost drug law enforcement by sharing intelligence, and the collating, analysing and disseminating of information on drug related offences in the region. A civil servant went on to say:

"As we took the initiatives on terrorism and narcotic drugs, our proposal to have the SAARC monitoring desks for both these areas was accepted. That's why we now see the SAARC monitoring desks for drugs and terrorism being located in Colombo. This was done at the height of the conflict and the extra regional linkages were crucial aspects we had to address" (Civil Servant, Interview 12).

Policy harmonisation between the SAARC and the UNDCP was further strengthened by signing a Memorandum of Understanding (MOU) between the SAARC and the UNDCP on 18th August 1995 to coordinate their endeavours in combating drug supply (trafficking) and drug demand (abuse) in the region (Arif and Karim, 2015). At the heart of the MOU are the exchange of information and technical co-operation for mutual benefit. The SAARC also has a MOU with the Colombo Plan with specific reference to promoting and encouraging NGOs in SAARC countries involved in drug demand reduction activities.

The above developments had unanimous support from Cabinet Ministers. Civil servants informed them about the strength of regional cooperation as a mechanism to both curb the drug trafficking problem and disrupt terrorist activities. This was the backdrop endorsed by elite decision-makers for Sri Lanka to participate in these regional activities (Civil Servant, Interview 12).

External Influence on Demand Reduction Policies and Programmes

Until the latter part of the twentieth century, international policies on drug control emphasised law enforcement as being able to reduce the size of the drug market and level of illicit drug use. Prior to the 1961 convention, international drug control conventions paid little attention to the reasons for demand for drugs, treatment and rehabilitation of drug dependency (Boister, 2001). This international approach mirrored the national response to the problem: emphasis on law enforcement, criminal sanctions and imprisonment, coupled with little stress on the nature of drug use and its effects.

As discussed earlier, the external pressure to introduce legislation on drug control in the early 1980s gave the impression to domestic policy actors that the desired response required in relation to the drug problem was largely a legal one. By the mid-1980s, although legislation was amended to reflect the UN drug control conventions, Sri Lanka had not introduced any national policy document on drug demand reduction and it lacked a co-ordinated national approach to drug treatment and rehabilitation.

The term “drug demand reduction” is used more recently to describe policies or programmes directed towards reducing the consumer demand for narcotic drugs and psychotropic substances covered by the international drug control conventions (UNODC, 1998). Article Thirty Eight of the Single Convention on Narcotic Drugs of 1961 in particular, amended by the 1972 Protocol and under Article Twenty of the Convention on Psychotropic Substances of 1971, states that “parties to these conventions are required to take all practicable measures for the prevention of abuse of narcotic drugs or psychotropic substances and for the early identification, treatment, education, aftercare, rehabilitation and social reintegration of the persons involved”.

The 1980s was also a period that witnessed the emergence of divergent views among policy makers on the care and treatment of drug users, not only in Sri

Lanka, but across the international community. As we have seen, the dominant response to managing drug problems in Sri Lanka was located within the criminal justice system, and heavily influenced by international and regional organisations, documents, and policy actors. These same policy actors appear to have influenced national policies and programmes for the care and treatment of drug users. This was a period where some national policy-makers continued to perceive drug use as an immoral behaviour deviating from the moral majority. Such perceptions were undoubtedly an impediment to the adoption of more humane policies addressing the needs of this population group (Psychiatrist, Interview 4). To a certain extent, the need to shift away from the negative perceptions and any prevailing unsupportive responses towards drug users also appears to have been influenced by national policy actors' engagement with organisations such as the SAARC and the United Nations:

"The international community was beginning to realise that law enforcement alone was not the answer to the problem. The most recent three UN conventions addressed this to a certain extent and the UN provided technical assistance to countries to look at the roots of the drug problem with a view to social and economic development. At the same time, some of our policy makers were of the view that drug addicts were bad, useless fellows and should be brought into Galle Face[7] *and shot. But later on, because we were party to these UN Narcotic Conventions and our involvement with the SAARC, the Policy-makers and the government had to accept that this is a problem that needs to be tackled in a different way*" (NGO Director, Interview 5).

The change in perception of solutions to the drug problem among international policy actors led to the recognition that responses and solutions, at least in part, should be considered beyond a solely law enforcement approach which is unable to provide a total solution to the problem. It arrived against the backdrop of an HIV/AIDS crisis related to injecting drug use in some western countries (WHO, 2006). This does not imply that the international system and the

[7] Galle Face is a promenade along the coast in the heart of the financial and business district of Colombo.

international epistemic actors advocating a law enforcement response made a fundamental shift away from the principle beliefs of prohibition and punishment. Rather there was acknowledgement that socio-economic problems are prominent causes for the demand for drugs and that provision should be available for drug users to access treatment and rehabilitation. The UN conference on drug abuse and illicit trafficking convened in Vienna in 1987 echoed this shift (Police Officer, Interview 10). It was attended by representatives from one hundred and thirty eight countries, including representatives from the NDDCB (United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988). One of the main documents to emerge from this conference was the 'Comprehensive Multidisciplinary Outline (CMO) of Future Activities in Drug Abuse Control'. This recognised the responsibility of countries to provide resources and equal status to address both the supply and demand for illicit drugs (Chatterjee, 1988). Although the conference made a major breakthrough, it has been argued that this document has not been able to bind countries in a multilateral convention to expend precious resources on the socio-economic roots of the drug problem (Boister, 2001). However, it appears to have influenced the formulation and content of the first ever Sri Lankan National Policy for the Prevention and Control of Drug Abuse published in 1994. As one policy-maker who was involved in the formulation of the first national policy on drugs stated:

"When the working group was set-up to formulate the national policy (the first national policy on drugs), and it was a multi-disciplinary one, we had to look into the UN drug control conventions we were party to and the comprehensive multi-disciplinary outline to synchronise our response. Our commitment to treatment and rehabilitation was spelled out in the national policy and it was something supplementary to our existing enforcement strategies" (Policy-maker, Interview 7).

The application of the recommendations contained in the CMO in the national setting also meant wider participation was required from various government departments beyond criminal justice and law enforcement, such as the

legislative organs, judiciary, public health and education departments, social services, economic affairs and non-governmental organisations. Policy makers at international level were beginning to see the drug problem in this wider context, rather than a narrow criminal law enforcement perspective. The CMO was multi-disciplinary in character. According to interview data, the multi-disciplinary agencies that were brought together by the NDDCB to draft the first national policy was set-up soon after the conference in Vienna in 1987, had representation from legal, law enforcement, health and social services. Whilst some multi-disciplinary thinking around drug problems might have been present prior to the publication of the CMO, the need to actively involve multi-agency representation in policy-making and implementation became more apparent and strengthened after the Vienna conference and the CMO (Policy-maker, Interview 8). The dominant voices, shifting agendas and priorities of these multi-disciplinary agencies will be fully explored in the next chapter.

The work conducted by the committee, reflecting the CMO and the UN drug control conventions Sri Lanka had become a party to, identified the following four pillars in the first national policy on drugs:

1. Enforcement
2. Preventative education and public awareness
3. Treatment, rehabilitation and after-care
4. International and regional cooperation

In contrast to the earlier phases of policy development whereby policies were largely limited to amending legislation to address supply reduction measures, the first national policy on drugs incorporated both supply and demand reduction measures. This was the first time that education, public awareness, treatment, rehabilitation and after-care had been combined alongside enforcement measures. Reflecting the CMO and the external guidelines, the first national policy on drugs states:

"The short-term and long-term action plans developed will be based on national priorities and would be formulated keeping in mind the local needs and suitably adapting the strategies which are outlined in the United Nations Comprehensive Multi-disciplinary Outline of Future Activities in Drug Abuse Control (CMO). The CMO is a compendium of practical action for combating drug abuse and illicit trafficking. The UN General Assembly has on several occasions urged governments to use the CMO in the formulation of their own programmes" (Sri Lankan National Policy for the Prevention and Control of Drug Abuse, 1994:2).

The content of the national policy mirrored the four directives outlined in the CMO, to address prevention and reduction of illicit demand, control of supply, action against illicit trafficking, and treatment and rehabilitation. However, it has been argued that at national level, it is for each government to determine which of the recommendations of the CMO could be appropriate in light of its prevailing economic, social and legislative conditions (Chatterjee, 1989). The text of the CMO was carefully drafted and was not designed to be a formal legal instrument where it created rights or imposed obligations of an international character (Chatterjee, 1989). By the same token, the national policy did not formally commit itself to any new proposals, specific programmes and resources for drug treatment and rehabilitation initiatives which would have meant that action was required. The CMO was adapted in a manner to suit the national context, giving due consideration to the availability of resources to implement drug demand reduction programmes (Policy-maker, Interview 8).

The inclusion of drug demand reduction interventions as part of a national drug policy requires investment in resources and technical expertise. Sri Lanka had little experience and expertise in drug demand reduction programmes and this was an area which was in its infancy and required attention and development after the 1987 Conference. Funding and provision of technical expertise to resource poor nations had been on the UNDCP agenda, and the first request for funding had been negotiated between NDDCB representatives and the UNDCP (Police Officer, Interview 10). These agenda items can be seen as

incentives to promote and harness the re-adjusted UN principles on drug control. They also occurred against the backdrop of a growing heroin epidemic in Sri Lanka, which evidently concerned some national policy-makers due to uncertainties around managing the problem. Similar to establishing law enforcement policies, programmes and practices in the early 1980s, institutionalising structures to implement and monitor treatment and rehabilitation programmes were a priority for the UN. Below are some of the national projects funded by the UNDCP to institutionalise demand reduction programmes, indicating the agencies involved and the immediate objectives:

Table 4: National drug control projects funded by the UNDCP

Title of project/year	Agencies involved	Objectives	Budget
Prevention and treatment of problems related to drug abuse in Sri Lanka / 1987	Funded by UNDCP, Executed by WHO, Implemented by NDDCB	To develop and institutionalise a managerial structure to plan and implement a comprehensive and effective programme for the reduction in demand for heroin To contain the actual heroin epidemic in a measurable manner	US $ 307,925
Drug abuse monitoring system (DAMS) / 1987	Funded by UNDCP, Executed by WHO, Implemented by NDDCB	To establish and institutionalise a system to monitor trends and patterns of drug abuse To establish and institutionalise an early warning system for such trends in order to permit early programme responses	US $ 166,500

Prevention and treatment of problems related to the abuse of drugs in Sri Lanka / 1991	Funded by UNDCP, Executed by WHO, Implemented by NDDCB	To strengthen the existing managerial structure to plan and implement a comprehensive and effective programme To promote healthy styles of life and initiate a measurable reduction in the demand for drugs To consolidate the achievements in the containment of heroin epidemic	US $ 480,250
Prevention and treatment of problems related to drugs / 1993	Phase 2 of the projects initiated by the UNDCP	To achieve a measurable reduction in the use of heroin and in drug related health and socioeconomic problems To evolve by action research, effective and locally applicable methods of preventive education, treatment and rehabilitation To promote healthier ways of life and to prevent the spread of public health problems related to drug abuse, in particular HIV infection	US $ 430,000

Source: Terminal evaluation report- AD/SLR/97/C71, UNODC, 2003

The involvement of the World Health Organisation (WHO) in matters related to drugs in Sri Lanka began in the context of advancing demand reduction programmes and offering technical support. The WHO, under the auspices of its parent organisation, the UN, worked within the parameters of the UN drug control conventions. Its initial remit was to evaluate medical, scientific and public health aspects of psychoactive substances in relation to the UN drug control conventions and make recommendations to the CND accordingly (Bewley-Taylor, 2012). Until the late 1980s, the work of the WHO's Expert Committee on Drug Dependence was limited to making recommendations to the UN Secretary General on which narcotic drugs and psychotropic substances should be considered for international control under the existing conventions. However, in light of the widened international perception to include demand reduction along with supply-side initiatives, the WHO's activities were also extended to address demand reduction strategies.

Referring to the emphasis now being placed by the WHO on the reduction of demand for illicit drugs, Dr Hu Ching-Li (former Assistant Director General of the WHO) informed the committee (WHO expert committee on drug dependence) of recent changes in the organisation's structure, as a result of which a new programme on substance abuse had been established, which would focus on prevention and control of alcohol and drug abuse" (WHO Expert Committee on Drug Dependence, 27th Report, 1991).

These new developments on the need to formulate demand reduction policies and programmes led to changes within the WHO organisational structure as well as giving birth to an epistemic community within Sri Lanka, the latter had a particular focus on formulating and implementing demand reduction policies and programmes. There existed a group of individuals within the NDDCB and from the Ministry of Health, Social Services, Education, Attorney General and Police Departments interested in demand reduction work. Initially, the WHO established contacts and connections with the NDDCB to execute the demand reduction programmes funded by the UNDCP. This was directed at the NDDCB as opposed to the health sector (Psychiatrist, Interview 4). Policy actors

interested in demand reduction within the NDDCB were also connected to people outside, mainly representing NGOs or individuals such as psychiatrists and priests who had a keen interest in drug treatment and rehabilitation. The widening range of people involved in the area of drugs enabled the NDDCB to frame the drug problem in a new way, from different perspectives and particularly in terms of understanding the needs of drug users.

Abstinence: the ultimate objective of national drug treatment.

Prohibition was firmly embedded within Sri Lankan society so the goal of abstinence was acceptable as the main objective of drug treatment. As discussed in the previous chapter, there had also been local interest groups and voices that supported abstinence in the development of drug policies. The 1980s was a period when abstinence was endorsed by the UN, Colombo Plan and SAARC and neatly slotted into the prevailing internationalised prohibitionist framework on drug control and their aspirations to achieve a 'drug-free' society. A further endorsement for abstinence was that any drug use, however insignificant it may be, would have an adverse bearing on socio-economic development. This was a common causal belief shared among the UN, Colombo Plan and SAARC, as a priority had been socio-economic development in member states.

By the late 1980s, the Drug Advisory Programme of the Colombo Plan shifted its emphasis from supply side initiatives to include demand reduction programmes. This was linked to the change in international perception on the drug problem, namely the re-adjusted principles outlined in the CMO. There was growing acknowledgement within the Colombo Plan that drug problems are multifaceted and that interventions should be provided for drug users. A psychiatrist, who had contact with the Colombo Plan stated:

"Earlier, they (Colombo Plan) helped us a lot with law enforcement matters. I remember in the late 80s there were quite a lot of resources given to the

Colombo Plan to help roll-out demand reduction programmes in member countries. The US was a major donor for these programmes. We (Sri Lanka) received some of these resources and it was mainly to do with drug education programmes, outreach work and rehabilitation. Their support and advice was greatly received by us because we didn't have much knowledge or expertise in the field" (Psychiatrist, Interview 4).

The majority of funding for demand reduction programmes and interventions in the Colombo Plan came from the United States Bureau of International Narcotics and Law Enforcement Affairs and the US Department of State (Colombo Plan Secretariat, 2010, Interview data). The US appears to have funded drug demand reduction programmes that embraced an abstinent-based approach as opposed to harm reduction. Abstinence dominated the policy landscape throughout the period under investigation. Consequently, the concept of rehabilitation and drug education gained popular momentum within the demand reduction sub-committee of the NDDCB as it was seen as a means to achieve abstinence and ultimately a drug-free society (Policy-maker, Interview 3).

The Colombo Plan Drug Advisory Programme, through the NDDCB, provided technical support on scaling up drug demand reduction activities, including advice and support on setting up and implementing drug education and rehabilitation programmes. The backing also included the funding of study tours and awarding scholarships to NGO representatives and those who took a keen interest on rehabilitation:

"The Colombo Plan organised a seminar on drug rehabilitation in 1993 for government and non-government organisations. They offered me a scholarship to go to Singapore for a 10-day practical training programme on rehabilitation in 1994. Later, I was offered another scholarship to visit New York for a 6-month training programme on the therapeutic community model of drug rehabilitation.

I came back and introduced the TC model in 1997. It is the model I use in all my rehab centres now" (NGO Director, Interview 5).

The Colombo Plan's credentials on harnessing demand reduction activities grew and it was seen as a knowledge broker who could harmonise and promote demand reduction policies and programmes in member states. It can be argued that Colombo Plan had conducted a significant amount of work on capacity building on demand reduction and to the development of a network of experts on drug education, treatment and rehabilitation in Sri Lanka. This was an endeavour Colombo Plan had been able to achieve with the support of the NDDCB and local NGOs:

"The popularity of Colombo Plan in their demand reduction work was at its peak in the 90s. They had a drug advisor who conducted very useful programmes. I must say they were instrumental in bringing national and international people together, co-ordinate training programmes, publish documents or guidelines and all sorts of resources to be used. Today, we have a group of experts in treatment and rehabilitation- all thanks to the Colombo Plan" (NGO Director, Interview 5).

There appears to have been considerable national interest in the rehabilitation of drug users from the late 1980s. This ranged from policy actors representing the NDDCB to those who had an interest outside the NDDCB. The latter included lay people such as Buddhist monks, Christian priests, some government Ministries and non-governmental organisations who had a desire to help drug users as part of their pre-existing social care provision. According to interview data, this was directed at enabling drug users to stop using drugs and helping them to restore and repair relationships with families.

During the mid-1990s, there had been some interest and attempts to introduce some harm reduction policies and programmes. According to interview data, those who had an interest in establishing such programmes within Sri Lanka

included a small group of psychiatrists, medical doctors and NGO representatives who returned to Sri Lanka following completion of their post-graduate education in the UK and the USA. Drawing on their experiences gained in studying, learning about policy and work experience resulted in the diffusion of ideas around harm reduction onto the policy-making environment within Sri Lanka. As an NGO director stated:

"I went to the US and studied at John Hopkins and I am a Humphrey fellow as well. So, when you study these drug strategies at international level or when you're exposed to this kind of learning environment and experience, you begin to question about some of your local policies. I was constantly questioning the NDDCB about our policies when I came back and as to why we don't introduce methadone maintenance" (NGO Director, Interview 01).

Apart from these national policy actors who had been exposed to international policies and programmes on drug policies and who were subsequently making attempts to introduce some harm reduction programmes back in Sri Lanka, the UNODC had also made efforts at introducing opioid substitution and needle and syringe exchange schemes. National policy actors saw these attempts as being related to the interests of the UNAIDS, a sister organisation of the UNODC, and their efforts to prevent HIV/AIDS. As one Policy-maker pointed out:

"In general the UNODC is happy with our policies and programmes. Who is behind promoting harm reduction is the UNAIDS. Their funds are based on harm reduction approaches and their main priority is AIDS prevention. So, I think although the UNODC initiated conversations about introducing harm reduction, who was really behind was the UNAIDS and if you look at our local drug scene there was no basis to introduce these programmes because we do not have very many injectors" (Civil Servant, Interview 06).

There had been tensions between the UNODC and the NDDCB, particularly on the subject of introducing a harm reduction approach (Civil Servant, Interview 6). These tensions existed within the broader context of endeavouring to achieve consensus between the UNODC and the NDDCB on national policies around supply reduction and policies for the treatment and care of drug users in Sri Lanka. This was further complicated as some knowledge experts on drug control located within the NDDCB were part of the international epistemic community on drug control. Some of the epistemic actors representing the NDDCB were also seconded or appointed in an ex-officio capacity to organisations such as the CPDAP and SAARC (Police officer, Interview 10). Moreover, some UNODC staff members were also part of this network where they met with national epistemic actors during workshops and conferences on drug control in the south Asian region. Collectively, they believed that prohibition of drugs should be the norm in every country and that drugs are a threat to national security, poverty alleviation and socio-economic development in resource poor countries (Civil Servant, Interview 6).

According to this same Civil Servant, UNODC activities are located in a broader context where the interests of UN organisations working in the area of HIV/AIDS prevention are interconnected with the work of the UNODC. Policy-makers, in particular the epistemic community in support of demand reduction measures within the NDDCB, saw these external attempts as unacceptable due to their cultural inappropriateness and their perception that the drug users were largely non-injecting. Although the group of experts on drug demand reduction policies and programmes within the NDDCB agreed and gained consensus with the UNODC on a number of core principles and beliefs on drug control, it appears this same group held contradictory views in relation to the content of an acceptable harm reduction policy. Furthermore, the civil servant went on to say:

"We agreed on a number of areas during our dealings with the UNODC. But we stood firm against their proposal to introduce harm reduction and this kind of international pressure. That doesn't mean we're against harm reduction. We

are against harm reduction in Sri Lanka. Before you introduce harm reduction programmes, you need to conduct a thorough analysis, look at the problem, the country and the culture and then only you can make a decision. For example, if you want to introduce harm reduction policies in Chennai, Bangladesh or in Pakistan, I would say yes, because, there are too many who inject drugs and are HIV positive. But don't come to Sri Lanka, simply because they want to tick a box and say that in their region majority of the countries have implemented harm reduction" (Civil Servant, Interview 06).

The absence of an injecting drug problem or any crisis related to HIV appears to have been the legitimising principle for the Sri Lankan epistemic community actors located within the NDDCB to reject harm reduction policies and programmes promoted by the UNODC. In doing so, the local drug problem was re-framed as being different from other countries where there had been problems related to injecting and HIV. As previously mentioned, funding was received from the UNDCP in 1993 (see table 4) to prevent the spread of public health problems related to drug abuse, in particular HIV infection, without any proposals or plans by the NDDCB to introduce needle exchange or comprehensive opioid substitution programmes (Police Officer, Interview 10).

Samarasinghe (1995), a former Chair of the NDDCB, also argued that levels of drug use which might be considered as being less harmful in richer societies, can cause graver harm in resource-poorer nations by the diversion of meagre financial resources away from basic-survival needs within poor families. This had been another argument put forward to external organisations against the adoption of harm reduction policies in Sri Lanka. Although the country conformed with the SAARC convention, which held that drug use, even use in small quantities or in less harmful ways, would have a negative impact on socio-economic development. It is important to note that there had been no attempts or any evidence to denote that harm reduction policies were promoted by the Colombo Plan or the SAARC, both being dominant epistemic communities with due recognition for their expertise in the drugs field. To this extent, it appears that the NDDCB acted as a counter epistemic community to

the UNODC when attempts were made at introducing harm reduction programmes, such as needle exchange and opioid substitution prescribing in Sri Lanka.

According to interview data, although these divergent views existed between the NDDCB and the UNODC, to a large extent the UNODC had been satisfied with the drug control policies adopted by Sri Lanka. This is mostly related to Sri Lanka being a signatory to all UN drug control conventions and the annual supply of information on all drug control activities to the INCB. This appears to be one of the criteria for obtaining economic aid for drug control activities, preserving the freedom to retain a national approach to drug treatment. As one policy-maker pointed out:

"So, the legislation is in place, people know the rules and Sri Lanka is reporting to the UNODC on various different areas. Now, the UNODC is not grumbling on us because the obligations have been met etc. The INCB hasn't faulted us. I mean that's really the whole point of this exercise that is not to be found fault with the INCB" (Policy-maker, Interview 8).

External Influences on Compulsory Treatment.

The introduction of compulsory treatment for those addicted to drugs had first been discussed in the early 1980s, and again in the last two decades by national policy actors who were influenced by sources external to Sri Lanka. As discussed previously, the NNAC had previously established links with Malaysian experts on drug control through the Colombo Plan in the early 1980s and this appears to have continued for two decades since. The Colombo Plan, as part of its effort in harmonising drug policies in member states, had facilitated study tours for Sri Lankan policy actors to learn from drug treatment models adopted in countries such as Malaysia, Singapore and Thailand. An NGO Director, who participated in these study tours stated:

I think, as far as I know, compulsory treatment came from countries like Malaysia, Thailand and Singapore. Most of our drug control board officers and some NGO people have been to these countries and looked at their treatment programmes. There were study tours arranged to visit these countries and the funding came from the Colombo Plan. In Malaysia, that's where majority of the study tours were, drug addicts were sent to detention facilities for a mandatory 2 year sentence since 1983. These centres were operated by the Ministry of Home Affairs where rehabilitation was the focus with strict rules and so on. At that time we were given the impression that Malaysia's efforts decreased the number of drug addicts in their country. So, we have been talking about this method for a long time" (NGO Director, Interview 5).

Member states of the Colombo Plan, Malaysia, Thailand and Singapore had made some progress in drug rehabilitation in the 1980s. Their intervention models were abstinence-based and situated within their respective criminal justice systems whereby a drug user was seen as a criminal requiring rehabilitation. Malaysia defined its drug problem as a national disaster and as a security concern during a heroin crisis among its youth (Civil Servant, Interview 12). A civil servant who had a close working relationship with the Colombo Plan and as someone who visited treatment programmes in Malaysia at the time stated:

"President Nixon in the US in the early 1970s called it (drug problem) the number one public enemy. This kind of thinking spread across the world and then in 1983 Malaysia declared drugs as a national disaster as it was a security concern for them. Malaysia and some countries in the SAARC thought that drug addicts should be forced into treatment as they saw no other way of making their countries drug-free societies. It became kind of like fashionable to follow the Malaysian model" (Civil Servant, Interview 9).

The Malaysian definition of drug use being a threat to national security found common ground with SAARC member states and influenced the prohibitionist

policy stand adopted by Sri Lanka. A belief prevailed within some Colombo Plan and SAARC member states that their legal systems should compel drug users to enter treatment, as the majority of their drug addicts were seen as not being motivated to change. This position also existed within the broader context of an internationalised prohibitionist framework supported by the Colombo Plan and the SAARC. Drug treatment programmes within Malaysia only provided a single treatment regime, which was an institutionalised, regimented rehabilitation programme. Very little was done to encourage drug users voluntarily into treatment, including a lack of emphasis on any medical treatment. The desire to adopt a Sri Lankan policy of compulsory treatment located within an institutional framework can be traced back to policy makers' study trips to treatment facilities in Malaysia, Thailand and Singapore[8] (Policy-maker, Interview 2).

Although compulsory treatment had been on the policy agenda, it had not been formulated into a policy or become a political priority. This is despite some NDDCB officials and NGO staff becoming exposed to, and learning about compulsory treatment models that operated outside Sri Lanka. However, it quickly became a priority two decades later in 2007 when pressure was exerted by the UN on Sri Lanka to give effect to the 1988 UN convention. Although Sri Lanka was a signatory, domestic legislation was not in place to give effect to the 1988 convention. Of significant importance was the introduction of legislation to control precursor chemicals. Although the NDDCB had established committees, arranged workshops and attended SAARC and other international conferences and workshops on precursor control since 1997, no domestic legislation was in place (Handbook of Drug Abuse Information, 2005: 83-85).

Pressure from the UN to give effect to a number of its conventions occurred against the backdrop of human rights allegations being levelled against the Sri

[8] Majority of national policy-makers visited and observed abstinence-based compulsory treatment systems in countries such as Malaysia, Thailand and Singapore. These study tours were mainly organised and sponsored by the Colombo Plan.

Lankan government by the UN at the same time. Additionally, drafting new and amending existing legislation to promote human rights and good governance became a top priority for the Sri Lankan government as it had to satisfy international scrutiny to ensure that Sri Lanka could continue to benefit from trade concessions awarded through the GSP[9] scheme. As one policy-maker who was involved in formulating the Drug Dependant Persons Treatment and Rehabilitation Act 2007 stated:

"The Minister of Justice understood the political importance of this at international level and was able to move things for us fast and the draft Bill on psychotropic substances, alongside the draft treatment and rehabilitation Bill was finalised. The legal draftsman had to prioritise finalizing these draft Bills over others. So, what really happened was, along with these two Bills related to our area, the draft Bill on international covenant on civil and political rights was tabled in Parliament all at once. The process was fast because the government was very keen on obtaining GSP incentives for the country" (Policy-maker, Interview 3).

The benefits granted through GSP were economically significant as the EU was the largest single market for Sri Lankan exports, valued at US $ 2.8 billion in 2007 and took 36% of all the country's exports (Centre for Policy Alternatives and Friedrich Ebert Stiftung, 2008). The clothing sector accounted for 40% of the total exports and the EU was considered as the country's second largest clothing importer (Centre for Policy Alternatives and Friedrich Ebert Stiftung, 2008). From 2006, pressure from the UN, United Kingdom and the United States had been mounting for Sri Lanka to conform to a number of international human rights instruments and UN conventions. The 1988 UN convention against illicit traffic in narcotics was one such convention that Sri Lanka had to

[9] The European Unions (EU) Generalised Scheme of Preferences (GSP) allows developing country exporters to pay less or no duties on their exports to the EU. However, it is granted to countries which ratify and implement core international conventions relating to human and labour rights, environment and good governance.

give effect to in order to continue enjoying the beneficiary status of the GSP scheme, which was due for review in 2008 (Policy-maker, Interview 2).

This international climate influenced the content of the updated drug policy in 2006 although there were other national drivers for its introduction, which will be explored later in Chapter Seven. Nonetheless, the updated national policy on drugs reflected external concerns regarding the need to enact domestic legislation concerning psychotropic substances and stated:

"The government is fully aware of its international obligations, particularly those stemming from the Single Convention on Narcotic Drugs 1961, Conventions on Psychotropic Substances 1971, and the United Nations Convention Against Illicit Trafficking Narcotic Drugs and Psychotropic Substances 1988 ratified by the government" (Updated National Policy for the Prevention and Control of Drug Abuse, 2006: 1-3).

"When drafting or modifying legislation, relevant model UN laws and UN/SAARC conventions ratified by the government will be given due consideration. Under the international drug control conventions, competent national authorities are empowered to issue certificates and authorisations for the import and export of narcotic drugs, and competent authorities empowered to regulate or enforce national controls over precursors and essential chemicals in accordance with the provisions of article 12 of the UN Convention against Illicit Trafficking Narcotic Drugs and Psychotropic Substances of 1988 will satisfy all requirements of conventions effectively" (Updated National Policy for the Prevention and Control of Drug Abuse, 2006: 1-3).

The international conventions on drug control, as documents, continued to be deemed relevant, credible and applicable by national policy actors. Due to political pressure being applied by external organisations and countries to introduce legislation to give effect to the 1988 UN convention, the outcome was to simultaneously draft two separate pieces of legislation: one concerning the

illicit traffic in narcotic drugs and psychotropic substances and the other concerning the treatment and rehabilitation of drug users. The result was that both drafts were tabled and debated in Parliament following Cabinet approval. The resultant law concerning treatment and rehabilitation became the Drug Dependant Persons Treatment and Rehabilitation Act and was enacted in Parliament towards the end of 2007. It includes compulsory treatment of drug users within institutional settings. Earlier information and updated knowledge about compulsory treatment gained from the study visits by some of the national policy actors on treatment models that existed in some Colombo Plan member states, particularly in Malaysia, had clearly and significantly influenced subsequent policy development in Sri Lanka. A substantial proportion of the content of the Malaysian Drug Dependants Treatment and Rehabilitation Act 1983 is comparable to the Drug Dependant Persons Treatment and Rehabilitation Act 2007 of Sri Lanka.

Examination of the text in the two Acts reveals that there are a number of similarities when comparing compulsory drug treatment between Malaysia and Sri Lanka. Both have the same title of Drug Dependant Persons Treatment and Rehabilitation Act. They both ensure legal provision for police officers to arrest suspected drug users, produce them in court and seek a compulsory treatment order from a Magistrate. In this regard, the inter-textuality between the Acts are as follows:

“An officer may take into custody any person whom he reasonably suspects to be a drug dependant.

Where a person who has undergone the tests (drug tests) referred to in Section 3 or 4 and, in consequence of such tests, is certified by government medical officer or a registered medical practitioner to be a drug dependant, the officer shall produce him, or cause him to appear before a Magistrate, and the Magistrate shall upon the recommendation of a Rehabilitation Officer and after giving such person an opportunity to make representations:

a) *Order such a person to undergo treatment and rehabilitation at a Rehabilitation Centre specified in the order for a period of two years and thereafter to undergo supervision by an officer at the place specified in the order for a period of two years; or*

b) *Order such person to undergo supervision by an officer at the place specified in the order for a period of not less than two and no more than three years".* (Drug Dependants Treatment and Rehabilitation Act 1983 of Malaysia: 1, 8).

The Sri Lankan legislation on compulsory treatment states:

"Where an Officer-in-Charge of a Police Station receives information that any person is a habitual user of dangerous drugs and has since become a drug dependant person, he shall forthwith take such steps as may be necessary to cause such person to be examined by a Government Medical Officer. The Government Medical Officer shall thereupon submit a report to the police officer who referred the drug dependant person to him or any other officer attached to the relevant Police Station, setting out the results of such examination.

A Magistrate before whom a person produced upon the completion of the procedure set out in subsections (1) and (2) (1 and 2 refer to arrest and a person undergoing a medical examination) shall make order that such person be sent for compulsory treatment and rehabilitation at any treatment centre designated or licensed under this Act, as may be determined by such Magistrate" (Drug Dependant Persons Treatment and Rehabilitation Act No 54 of 2007: 4-5).

Although a mandatory minimum of a two year sentence to receive drug treatment and rehabilitation does not exist within the Drug Dependant Person's Treatment and Rehabilitation Act of Sri Lanka, the principles around arbitrary arrests of suspected drug users and making legal provision for the police and

courts, following a medical examination, to admit a person for compulsory drug treatment and rehabilitation are key tenets shared by both Acts. While this inter-textuality exists between the two legislations, there were a number of differences in the compulsory treatment legislation enacted in Sri Lanka, suggesting that the Malaysian legislation had been adapted to suit the Sri Lankan context. In addition, the Sri Lankan legislation has also incorporated licensing requirements for all drug treatment and rehabilitation centres with minimum standards and addresses the shortcomings arising from inhumane treatment of those undergoing drug treatment and rehabilitation. These areas will be addressed further in the next chapter.

The introduction of compulsory treatment within Sri Lanka has not been without opposition from the international community, particularly, the UNODC. Although the UNODC did not publicly oppose compulsory treatment programmes that previously existed in some Colombo Plan member states, there had been later antagonism, particularly in relation to the compulsory treatment provision within institutional settings not conforming with human rights' principles (UNODC, 2009:2). Within Sri Lanka, the available psychosocial provision in prisons was unable to cater for the growing numbers of drug users becoming incarcerated. According to the Handbook of Drug Abuse Information (2007), of those who were admitted to prison for a narcotic related offence, only 10% entered treatment in 2000, 11% in 2004 and 12% in 2006. UNODC officials had raised concerns with the NDDCB in regards to this treatment gap, whereby a need for alternatives to imprisonment was highlighted and encouraged as the preferred policy choice, instead of legislating for compulsory treatment within institutional settings. This tension was revealed by a policy-maker who stated that:

"Now, within this Act, what is also included is compulsory treatment for drug dependants. The UNODC are particularly not happy with the compulsory treatment element. They are arguing about it from a human rights perspective. As far as human rights are concerned, they are saying that we cannot force someone to have treatment. But we haven't got any official letter or position on this declared by the UNODC. This was raised mainly at personal level when we

met UNODC officials at meetings and through phone conversations. I suppose, overall, the UNODC is generally happy with our drug control mechanisms. We have signed up to all three conventions on drug control and we provide the information they require on all drug control activities on an annual basis" (Policy-maker, Interview 3).

Although community-based treatment as an alternative to imprisonment is encouraged within the international drug control conventions that Sri Lanka is a party to, a sanction-orientated treatment approach as opposed to a health-orientated one had been followed despite informal pressure being applied by some UNODC officials. It appears that the compulsory drug treatment principles adopted by Malaysia in 1983 were still deemed relevant for policy-makers in Sri Lanka in 2007.

Conclusion.

International drug control conventions that Sri Lanka had become party to and organisations such as the Colombo Plan, SAARC, UNODC and their respective epistemic actors have had a significant influence in shaping national drug policies so as to conform with UN drug control conventions. These external policy actors diffused international drug control principles and norms through various forums, offered support to the Sri Lankan government to conform with international drug control conventions, funded the setting up of the NDDCB to institutionalise the drug policy-making process, and in some cases utilised coercive methods to ensure that national legislation was amended to give effect to drug control conventions. The dominant response to manage drug problems through the criminal justice system was significantly influenced by these external policy actors and the UN and the SAARC conventions on drugs. Both the threats to national sovereignty and security arising out of the on-going armed conflict in the north and east in Sri Lanka and links between this terrorist activity and its financial proceeds from drug-trafficking became the overarching legitimising influences for collective action and the common thread influencing both the national and external policy actors who came into being during the

period under investigation. Additionally, both the Colombo Plan and the SAARC endorsed the aim of drug prohibition as each had a causal belief that drugs were a major obstacle to development and poverty alleviation in its member states.

Although criminal justice legislation and drug prohibition were the dominant policy responses, there was growing concern within the UNODC and the SAARC that law enforcement alone would not be the solution to the drug problem. The re-adjustment of international principles around drug control influenced Sri Lanka to follow suit and adopt drug demand reduction policies and programmes such as drug education, treatment and rehabilitation to exist alongside the law enforcement strategies.

External organisations, particularly the Colombo Plan and the UNODC, supported the establishment of a national epistemic community on drugs located primarily within the NDDCB. Some NGOs also received support from these organisations to set-up and implement drug demand reduction programmes within Sri Lanka. Some of those personnel who had been financially supported to participate in conferences, workshops and study tours abroad went on to become national policy entrepreneurs in the field of drugs. The introduction of compulsory treatment within Sri Lanka is one example of how national policy makers' exposure to abstinence-based treatment models established within the criminal justice system, particularly in Malaysia, subsequently became policy in Sri Lanka.

Although policy emulation and learning from external sources largely influenced and shaped the drug policy landscape in Sri Lanka, over time with growing knowledge and experience, the NDDCB also acted as a counter epistemic community in regards to challenging and rejecting harm reduction policies and programmes diffused and promoted by the UNODC.

Chapter Six: Understanding National Drug Policy-making

Introduction.

The previous chapter discussed how external influences became a precursor to contemporary drug policy-making, particularly focusing on how various international conventions, standards, documents and guidelines on drug control instigated national action. However, these external influences should be viewed in the context of the prevailing national concerns and interests and how they interacted with each other to lead to the development of new national policies and legislation.

While this chapter is connected with the previous chapter, a comprehensive empirical account will be provided on the key national actors involved and their influence in shaping drug policies and legislation during the period 1984-2008. Examination will be directed towards the transformation of national drug policies, with amendments to the Poisons, Opium and Dangerous Drug Ordinance in 1984, the formulation of the first national policy on drugs in 1994 and finally the creation of the Drug Dependant Persons Treatment and Rehabilitation Act in 2007. These developments introduced significant changes in the way the criminal justice agencies, the NDDCB, Health and the NGO sectors responded to the drug problem. The update made to the first national policy on drugs in 2006 will be discussed in the next chapter due to its strong links with the politics of policy-making.

The rationale for the development of national policies, their continuities or shifts during the period under investigation based upon the unique economic, political, social and institutional contexts existing in Sri Lanka will be explored in detail. Consensus and contradiction in developing national drug policies between professional groups, government and non-government agencies will be discussed in terms of how the drug problem was framed and why a punitive

response to the drug problem prevailed throughout the period under investigation.

The National Policy-Making Environment: 1984-1993.

Between 1980 and 1985, there was a decline in the use of opium in Sri Lanka, which coincided with the rapid increase in the number of heroin users in the country (Report on Illicit Drug Trafficking and Drug Abuse in Sri Lanka, NDDCB 1986). This reduction was possibly due to the emerging growth and transit of heroin on an international scale originating from countries in the Golden Triangle[10]. The repeal of the long-standing opium licensing system permitting its supply to registered users coupled with a reduction in opium availability might have forced many habitual opium users to change to heroin. The introduction of heroin into the local drug market and growth in young people using it was a new phenomenon of concern to drug policy-makers (Civil Servant, Interview 9).

The Poisons, Opium and Dangerous Drug Ordinance had come into operation in 1936 and mainly dealt with opium and ganja. Any previous knowledge gained about the drug problem was limited to an ageing cohort of opium and cannabis users. The novelty of a heroin epidemic, introduced by tourists in the late 1970s was largely confined to Colombo and some parts of southern Sri Lanka (NDDCB, 2000). According to interview data, it also coincided with trade liberalisation and the development of an open market-based economy introduced by a new right-wing government, who had favoured an increase in the growth of both tourism and free trade. Within this context, politicians and law enforcement personnel viewed the existing legislation at the time as being outdated to manage the emerging new trends of drug use and trafficking. This occurred in the context of some NNAC members and politicians already coming into contact with epistemic actors, such as the UNCND and the Colombo Plan,

[10] The Golden Triangle is an area in Asia located where the borders of Burma, Laos and Thailand meet and is known to produce a significant amount of opium and heroin in the world.

who introduced the requirement for the government to establish a legal and procedural framework to regulate, and criminalise the availability and use of drugs in Sri Lanka.

By 1982, Interpol confirmed Sri Lanka's status as a transit country for the movement of heroin from countries in the Golden Triangle into Europe, with organised international drug trafficking syndicates operating within Sri Lanka (Report of the International Narcotics Control Board, 1982). During this period, evidence also emerged of a link between heroin trafficking carried out by the LTTE and financial proceeds being used to fund terrorism (Jayasuriya, 1995). With the escalation of violence between the majority Sinhalese and the minority Tamils, and the demand for a separate Tamil state in the North and East of Sri Lanka, drug trafficking was perceived as a major problem and a direct threat to the stability of government. The report published in 1986 on illicit drug trafficking and drug abuse in Sri Lanka states:

"Sri Lankan Tamils have been arrested for drug trafficking mainly in Italy, France, Spain, West Germany, Switzerland and the United Kingdom. Investigations have established a definite link between heroin trafficking and the Tamil terrorist movement in Sri Lanka. This connection has been established both by documentary and other evidence gathered here and abroad during investigations, and on admission made by those arrested" (Report on Illicit Drug Trafficking and Drug Abuse in Sri Lanka, NDDCB, 1986:7).

A drug policy-maker who was interviewed, endorsing the above, stated:

"I must mention that in the 1980s and in the 90s as well, narco-terrorists relied on cash proceeds to procure military arms through drugs smuggling. The LTTE was responsible for large consignments of drugs being trafficked via Sri Lanka to the west and this was a threat to our security and independence" (Policy-maker, Interview 11).

By the early 1980s, a discourse was emerging around drugs being an existential threat to national security. Although this idea was first suggested by external policy actors such as the USA, UNCND and the Colombo Plan, Sri Lankan policy actors soon began to share this belief due to dual concerns around a growing terrorist threat and links with drug trafficking (Policy-maker, Interview 8). In this regard, the national policy actors were able to find common ground with the principles endorsed by actors who supported international drug control conventions, as they agreed with emerging national security concerns. 'Narco-terrorism' was a term commonly used by policy actors representing law enforcement agencies and in documents published by the NDDCB. Policy makers feared that narco-terrorists, primarily the LTTE, could challenge the security of the state. It is argued that narco-terrorism as a concept asserts that guerrilla movements finance their operations largely through drug trafficking and the principals in the drug industry employ extreme violence (Campbell, 1992) The 'threat discourse' increased the perceived dangerousness of the availability of drugs so that the institutionalisation of drug policies to negate these threats became more urgent, acceptable, legitimate and significant. These developments strengthened the principle belief in an absolute prohibition of drugs. This was the backdrop in the early 1980s which led to the amendments to the Poisons, Opium and Dangerous Drugs Ordinance.

Amending National Legislation on Drug Control in 1984: actors and interests

Chapter Four discussed the establishment of the *ad-hoc* NNAC, with the instruction from the Colombo Plan coinciding with a UN mission visiting Sri Lanka in 1973. Government departments represented on the NNAC committee came from the Ministries of Defence and Foreign Affairs, Health, Education and the Departments of Police, Customs and Excise, and the Attorney General. Some committee members who represented these departments in the NNAC continued to be involved in drug policy formulation, which has remained under the purview of the Ministry of Defence for the entire period from 1973 to 2016. Although there were representatives from government departments, this

committee had no legal mandate nor was considered as a statutory authority. Its activities were largely influenced by senior law enforcement officers and their work was monitored by the Deputy Minister of Defence, who was also its Chair. A senior police officer, who founded the Police Narcotic Bureau, became the first secretary of the NNAC (Police Officer, Interview 10). He was seen as being instrumental in introducing amendments to the Poisons, Opium and Dangerous Drugs Ordinance. As a policy entrepreneur and knowledge expert, he had the support from the Deputy Minister of Defence and the President. As one Policy-maker stated:

"In 1973, the Narcotics Advisory Committee was formed to advise the government on drug related matters. Deputy Inspector General Mr Sundaralingam was the secretary of this ad hoc committee and I functioned unofficially as Sunda's (a shortened form for the name Sundaralingam) assistant secretary. This was the policymaking body at that time. Sunda led on making the amendments to the dangerous drugs ordinance with my support and with the assistance of the Attorney General's (AG) department. I met with a senior civil servant who used to work for the AG department and he asked me if he should amend the law to strengthen our hands so we can keep certain people in custody for up to three months" (Police officer, Interview 10).

Law enforcement personnel representatives within the NNAC had a significant influence in the review and development of drug control policies and were able to spearhead changes to existing legislation. They worked closely and in partnership with the Deputy Minister of Defence and the Attorney General's Department. According to interview data, these policy entrepreneurs had support from the Deputy Defence Minister and from the President. Some senior police officers also had direct access to the President in regards to matters concerning drug control (Police Officer, Interview 10). The President was keen to introduce amendments to legislation so as to be on a par with drug legislation adopted in some Asian countries. Policy actors who were involved in bringing changes to legislation believed that the prohibition of drugs and use of law enforcement were the most important components to address the drug

problem and deter drug use. Initially, members of the NNAC proposed the introduction of new drug legislation to come into line with UN conventions. However, this proposal was withdrawn on the advice of the Attorney General as he was of the opinion that amendments to the Poisons, Opium and Dangerous Drugs Ordinance were more appropriate as it was a tried and tested law in the statute book (Hansard, March 22, 1984). Amendments were to strengthen the role and remit of law enforcement agencies and at the time any new proposals on stringent law enforcement on matters related to illicit drugs would carry unquestioned political legitimacy (Police Officer, Interview 10). This legitimacy was underpinned by the co-operation of three powerful government departments: the Executive, Defence Ministry and the Attorney General. All were highly influential in the area of legislative change, their representatives led the development of the drug policy amendments and all three departments shared the principal belief of drug prohibition and law enforcement as the aim.

Draft amendments to legislation were tabled in Cabinet meetings where there was unanimous support for it to be tabled in Parliament for approval and enactment (Civil Servant, Interview 6). The Poisons, Opium and Dangerous Drugs (Amendment) Bill was debated in Parliament on 22 March 1984. During the debate, the need for national legislation to be in harmony with neighbouring countries in the region was constantly highlighted, including a tough law enforcement response to deal with emerging drug trends. The Minister of Parliamentary Affairs and Sport, the chief government whip stated that:

"Amendments to several provisions of the existing law have become necessary as the present legislation formulated many years ago was not meant to cater either to the magnitude or nature of the present drug problems. Its penalty structure which provides for a maximum fine of Rs 1,000 and/or 12 months imprisonment following conviction after summary trial, and a fine of Rs 1,000 and/or 10 years imprisonment following indictment in the Supreme Court, is totally inadequate. These are about the most lenient in the region" (Hon. M. Vincent Perera, Hansard, 22 March 1984: 631).

The Amendment Bill also introduced the death sentence for drug related offences. It made provision to either sentence a person to death or to life imprisonment, for offences related to the manufacture of heroin, cocaine and morphine, opium; and/or the trafficking, possession, import or export of a minimum amount of five hundred grams of opium, or three grams of morphine, or two grams of cocaine or two grams of heroin (Handbook of Drug Abuse Information, 2007). Less severe offences warranted short prison sentences or fines. The Bill also made provision for a drug user found in possession of a small quantity of drugs for their personal use to be sentenced to death. The then President, Mr J.R Jayawardena exerted significant influence to introduce the death penalty for punishment of both drug suppliers and individual drug users (Police Officer, Interview 10). He held executive power and was able to obtain unilateral agreement from not only Cabinet colleagues to back the Amendment Bill, but also the support for the death sentence from Members of Parliament. Although consensus among Sri Lankan politicians from the various political parties is rare, it was significant that there was uniform consensus to support the Bill and no-one disagreed with the introduction of the use of the death penalty. Although consensus was reached at the political level, some policy-makers from the Drug Control Board did not support the use of the death penalty. Hence, it was entirely a political decision. One policy-maker who was involved in formulating the 1984 Amendment Bill stated:

"Our President at the time, Mr J.R Jayawardena, wanted to introduce the death sentence. He was keen to show the whole of Asia that we are quite serious about law enforcement when it comes to illegal drugs. He wanted to go even harder than Singapore. I think it was partly because he started the open economy and free trade under the capitalism banner. I was not keen on the idea because we were not going to implement the death penalty. If you really look at it, for something small like 2 grams of heroin, someone can be sentenced to death. I passed on my views to the President via our Deputy Minister of Defence at the time. But it became law in the end" (Police officer, Interview 10).

Policy-makers who represented the NNAC were not in total agreement with the President's proposal to introduce the death penalty for all drug related offences. The introduction of a death penalty could be viewed as mere rhetoric and symbolic, considering that, although a judge could sentence someone to death, it might not be carried out. Its introduction signalled a tough law enforcement and zero tolerance approach in an attempt to deter drug use and dealing. A psychiatrist who represented the drug control board stated:

"The death sentence was copied from Malaysia and Singapore without knowing much about drug control and how it works in practice. The President just copied it without knowing how it works at ground level. You can't just catch the fellows, sentence them to death and think the problem will go away" (Psychiatrist, Interview 4).

The President was influenced by other south east Asian countries, in particular Singapore and Malaysia. These were both similar economically, capitalist countries with legislation to use the death penalty for people convicted of drug related offences. Sri Lankan elite decision-makers at the time were inspired by these countries' economic growth, indicating a desire to follow their path to development (Civil Servant, Interview 9). There is no evidence to denote that knowledge experts on drug control or any external policy actor advocated the introduction of the death sentence to form part of a national response (Psychiatrist, Interview 4).

During the Parliamentary debate on the Amendment Bill, the Sri Lankan Minister of Education endorsed the President's proposal on the death sentence:

"Some may think that the death penalty is too harsh a penalty. I do not think so. Many countries have come to the stage where they accept the death penalty" (Hon. Ranil Wickremasinghe, Hansard, 22 March 1984:643).

According to interview data, law enforcement personnel and some medical professionals involved in drug policy making also had widely differing views about the introduction of the death sentence which was in stark contrast to politicians who supported its introduction. The President's executive power and his influence on government ministers to introduce the death sentence are remarkable. As the most powerful politician, the Executive President had endorsed the introduction of the death sentence and his government ministers followed suit and all debated the case for it in Parliament. Successive Presidents' influence and their interest in drug policies and drug policy rhetoric in relation to tough law enforcement approaches will be discussed in detail in the next chapter, 'The politics of drug policy-making'.

There had been consensus between Members of Parliament representing both the government and the opposition over the belief that drugs are a 'menace', a threat to the social fabric and the political system in Sri Lanka. Harmonising legislation in line with other countries in the region and adoption of a tough law enforcement response had political support. In response to a claim from opposition Parliamentarian Sarath Muttetuwegama stating that drug trafficking in recent years had increased due to the introduction of a liberal economic policy, the Minister of Education stated:

"We should not think of drugs as a problem of an open economy or a closed economy. It took some time for this menace to come to Sri Lanka. In fact the use of drugs can always become a threat to the political system, to the social system of our country. There are some countries, as my good friend the Hon member for Kotmale pointed out, in places like South America where drugs have played an important role in politics, in making governments and in bringing down governments. It is not merely a question of the health of the nation being threatened, but both the political system and the social system as a result of the use of drugs in society" (Hon. Ranil Wickremasinghe, Hansard, 22 March 1984:641).

Cabinet Ministers and Members of Parliament were both stakeholders in the policy-making process, and as legislators, placed great emphasis on the subject of drugs and had been interested in amending existing legislation on drugs. During the early 1980s, drugs were seen as a major political issue with much of the debate focused on law enforcement: legal and penal aspects of control. The response to the drug problem was conceptualised to be punitive rather than humane. Legislators placed political stability and the security of the nation at the highest level and these overshadowed any health needs of those individuals who used drugs. There was no provision in the Amendment Bill for drug treatment and rehabilitation, as the focus and debate had been on law enforcement to reduce the availability of drugs in the local market. The ownership of addiction was left in the hands of law enforcement agencies and was perceived as the correct course of action by the country's highest level policy-making system, the Parliament.

Defining the Drug problem: penal versus health opinions.

The treatment of heroin use was almost unknown by practising medical doctors during the early 1980s until some heroin users came to general hospitals due to experiencing the effects of arsenic poisoning in contaminated heroin. Some heroin users had died due to arsenic added to heroin imported from India (Psychiatrist, Interview 4). Doctors had also seen heroin users in some general hospitals when the heroin supply in the local drug market had been scarce. Inability to obtain heroin had prompted drug users to access medical facilities seeking help to alleviate withdrawal symptoms. Overall, there was little expertise in the treatment and management of drug misuse within the medical profession.

The new development of a heroin epidemic, a lack of expertise within the health sector to manage this and its definition being put outside the health system encouraged groups independent of the health service to become more involved in the subject of drugs. There had been support from powerful

positions of authority in government to keep the drug problem outside the health system during the early 1980s. The most senior politician in the health service, the Minister of Health, during the Parliamentary debate on the Poisons, Opium and Dangerous Drug Ordinance Amendment Bill stated that:

"We are willing to give whatever assistance we can, but since we are at the moment not fully geared to tackle the medical aspect of this problem, all co-operation extended to us would be welcome. So, on this occasion, I would like to call upon particularly the non-governmental organisations to think seriously about establishing drug rehabilitation centres" (Hon. Dr. Ranjith Atapattu, Hansard, 22 March 1984:650).

This statement conveyed the message that the Health Ministry was not accepting much or any responsibility to play any part in the management or treatment of the medical aspects of drug misuse. The statement could be taken at face value with the medical sector lacking clinical experience and knowledge to treat this new health problem. However it might also be viewed as the Health Ministry adopting the position of not welcoming the challenge posed by an emerging and growing drug misuse problem, not being forthright in stating this and shifting any responsibility and interest in addressing it onto other agencies. Not only does this endorse the lack of a medical or health conceptualisation to the official response to deal with drug misuse, it leaves other agencies with a clear opportunity to become involved, take over and impose their belief system in defining the problem and developing policies and solutions.

The ministerial will was, therefore, supportive of a punitive response and excluded a multi-disciplinary approach involving medical treatment or prevention. There was little opportunity or support for civil servants to develop a multi-faceted approach for debate. Civil servants in the Ministry of Health supported the Health Minister's view. There were other competing financial priorities in terms of public health problems. Any responsibility towards the drug problem was left outside the health service. The Health Minister's statement

also signalled a message that interventions should primarily stem from groups independent of the health sector and that the 'drug problem' does not require a health response. Although, a policy-maker who was a practising psychiatrist at the time made attempts to assert that the drug problem was a health issue, it appears that the Minister of Health and the Secretary to the Ministry of Health left it as a matter outside the health system:

"Now I remember having a number of arguments with the Ministry of Health. I said that alcohol and drugs are essentially a health issue. But the Ministry Secretary, a very senior civil servant at the time, did not want to accept it as a health issue. His answer was that he had enough of issues to deal with and that he had to prioritise tackling malaria, TB, cholera and so on" (Policy-maker and Psychiatrist, Interview 4).

Tackling the problems of malaria, tuberculosis and cholera were public health priorities the Health Ministry should address but they appeared to overshadow the health needs of drug users. This further suggests that the country's drug problem was not a priority area for intervention from the Ministry of Health. The posts of Minister of Health and the Secretary to the Ministry of Health are powerful positions of authority in government office. Not only did their views reduce any responsibility for the drug problem, they influenced groups outside the health sector to be more involved in tackling the drug problem.

Whilst detoxification or management of drug withdrawal can be viewed as requiring a medical response, the opting-out policy response by the health ministry would have left many drug misusers with few options. The 'cold turkey' method of drug withdrawal with no use of substitute or symptomatic medication needed no response from doctors and remains when there is no other available option to alleviate withdrawal symptoms. Although not government policy or forming part of any comprehensive treatment programme, the practice of symptomatic prescribing was undertaken by some doctors and psychiatrists, but, limited to the general hospital in Colombo and the psychiatric hospitals in

Mulleriya and Angoda. In this context, the range of approaches and services needed to form a comprehensive and official policy response for drug misuse in the areas of education, prevention, treatment, rehabilitation was left to services outside the health sector.

Against this backdrop, official interest in matters related to drug control within the Police Department was further amplified with the amendment of the Poisons, Opium and Dangerous Drugs Ordinance in 1984. As law enforcement became the means of drug control within the amended ordinance, increasingly more drug users were being arrested as a result. As previously stated, there were only 8 heroin-related arrests in 1981. This had increased to 6,650 by 1990 (Handbook of Drug Abuse Information, 2008). Police officers, as a professional group, came into contact with significant numbers of drug users by virtue of their new role of stringent law enforcement against drug users and traffickers. Enforcement action was largely concentrated in the Colombo district where heroin use was more prevalent than in other districts of the country (Police Officer, Interview 14).

The Poisons, Opium and Dangerous Drugs Ordinance Amendment Act No11 of 1984 also led to the establishment of the National Dangerous Drug Control Board as a statutory institution. Its role and remit included the formulation and review of a national policy on drugs. Additionally, coordination of prevention, treatment and rehabilitation, enforcement, education, research and other activities related to drug control also formed part of the remit of the NDDCB. The establishment of the NDDCB can be seen as an attempt to depart from ad hoc policy-making and formalising the implementation of strategies and interventions to control the demand and supply of drugs. Its structural positioning was again outside the health system as the NDDCB was set-up as an institution under the Ministry of Defence. Although not formally appointed, some doctors and senior officials from customs and police initially took part in board proceedings (Police officer, Interview 10).

A senior police officer, who was a member of the NNAC, was appointed as the Chairman of the first NDDCB. This was a dual role whereby the Chairman had to lead on activities at the PNB, as well as the NDDCB. The appointment was made by the President of Sri Lanka and can be seen as a political act. It signified the continued presence of law enforcement personnel infiltrating the newly formed drug policy-making body, the NDDCB. The first Chairman, as a policy entrepreneur, had a keen interest in drug control activities and can be regarded as someone instrumental in understanding the emerging heroin epidemic and in shaping subsequent drug policies. Previously, he had set-up systems within the PNB to collect information on arrested drug users. For example, demographic information of drug users, type of drug(s) used, how it was used and the quantity consumed. The rationale for collection of such information was mainly related to the need to understand the nature and magnitude of the emerging heroin problem (Police Officer, Interview 10). Law enforcement personnel now had first-hand information and were in an ideal position to accurately describe the emerging heroin problem.

Doctors' Divergent Views on Defining the Drug Problem.

With growing intelligence on drugs, the PNB was in a position of authority to claim that opium use was declining and that heroin use among young Sri Lankans was increasing (Report on Illicit Drug Trafficking and Drug Abuse in Sri Lanka, NDDCB, 1986). The police also claimed that heroin use was concentrated within the Colombo district but with slow spread to other cities in Sri Lanka. According to the PNB, the typical heroin user at the time was male, young, from a lower socio-economic background and funded their habit through petty crime. With a growing knowledge on the heroin problem, perhaps limited to the PNB in the early 1980s, new facts began to emerge about the heroin problem.

Although drug use was criminalised and the drug user was seen as a criminal, there was acknowledgement within the PNB that a punitive response by itself

was inadequate. This perception spread from the PNB into the newly established NDDCB, as a result of appointing a Chairman who had a background in the PNB. The new Chairman during his tenure at the PNB had instructed local police stations to escort drug users to the general hospital in Colombo for treatment (Police Officer, Interview 10). There were no formal arrangements or legislation to divert drug users into treatment at the time. However, the idea of 'including treatment' as opposed to 'only punishment' began to emerge among policy-makers during this time.

Coincidentally, within the first two years of inception of the NDDCB, the idea emerged that drug users also require treatment and rehabilitation and that the problem cannot be tackled solely through law enforcement. This invited people and organizations outside the penal system to add their views on the drug problem, particularly the medical profession. There appears to have been divergent opinions within the medical profession on how the drug problem was defined and conceptualised, as well as a lack of interest in the subject of drug treatment. In general, doctors were unaware of the growing heroin problem in the early 1980s. A senior police officer stated:

"Doctors said that heroin use has not come to their notice anyway. Then I said look, this is an emerging problem and I showed my statistics around referring these individuals to health authorities. Then their eyebrows went up. We took the lead on enforcement and attained credibility for what we did. And then we approached others and said that we can't do this on our own and that they also need to join hands" (Police officer, Interview 10).

Although there was no formal arrangement or instruction from the Health Ministry issued to medical staff to be more involved in the treatment of drug use, there was a group of doctors who showed interest in the area of treatment for drug addiction. One of these doctors informally represented the NDDCB at the request of the Chairman. It was within this context a workshop was held and led by the new NDDCB Chairman on 31st March 1985 to explore the

‘medical aspects of drug abuse’. Prominent physicians, surgeons, psychiatrists and the President of the Sri Lanka Medical Association, similar to the British Medical Association in the UK, attended this workshop. According to documentary data, the primary objective of this workshop was to recommend appropriate guidelines for services utilising pre-existing health resources, so as to begin to establish some treatment for drug users. In a landmark move, the workshop defined drug abuse as a health problem and emphasised the following:

1. The expansion of current health facilities for detoxification.
2. The training of doctors regarding the signs and symptoms of use of dangerous drugs such as heroin, cocaine, dexamphetamine, LSD; and the treatment and management of drug dependant persons.
3. The evaluation of the medical use of methadone in opiate detoxification procedures.
4. The inclusion of general practitioners and other doctors, in addition to psychiatrists, to augment the medical expertise available when developing treatment and rehabilitation programmes in the country.
5. Undertake research into the causal relationships in drug addiction in Sri Lanka.
6. Institute programmes to increase the motivation of drug addicts to receive voluntary treatment and rehabilitation.

(Extract/compilation from the transcript of the workshop on medical aspects of drug abuse, NDDCB, 1985).

The workshop also recommended the expansion of representation on the NDDCB to include ex-officio, the Principal Collector of Customs, Director-General of Health Services and the Secretary to the Ministry of Education. Correspondingly, the Sri Lanka Medical Association asked that they be given an opportunity to be involved with the NDDCB activities, particularly in relation to drug treatment. The need for a multi-agency and a partnership approach to managing the drug problem was beginning to emerge. Consequently, the

NDDCB Amendment Act No 41 of 1986 expanded the membership of the NDDCB and made it a statutory responsibility to appoint the following representatives: Secretary to the Ministry of the Minister in charge of the subject of Education, Inspector-General of Police, the Director-General of Health Services, the Principal Collector of Customs, the Government Analyst, and the Commissioner for Ayurveda. The new, expanded membership of the NDDCB now consisted of representation from more government departments as per the NDDCB amendment act No 41 of 1986 and had the potential to respond to the drug problem from a wide variety of perspectives.

Although the medical workshop in 1985 concluded that drug abuse was a health problem and members were periodically appointed from the Ministry of Health to represent the NDDCB, any suggestions made by doctors concerning the treatment of drug dependency stopped short of implementation. There were a number of inter-related factors that continued to leave treatment for drug addiction excluded from provision by the health service.

Successive Chairs appointed to the NDDCB were either medical doctors or personnel who had previously represented legal or criminal justice agencies. According to interview data, they were usually appointed by the President, which signified the importance of this position. This presidential influence extends to appointing some other members of the Board as well. In general, the doctors who were appointed either as Chair or membership of the NDDCB had divergent views on the official response to the drug problem. A psychiatrist reflecting on this period stated:

“From the very beginning, there were ideological differences. Some of the doctors supported the disease concept and said that drug addicts should receive treatment. They were mainly a group of compassionate doctors. But, others were more behaviourally orientated and said that drug addiction had no biological basis and that drug users were useless fellows and that this is a pattern of life style they have learned and got used to. Some of these doctors

believed that drug addicts shouldn't receive any medical treatment and said that drug addiction had nothing to do with medicine and had no biological basis" (Psychiatrist, Interview 4).

The majority of doctors who were interested in the treatment of addiction were not central to drug policy-making. Interview data suggests that while some doctors who represented the NDDCB favoured a medical response others had mixed views on the response to the drug problem. In general, there had been a lack of interest in, and conceptualisation of, addiction among the doctors who were members of the NDDCB. Addiction was viewed as a bad habit and a form of indulgence and not as an illness requiring medical attention. There were strong moral influences with some doctors framing drug addiction as a deviant activity and the display of any untoward behaviour did not warrant the attention of the medical profession. The same psychiatrist, endorsing this general perception of drug users held by doctors stated:

"Most doctors who got to the top of policy-making forums felt that drug addicts are bad people and that they should be rehabilitated. They didn't look at the holistic picture and the role medical professionals can play. Historically, the person who held the post of Chairman in the drug control board didn't have any clinical experience. They were not looking after patients although they were doctors. So they had this 'good and bad idea'. They supported rehabilitation, drug education and prevention, but, no medical treatment as such. That is why I used to call them humbugs" (Psychiatrist, Interview 4).

Within the context of the overall unwillingness among the medical profession to define the drug problem as a health issue, doctors who supported treatment for addiction were in favour of introducing Methadone and Clonidine as medication in the treatment for withdrawal of opiate dependency. A large majority of this group of doctors had undertaken both post-graduate medical training and National Health Service work experience in Britain, where they gained knowledge of drug treatment models and where substitute prescribing for

opiate dependency was more prevalent. However, as previously discussed, doctors who actively supported a medical response to the drug problem and drug treatment were occupying less influential positions within policy-making and their views were not heard or acknowledged by decision makers in the NDDCB and the Ministry of Health. The opinions held by doctors about drug problems existed at a time when a prohibitionist policy towards drugs dominated following the enactment of the Poisons, Opium and Dangerous Drug Amendment Act No 13 of 1984.

Moral Hygiene, NGOs and the Growth of Drug Rehabilitation.

The late 1980s marked the arrival of NGOs into drugs work. The majority of their attention focused on drug education, prevention and rehabilitation, the latter largely being Buddhist and Christian faith-based, and supported by the government and the NDDCB. 1987 is significant for the development of the following national schemes within Sri Lanka:

- The setting up of an Alcohol and Drug Information Centre (ADIC[11]) by the International Organisation of Good Templars (IOGT[12], an international NGO).
- NDDCB commencing a 3-year joint project with the UN on prevention and treatment for problems related to drug abuse.
- The setting up of the Federation of Non-Government Organisations Against Drug Abuse (FONGOADA) as an umbrella organisation to represent NGOs working in the field of drug abuse.

[11] ADIC was established in 1987 as a charitable organization in Sri Lanka. It is involved in drug and alcohol demand reduction, is a resource centre and participates in international networks such as the Global Alcohol Policy Alliance (GAPA), the Framework convention Alliance on Tobacco Control (FCTC), the International Federation of Non-Governmental Organization (IFNGO) and IOGT International.

[12] IOGT is a worldwide community of non-governmental organisations that promotes people around the world towards a lifestyle free from alcohol and other intoxicating drugs.

- The NDDCB, UN Development Programme and the WHO developing a drug abuse monitoring system to collect data.
- The launch of the first residential drug rehabilitation facility, popularly known as “Navadiganthaya” (New Horizons) by the “Sumithrayo”, a local NGO part of Befrienders[13].

As discussed in the previous chapter, external influences from organisations such as the UN, Colombo Plan and the SAARC changed the emphasis from following a prohibitionist-only approach to include the introduction of drug education, treatment and rehabilitation, in addition to the supply-reduction programmes in its member states. The schemes developed in 1987 coincided with the publication of the ‘Comprehensive Multidisciplinary Outline (CMO) of Future Activities in Drug Abuse Control’ that originated from a 1987 UN conference on drug abuse and illicit trafficking held in Vienna. This document recognised the responsibility of countries to provide resources and equal status to address both the supply and demand for illicit drugs in member states (United Nations, 1988).

Initially, financial support was provided by the NDDCB through FONGOADA to the NGOs engaging in drugs work. In the late 1980s, the Chair for the NDDCB had been a Commissioner of Prisons. Financial support from this Chair was given to a prominent Buddhist monk to establish a residential drug rehabilitation centre. This monk had previous experience in rehabilitating young offenders through a work partnership with the Ministry of Justice on a prison diversion scheme wherein rehabilitation was allowed in the community, as opposed to a prison sentence (Policy-maker, Interview 7). After receiving support to develop residential drug rehabilitation schemes he established the “Mithuru Mithuro Movement”, an NGO renowned for drug rehabilitation with eight residential rehabilitation centres across the country. In the late 1990s, this monk was appointed as a member of the NDDCB, where he advised and became a

[13] Befrienders is a charity that helps people worldwide who feel suicidal.

knowledge expert on matters related to drug treatment and rehabilitation for over a decade (Psychiatrist, Interview 4).

The NDDCB expanded its position of developing national policies to include the provision of drug treatment and rehabilitation, with the establishment of a residential rehabilitation facility known as “Meth Sevana” in Kandy in 1990. In 1991, two more treatment facilities were established in Galle and Colombo districts. The NDDCB took over “Navadiganthaya” that had been set up by the local branch of Befrienders in 1993 (Report on Recent Developments in Treatment, NDDCB, 1999). The impetus for the provision of rehabilitation in the country was largely due to the demand by some sections of the public for the provision of help for drug users and some NDDCB board members having experience and knowledge of setting up ’10-day community-based treatment camps’ for drug users. These had been established in the mid-1980s, with local communities involved in providing drug education, life-skills training, counselling and practical support for those who used heroin. The treatment camp approach had been jointly pioneered by a Buddhist monk, a professor of forensic medicine at the Colombo University and a university lecturer in social services (Report on Recent Developments in Treatment, NDDCB, 1999). While the professor subsequently became a NDDCB Chair, the lecturer became an Executive Director of the NDDCB. These developments led to the emergence of a small national epistemic community that advocated for the rehabilitation of drug users. While some of these epistemic community actors were located within the NDDCB, others represented academic institutions, government departments and faith-based organisations that operated outside the workings of the NDDCB.

The growth of rehabilitation prevailed within the context of a drug problem not being defined as a health issue and the lack of medical treatment facilities. Although the majority of residential rehabilitation centres offered the ‘cold turkey’ method, some offered drug-withdrawal programmes consisting of symptomatic prescribing using non-opiate based drugs to alleviate withdrawal symptoms coupled with physical exercise, meditation and spiritual healing.

Symptomatic prescribing was provided by private doctors on a medical-session basis. According to the Handbook of Drug Abuse Information published by the NDDCB on treatment and rehabilitation, policy-makers held the view that drug treatment essentially meant 'rehabilitation' as the two terms ‘treatment’ and ‘rehabilitation’ were regarded as one and the same by policy makers and in policy terminology. As a result, the majority of the funding provided by international organisations for drug 'treatment' was directed to the development of rehabilitation facilities.

The rationale for the growth of rehabilitation was twofold:

Firstly, there existed a belief among policy-makers and politicians that a drug-free society is absolutely required for the socio-economic development of the country, particularly as young people were considered as the wealth of the nation. Hence young drug users had to become abstinent so as to be productive and contribute towards socio-economic development. Secondly, ‘rehabilitation’ was seen as a means to instil lost or deteriorated morals of behaviour in those who used drugs (NGO Director, Interview 5). The official support given to rehabilitation became regarded as almost a panacea to the drug problem. The integration of drug users back into society as “good citizens” through residential rehabilitation programmes became the populist policy (NGO Director, Interview 5). There was no shift in these two views during the period studied. A policy-maker who represented the NDDCB stated:

“Our goal was to make drug users good citizens and help them go back to their community after giving up their chosen lifestyle (drug use). Drug use is an illegal activity and an indication of the breakdown of our cultural values. It ruins our families and has a knock on effect on our welfare and our development. It is also against Buddhism and this is a majority Buddhist country. So, it was not difficult at all to gain support for our rehabilitation programmes. In fact it was welcomed and as far as I can remember majority supported this kind of drug treatment. It’s the case even now” (Policy maker, Interview 2).

Buddhism identifies five precepts as part of its moral code and as the path to liberation. They include: abstinence from killing, stealing, sexual misconduct, false speech and use of intoxicants. The dangers of intoxicant use are enumerated in a number of the Lord Buddha's sermons, the most famous being the Sigalovada Sutta, known as the layperson's code of discipline, which states that intoxicant use causes economic downfall (Dahlke et al, 2008). The parable of Mahadhanasetthi tells of a man who spent a vast fortune by drinking alcohol with evil friends and was reduced to beggary in his old age. It is a popular example of a human being whose life was ruined by alcohol. The religious-moral model of drug rehabilitation had to have support from policy actors across government and non-government organizations, and was in congruence with abstinence as the only goal of treatment and prohibition as the dominant policy.

There had been continuous support from successive Chairs appointed to the NDDCB to continue providing rehabilitation despite their various professional backgrounds. However, some doctors who led the Board took a keen interest in revising the accepted rehabilitation philosophy and reduced both the duration of the rehabilitation programme from 18 to 6 months and diluted the militaristic style of the physical exercises, meditation and spiritualistic aspects of the regime. Those who supported rehabilitation were also staunch supporters of the temperance movement at the time and were strong Buddhist followers (NGO Director, Interview 1). Buddhism and its influence on drug policy-making will be discussed in more detail in the next chapter as Buddhism had strong links to governance and political welfare.

The First National Policy on Drugs (1994) and the 90s Policy Landscape.

The progress towards a national policy concerning a response to illicit drugs can be traced back to the late 1980s. Although legislation was amended and the NDDCB was created in 1984 to coordinate all activities related to drug control, the need for the formulation of a national policy on drugs was raised by both national and international policy actors. As discussed in the previous

chapter, the impetus for its development was largely driven by the United Nations who wished to see a cohesive single policy document, one that outlined a national stand on illicit drugs (Civil Servant, Interview 11). The first national policy on drugs also states that "the UN General Assembly had also on several occasions urged governments to use the Comprehensive Multi-disciplinary Outline (CMO) in the formulation of their own policies and programmes" (Sri Lankan National Policy for the Prevention and Control of Drug Abuse, 1994: 3). As the CMO was multi-disciplinary in outline, its application in Sri Lanka invited broadening the involvement of existing stakeholders from law enforcement departments to include other government and non-government agencies. These external developments also influenced the involvement of multi-disciplinary personnel in the creation of the first national policy on drugs.

By the late 1980s the NDDCB was perceived by the public as the principal institution for coordination of all drug control activities within the country and it was within the remit of the NDDCB to develop a national policy on drugs. The NDDCB had established its status as a national epistemic community in the area of drug control, due to gaining more experience in the area and exposure to the influences of international organisations such as the UN, SAARC and Colombo Plan. These helped drug policy-making to become institutionalised within the NDDCB. Prior to this NDDCB policy lead, and as discussed before, divergent views existed among government departments and professional groups on the drug problem and the implementation of drug control activities. This resulted in the drug problem continuing to be viewed and framed within different disciplinary perspectives. A civil servant, who was involved in drug policy-making at the time, succinctly described these conflicting views as:

"At that time only the law in relation to drugs was intact. There was no national policy as such. People had different views when it came to operations. The government had to articulate its commitment and its strategy to deal with the drug problem despite these different views. They all saw it from a different light and gave priority to their own area. Even the judiciary had different views about

drug control. The Foreign Ministry representatives were keen on international corporation to accede to the 1971 and 1988 UN conventions. The Police and the Ministry of Defence were saying that it's a matter to do with security and were keen to focus on supply reduction programmes. Some doctors said that the drug problem is a medical problem, social services representatives said that it's a social problem, customs said that they have a huge role in interdictions and border protection and so on. So, the board (NDDCB) felt that there should be a national policy so you can reduce different opinions. But I must say that people really focused on law enforcement and strict controls in the end as it was the easy thing to do" (Civil Servant, Interview 9).

The NDDCB saw the involvement of stakeholders as an opportunity to unify these multi-disciplinary views, although it happened within the context of a dominant penal approach to managing the problem. There was also recognition that drug problems are multifaceted and cannot be tackled by one single agency and required responses from a range of government departments. However, it is noteworthy that although non-governmental organisations ventured into the area of drugs work, they were not formally involved in the formulation of the first national policy on drugs (Civil Servant, Interview 6).

The security discourse, the idea that drug trafficking is a threat to security, sovereignty and development intensified during the drafting of the policy as fighting increased between the armed forces and the LTTE. There was disruption to civic life and public services as a result of regular bombings in the Colombo district and elsewhere. During the early 1990s, the idea that the LTTE were funding their armed struggle through drug trafficking gained more credence among politicians and civil servants working in government Ministries such as Defence, Justice, Foreign Affairs and the Attorney General Department (Member of Parliament, Interview 13). Their focus here was on border control and the disruption of international syndicates as the LTTE used Sri Lanka as a trans-shipment point for illicit drugs to be moved to Europe. It was within this context that a past Chair of the NDDCB led the development of the first national policy on drugs with the afore mentioned government ministries and

departments such as Attorney General, Police, Customs, and Health (Policy-maker, Interview 7). Once more, stringent law enforcement as a policy option carried unquestioned legitimacy due to the continuing perception of drugs as a threat to national security and sovereignty.

The political will for the creation of the first national policy on drugs cannot be ignored as the Executive President, the person who was also holding the portfolio of Minister of Defence at the time, was a driving force to ensure the development of a national policy. There appears to have been close coordination between the NDDCB and the President's office. As the Chairman who led the development of the national policy stated:

"We developed the national policy during his excellency Mr. Premadasa's (President) time. He was the person in-charge of the subject and was very much interested in having a national policy. He wanted to make sure that we are tough on enforcement and that our policy was in harmony with international conventions. In fact, there was a consultant at the Foreign Affairs Ministry, who was asked by the President to oversee this policy development. He was a very senior diplomat at the time. We at the NDDCB drafted the policy and this consultant went over it and hashed it as such- I mean some areas so the policy fully complies with international drug control conventions. Mr…… (Consultant to the Foreign Affairs Ministry) escorted me to one of the Cabinet meetings and he himself presented the policy. Because the President had a lot of trust and confidence in Mr….. (Consultant to the Foreign Affairs Ministry), it was ratified at Cabinet level without any problems" (Policy-maker, Interview 7).

The Introduction of Demand Reduction Approaches.

The first Sri Lankan National Policy for the Prevention and Control of Drug Abuse published in 1994 acknowledged the growing use of cannabis and heroin among the local population and identified four responses: enforcement; preventative education and public awareness; treatment and rehabilitation and

international and regional co-operation. Although supply reduction outweighed demand reduction measures, the government, for the first time articulated its commitment to demand reduction through the publication of this policy document. Abstinence from illicit drugs continued to remain the ultimate goal and received support from civil servants and the government despite this not been clearly stated in the policy document. Efforts to reduce demand for illicit drugs through primary prevention involved the mass media and school education; both had unanimous support from all concerned government departments and ministries (Civil Servant, Interview 6). As the first national policy on drugs states:

"Accepting that prevention is more efficient and cost-effective than either enforcement or and treatment, the Government will facilitate better use of all preventative educational opportunities. Focus will be on formed curricula, informal and non-formal education activities and the use of mass media" (Sri Lankan National Policy for the Prevention and Control of Drug Abuse, 1994: 3).

The medical and legal professions' support for primary prevention was significant as they believed that discouraging the initiation of drug use, especially among adolescents and young adults was pivotal in containing the drug problem. It also found common ground with the casual belief of drug use being an obstacle to socio-economic development (Policy-maker, Interview 3). According to the national policy, a clearly defined role for preventative education was placed outside the spheres of the health system. The implementation agencies identified for preventative education and public awareness were: Ministries of Defence, Education, Cultural Affairs, Labour and Social Services, Public Administration and Home Affairs, Youth Affairs and Sport, the Department of Information and NGOs (Sri Lankan National Policy for the Prevention and Control of Drug Abuse, 1994).

The policy also states that "in order that the process of treatment be complete, the phase of treatment and detoxification must be integrated with the phases of

rehabilitation and after-care" (Sri Lankan National Policy for the Prevention and Control of Drug Abuse, 1994: 4). This was the first time the role of the health sector had been formally identified in regards to treatment in a national policy document. The policy further states that:

"In view of the large number of persons voluntarily seeking treatment, a short term action plan will be drawn up by the Ministry of Health to deal with the immediate problem. On a long term basis the Department of Health will be responsible for co-ordinating and giving guidance to the development and maintenance of a comprehensive national treatment programme for drug dependants" (Sri Lankan National Policy for the Prevention and Control of Drug Abuse, 1994: 5).

The NDDCB failed to undertake sufficient consultation with the Ministry of Health to ensure that the treatment arm of the national policy was clearly articulated with clear milestones and measurements. Rehabilitation was the central focus of the NDDCB and was perceived to be sufficient to address the problem from the point of demand reduction. The lack in conceptualisation of the drug problem as a health issue but inclining more towards defining it as a social issue by the NDDCB meant that a limited role was awarded to the health sector for its management. As the Chair who led the development of the first drug policy stated:

"It was recognised that this (drug problem) was not an exclusive field and that this could be tackled by one agency- it was not purely a medical problem. These people (drug users) required counselling and social work to get out of the habit and remain out of the habit. Even if they relapsed, they were required to come back to counselling and rehabilitation. I felt the subject was better placed with the Ministry of Defence rather than Health because if it was with health, the drug problem would have been heavily medicalised- it shouldn't be as it is mainly a social problem" (Policy-maker, Interview 7).

Similarly, a lack in commitment from the Health Ministry to deal with the medical aspects of the drug problem meant that two decades later, a comprehensive national treatment programme was still overdue (Psychiatrist, Interview 4). The doctors who argued the case for treatment were not heard and their agenda was not articulated at political level as vigorously as some of the security and control measures during policy development.

Treatment and the Prison System.

The number of people imprisoned for narcotic related offences in the 1990s increased in line with law enforcement becoming the populist policy and becoming firmly embedded within the responsibility of the criminal justice system. Considering the entire prison population, 'narcotic related prison admissions' as a single category stood at 32.6% in 1995 (NDDCB, 2000), 41.3% in 1996 (NDDCB, 2000), 44.6% in 2000 (NDDCB, 2002) and 40.7% in 2005 (NDDCB, 2007). These figures suggest that just under half the entire prison population were admitted due to narcotic related offences. The growing number of prisoners with drug problems was of concern to the Ministry of Justice and prison officials due to prison overcrowding, and their belief that drug users had the potential to become 'harder criminals' when associating with prisoners who are part of organised gangs, have committed murder and other types of violent offences (Policy-maker, Interview 7). The treatment of drug users in prison had also been discussed during the development of the first national policy on drugs. Although there had been no reference to the development of drug treatment within prisons, alternatives to imprisonment such as treatment and rehabilitation did become a feature of the first national policy on drugs. Some policy-makers within the NDDCB acknowledged that drug users should be dealt outside the prison system. This was largely due to the drug problem continuing to be defined as a social issue. A policy-maker stated:

"As you know, my background is prisons. With that experience, I came to realise that drug addiction is more rather a social problem. It is to do with relationships; your family, friends and so on. There can be alternatives than ending up in prison, which results in plenty of negative effects on that individual. I think traffickers should be dealt within the prison but not drug addicts" (Policy-maker, Interview 7).

However, these views were not necessarily shared by the majority of politicians and senior civil servants who both preferred to apply a stringent law enforcement approach and to continue implementing a penal approach to managing the problem due to its political and public appeal. By now, a penal approach to managing the drug problem was strongly accepted as an institutional norm, particularly within the NDDCB. As one civil servant stated:

"The easiest thing to do is to convict someone and send that person to prison because the public at large thinks that the problem is solved when drug addicts are punished. So, our politicians wanted to please this type of public mind-set. Our institutions also adopted this type of thinking because it was an expectation as the NDDCB comes under the government" (Civil Servant, Interview 9).

Against this backdrop in the mid-1990s, the NDDCB expanded its treatment and rehabilitation programmes from out in the community to include some remand and open prisons with funding support from the UNODC. Existing community treatment staff of the NDDCB helped set-up and implement drug education and rehabilitation programmes in some remand and open prisons. Predominantly, a psychosocial approach was inherent in these programmes and did not consist of any medical interventions such as opioid substitute prescribing or opioid detoxification programmes. Although these interventions were available within the prison environment, the prison drug intervention became popularly known as the 'prisoner diversion scheme' (NGO Director, Interview 5). Total abstinence from drugs and the reintegration of prisoners back into society were the ultimate goals. Prison drug interventions were

introduced virtually without any research evidence on the nature and extent of the drug problem in prisons apart from some offender data on the distribution of prison admissions by type of drug. This, on average between 1998 and 2004, stood at 88% for heroin, 11% for cannabis and the remainder for other types of drugs (NDDCB, 2005). Interventions for prisoners with drug problems also took place in the absence of a publicised policy or strategy on prison drug treatment.

Drug Dependant Persons Treatment & Rehabilitation Act 2007.

The Drug Dependant Persons Treatment and Rehabilitation Act No 54 of 2007 aimed to regulate drug treatment centres, including the introduction of a legal licensing requirement to establish private treatment centres for the purpose of drug treatment and rehabilitation. It also provided powers to the police and the courts, following a medical examination, to admit a person to a designated[14] or licensed[15] treatment centre for compulsory treatment and rehabilitation.

The committee which formulated the drug treatment and rehabilitation Act was led by the Government Legal Draftsman and included representation from the NDDCB, Prisons, Ministry of Social Services, Attorney General's Department, Department of Police and the Ministry of Health. During the drafting period, the NDDCB took a leading role in articulating the required standards for private treatment and rehabilitation centres. The minimum standards included describing the range and content of facilities and services for those undergoing treatment, the qualifications of the staff running the treatment programmes and management arrangements for the centres. Additionally, a regulatory and an inspection role, which issues licenses and monitors the implementation of standards in private treatment centres, was awarded to the NDDCB through

[14] President Mahinda Rajapakse, on the recommendation of the NDDCB, designated Pallekele, Wataraka, Taldena, Weeravila, Anuradhapura, Pallensena, Kandhawatta and Meethirigala prisons as treatment and rehabilitation centers of the government as per No1653/19, 12th May 2010 extraordinary gazette notification.

[15] Private or non-government treatment parties have to obtain a license from the NDDCB to establish a drug treatment and rehabilitation centre.

this Act. There had been unanimous support from all parties involved in drafting this Bill for inclusion of such provision due to the professional reputation of the NDDCB, its knowledge and expertise on the subject matter and it being government-led (Policy-maker, Interview 3).

Compulsory Treatment and Human Rights.

Although the Act was introduced in 2007, the idea of compulsory treatment had been suggested at the SAARC much earlier. Legislation and the provision of facilities for compulsory treatment were first identified in the first national policy on drugs in 1994. While these were highly significant policy markers which later acted as drivers for the introduction of this Act, policy-makers at the NDDCB had mixed views about the success of community drug treatment and rehabilitation programmes, due to high drop out and relapse rates. These factors, along with external influences as discussed in the previous chapter, influenced the NDDCB to explore treatment and rehabilitation in prisons (Policy-maker, Interview 2).

Over the last two decades, the number of community drug treatment and rehabilitation centres initiated by the NDDCB and the NGO sector grew significantly. Similarly, the number of prisoners receiving drug treatment and rehabilitation as part of the prisoner diversion scheme also expanded. However, the number of available treatment spaces, in view of the increasing number of imprisoned drug users, was not considered to be sufficient. According to the Handbook of Drug Abuse Information (2007), of those who were admitted to prison for a narcotic related offence, only 10% entered treatment in 2000, 11% in 2004 and 12% in 2006. This treatment gap, as discussed in the previous chapter, was of concern to UNODC officials and some senior civil servants working in the Ministries of Foreign Affairs and Justice. It occurred in a wider context of human rights allegations being levelled against the government by the UN. As discussed in the previous chapter, the Sri Lankan government at that time attached greater importance

on the drafting of legislation in order to comply and give effect to the 1988 convention on illicit traffic in narcotic drugs and psychotropic substances. Moreover, drafting new and amending existing legislation to promote human rights and good governance was on the government's agenda and received high priority in order to satisfy an international audience to ensure that Sri Lanka continued to benefit from trade concessions awarded through the GSP[16] scheme.

The need to regulate private treatment and rehabilitation centres was periodically raised by government and non-government agencies due to alleged human rights violations committed by organisations in the name of 'treating' drug users for their addiction (NGO Director, Interview 1). Some of these allegations include: beatings, tying to trees, forced labour, denial of food, restrictions on the means to contact friends or family, and isolation (NGO Director, Interview 1). Although the government's priority was to draft legislation giving effect to the 1988 UN Convention, the NDDCB thought it was opportune to include legislation regarding drug treatment and rehabilitation, to ensure that the overall numbers in treatment would increase through compulsory prison treatment. This was based on the belief that better outcomes can be produced when drug users can be contained within a closed environment for a longer period with few opportunities to drop out of treatment (Policy-maker, Interview 2). The NDDCB's agenda regarding the regulation of private treatment centres, including making it an offence to physically or verbally abuse those in treatment was combined into the same 2007 Act, due to major delays experienced generally in drafting and enacting legislation at the time (Policy-maker, Interview 2). Although compulsory treatment had been on the NDDCB policy agenda for a number of years, it had received little political support or priority. However, due to political pressure being applied by the UN to introduce legislation to give effect to the 1988 UN convention, the outcome was to concurrently draft two separate pieces of legislation: one concerning the illicit

[16] The European Unions (EU) Generalised Scheme of Preferences (GSP) allows developing country exporters to pay less or no duties on their exports to the EU. However, it is granted to countries which ratify and implement core international conventions relating to human and labour rights, environment and good governance.

traffic in narcotic drugs and psychotropic substances and the other for the treatment and rehabilitation of drug users. The upshot was tabling and debating both legislative drafts in Parliament following Cabinet approval. As one policy-maker who was involved in formulating the compulsory treatment Act stated:

"The Minister of Justice understood the political importance of this at international level and was able to move things for us fast and the draft Bill on psychotropic substances, alongside the draft treatment and rehabilitation Bill was finalised. The legal draftsman had to prioritise finalizing these draft Bills over others. So, what really happened was, along with these two Bills related to our area, the draft Bill on international covenant on civil and political rights was tabled in Parliament all at once. The process was fast because the government was very keen on obtaining GSP incentives for the country" (Policy-maker, Interview 3).

Part two of the Act that looked at voluntary admission to a treatment centre states:

"Upon admission, such person may continue as an inmate of a treatment centre, until the assessment panel[17] and the medical officer in charge of the treatment centre are of the opinion that he may be discharged as he has successfully completed the course of treatment undertaken. Conditions for discharge shall be determined by the rules of each treatment centre" (Drug Dependant Persons Treatment and Rehabilitation Act No 54 of 2007:4).

Within this background, a drug user could voluntarily seek treatment in the community but their discharge from treatment is dependent on the outcome of

[17] The Minister in charge of the subject appoints persons to assessment panels. The function of the assessment panel consist of biopsychosocial assessments of people seeking admission to treatment centers either designated or licensed, their level of motivation to become abstinent, progress made whilst in treatment and the recommendation to the NDDCB on the discharge of inmates.

a decision of an assessment panel. A human rights violation exists when forced treatment takes place following a voluntary admission to a treatment centre, as it can infringe on a person's movement or the deprivation of their liberty without a lawful conviction or following a due court procedure (NGO Director, Interview 1). Although NGOs were not consulted during the drafting of this act, an NGO Director who was involved in drug education and prevention work, opposing compulsory treatment stated:

"We were not consulted as such on drafting this act. It was the NDDCB that was very much involved in the whole process. Many people have bought compulsory treatment because of the criminality attached to drug use and this government is tough on drugs or at least they are seen to be tough on drugs. This is mainly because we have continued to follow a deterrent approach in Sri Lanka. But, I am of the view that compulsory treatment doesn't work. Its a decision the drug user has to take. The moment you bring in this kind of compulsory treatment, and I think that is probably why we have hardly had any referrals in the last few months, people don't come forward seeking help. They may be frightened to disclose their drug use because of compulsory treatment. So, what's going to happen is they will further go underground" (NGO Director, Interview 1).

The majority of Chairs of the NDDCB supported compulsory treatment despite their various professional backgrounds and experiences. It was partly due to the belief of it being able to benefit a large number of people with drug addiction, which would subsequently control drug abuse and addiction and would benefit society as a whole. The criminal justice system was viewed as the method to bring drug users into treatment, so as to safeguard and promote the interests and well-being of the community at large (Policy-maker, Interview 3). There had also been a belief that drug users should be integrated back into society and make them economically active through rehabilitation programmes. The ideal of rehabilitation was seen as a means to instil lost or deteriorated morals of behaviour in those who used drugs and it had prevailed for over two decades since its introduction in the late 1980s. It continued to be regarded by

the majority of policy-makers and politicians as the panacea to the drug problem. With the introduction of the 2007 Act the police, prisons and courts were awarded a formal role in the rehabilitation of drug users.

The widening of police powers to arrest suspected 'habitual' drug users for examination by a government medical officer before being produced before a magistrate is a key tenet of this Act. As a policy-maker involved in the formulation and implementation of this Act stated:

"When you take for example a drug dependant, in the past police could not arrest them unless they possessed heroin or some other illegal drug. Now with this act, the police can arrest a person whom they suspect of using drugs. That's the first step. Once the arrest has been made, the police can refer the individual to a doctor. We have informed all doctors in the country with a circular to submit their reports when a request is made by the police. Second step includes obtaining that medical certificate to say if that person is a drug dependant or not. With that report, the drug dependant will be produced in front of a magistrate. Finally, the magistrate can decide on the punishment. The drug dependant then can be sent to treatment for 6 months 1 year and so on. This is the act in a nutshell" (Policy-maker, Interview 2).

The magistrate can sanction that person to receive compulsory treatment and rehabilitation at any treatment centre designated or licensed under the Act. The Act would appear to be flawed with an infringement of human rights arising out of the police having the power to arrest people suspected of using drugs irrespective of whether a criminal offence had been committed. The police were also given the power to apprehend anyone absconding from a programme and return them to the treatment centre (Drug Dependant Persons Treatment and Rehabilitation Act No 54, 2007).

The Act's unintended consequences may result in compulsory treatment being applied to a person not based solely on them having a drug problem, but upon

an infringement of another drug law relating to e.g. possession. It is also likely to deny an individual the opportunity to cease or modify their treatment plan or to review their need for treatment (Psychiatrist, Interview 4). There could be further limitation in that compulsory intervention will not be provided for longer than required. The majority of drug users are also likely to exist outside the treatment system due to the fear of being locked away following disclosure of drug use. A psychiatrist pointed out that:

"This Act has strengthened the police and court system. By doing that, they have further made the drug addict look like a demon and a criminal. People will fear coming forward looking for treatment. We don't know if there will be arbitrary arrest and if drug addicts will be kept in prison for periods unnecessary. The NDDCB also widened their wings a bit more by formally going into prison treatment and again the health sector had been left out of the equation" (Psychiatrist, Interview 4).

Rejection of a Medical Model of Treatment.

There had been some discussion on the use of substitute medication in the treatment of drug use in prisons, which would have given a role to the medical profession. It was suggested by the Ministry of Justice representative who took part in the committee that looked at implementation of the Act. As per the minutes held by the NDDCB Secretariat:

"When the committee was considering the topics of programme, the Chairman suggested to eliminate the pharmacological model and multi-disciplinary model out of the sub topic 1. As reasons for that he noted, if drugs will be given to the patients, prohibited drugs also will come into the scene. Though Mrs…… (Ministry of Justice Representative) noted the importance of the pharmacological model other members disagreed to use the drugs at the treatment centres. Mr….. stated that, some precursor chemicals are included both in the permitted drugs and prohibited drugs. Though we use only

permitted drugs the addiction can be continued because of that reason. Therefore it was decided that, it is not good to use drugs for treatment. Mr….. suggested that, the patients should be put to work in full and then they can abstain from drug dependence" (NDDCB Minutes of the 4th meeting of the Drug Dependant Persons Treatment and Rehabilitation Act No 54 of 2007, held on 6th August 2008 at 10.30am).

The majority of these committee members maintained a belief in total abstinence as the overall treatment goal. This was the standard response to any emergent opinion for a medical model to be included which could involve substitute or symptomatic prescribing of drugs. Fear was expressed that illicit drugs could become available to drug users if medical prescribing was permitted.

During the Parliamentary debate on the draft Bill, a Member of Parliament identified the need to establish drug treatment within the health sector:

"While it is laudable about the government's intention to treat and rehabilitate drug addicts for the betterment and development of our country, the focus should have also been on building the infrastructure and having a proper system within identified hospitals to cater towards the treatment needs of drug addicts. We should create a system where a drug addict can go into a hospital and receive treatment from a doctor. Unfortunately this does not happen in our country. This gap should be tackled within our health service and we should take steps towards developing the necessary policies and systems" (Hon. R. M Pathma Udayashantha Gunasekera, Hansard, 10th October 2007: 1035).

The medical role continued to be marginalised as the management and treatment of drug problems became more embedded within the criminal justice system. At an organisational level, the role of doctors in the management of the drug problem continued to have less significance as policy-makers within the

NDDCB defined the drug problem as a social issue within the responsibility of an established legal punitive framework.

Conclusion.

The discourse which emerged in the early 1980s regarding drugs as an existential threat to national security and sovereignty gradually intensified due to the effects of terrorism and its links to drug trafficking, which in turn strengthened the principle belief in an absolute prohibition on drugs. The NDDCB, together with law enforcement agencies and politicians, had a significant influence in shaping the national policy landscape. Policy-making inside this milieu became institutionalized within the NDDCB where its expertise on matters related to drug control incrementally grew and was regarded as a national epistemic community by both national and international policy actors.

Strong moral influences prevailed whereby drug use was criminalised and the drug user was demonised and these views continued to exist both within and outside the NDDCB. These influences existed within a broad Buddhist cultural framework where abstinence from drugs was the desired outcome. The rehabilitation ideal gained momentum throughout the period under investigation as it had the support from politicians, prominent Buddhist monks and the NDDCB. Rehabilitation was regarded as a means to instil lost or deteriorated morals of behaviour in those who used drugs and was in congruence with those who advocated abstinence.

Attempts to define the drug problem as a matter for the health sector were endlessly defeated by stakeholders who believed that the drug problem is a ‘social issue’. Stakeholders predominantly endorsed psychosocial interventions as treatment responses located within the criminal justice system. The NDDCB, who strongly believed in this approach, widened its remit from policy development to include the provision of drug treatment and rehabilitation. The

Ministry of Health's lack of interest in drug treatment and their covert support for a punitive response to the drug problem stood in the way of defining the problem as a concern for the health sector. The Executive President's interest and involvement in matters related to drug policy and legislation had also been a significant driver for the continuity of a penal approach to managing the drug problem.

The regulation of drug treatment centres and the introduction of compulsory treatment which had been on the policy agenda for a considerable period became a policy reality when the government prioritized enacting legislation to give effect to the 1988 UN conventions that Sri Lanka was a party to. As trade concessions were attached to nations in compliance with the UN drug control, enacting legislation to give effect to these conventions gained immediate political and policy action as the economic benefits were considered as enormous.

Chapter Seven: Politics of Drug Policy-Making

Introduction.

This chapter describes the political climate in which drug policies evolved during the period under discussion. Consideration is given to the ideologies, interests and influence of stakeholders operating at the political level. Particular attention will be paid towards the power structures and their association with stakeholders who had a keen interest in shaping drug policies. The President's influence on policy-making, particularly to deter drug-related crime, and the political rhetoric involved in drug policy-making will be explored.

The relationship between prohibition and the moral underpinning to policy-making discussed in Chapter Six will be explored from the point of the political perspective. It is argued that the legitimisation and continuation of a penal approach to managing the drug problem was endorsed by powerful politicians and elite stakeholders and was inextricably linked to the need to maintain a moral and secure society. However, the role of political groups active in the area of drug policy and service provision require examination so as to understand their ideological positions and power to influence governmental decision-making. Of particular importance is the examination of prominent Buddhist monks who have significantly influenced the development of drug policies.

The identification and involvement of tobacco and alcohol lobby groups, their interests and ideologies in policy development is worthy of study as they set the scene for drug policies developed after 2004. It is discussed how and why alcohol, tobacco and drugs became political tools in contemporary drug policy-making. In addition to previous discussions on why a medical conceptualisation to the drug problem did not exist, this chapter will explore why a public health approach to managing the drug problem did not receive any support and describes the factors which allowed elite stakeholders and politicians to

maintain the penal approach. Finally, this chapter will conclude by discussing how the use of evidence and information was utilised to maintain the policy status quo.

Ideological Views held by Elite Stakeholders and Presidents.

The previous chapter described the co-operation and consensus achieved by senior staff working in the government: the Executive, Ministries of Defence and Justice and the Attorney General resulting in legislative changes to drug laws including the introduction of the death penalty for drug-related offences. President J.R Jayawardena was the significant force behind the introduction of the death penalty for drug-offences in 1984. President Ranasinghe Premadasa was instrumental in formulating the first national policy on drugs beginning in 1994 and maintaining a tough law enforcement approach. Similarly, President Chandrika Bandaranaike Kumaratunga and President Ranasinghe Premadasa had also been keen or seen to be keen on stringent law enforcement. The fact that the President, the most powerful politician in the country, had a keen interest in, and control over drug policy, is indicative of its importance to the core of economic, political and social decision-making. The President was not alone in developing drug policies or making executive decisions. In addition, the ideologies of the stakeholders, such as civil servants, who came into contact with the President had a significant influence in establishing the drug policy-making environment and in determining law enforcement as the dominant approach to managing the problem.

Following on from the enactment of the national constitution in 1978, the offices of President and the Ministry of Defence were established. Law enforcement as the method to tackle drug problems became the preferred policy option shared by all successive Presidents, although, some intensified enforcement activities more than others (Member of Parliament, Interview 13). The NDDCB was located within the Ministry of Defence along with the three armed forces (Army, Navy and Air Force), Department of Civil Defence, National Cadet Corps, Veteran's Welfare Authority, Sri Lanka Coast Guard, Department for

Registration of Persons, State Intelligence Service and the Defence academia. During the period under investigation, as per the Sri Lanka Gazette Notifications on Ministries and Functions, the portfolio of Minister of Defence was held by the President, except on a couple of occasions and for a brief period when a Cabinet Minister held this portfolio. Overall, drug policies have evolved within a Defence Ministry where national security was the core principle. The President was in charge of the NDDCB and Defence Ministry, hence drug problems viewed as a significant threat to national security, sovereignty and socio-economic development was not surprising as drug supply was considered to be part of fund-raising activities by the LTTE. Initially, the development of drug policies had been initiated by external stakeholders but their continuation became a security concern at national level, by association with the ongoing war in the north and east with the LTTE from 1983. The view that drugs were of concern for national security was strengthened and solidified by civil servants who worked closely with the President. A civil servant who had been advising one of the Presidents stated:

"As an advisor to the President, we play various roles and it is not just limited to the subject of drugs although previously I was appointed as a member of the drug control board when I was functioning as the Secretary to the Ministry of Defence and therefore had knowledge on the subject matter. Not only this, I used to represent Sri Lanka at UN meetings on drug control. So, I was very much in tune with the legal requirements. My advice to the President has been mainly around law enforcement to combat the drug menace. I believe that we should keep the NDDCB within the Ministry of Defence because of narco-terrorism and the threat we had from the LTTE. It means the President can keep a close eye on enforcement. Also, narcotics in general had a huge impact on our poverty alleviation programmes" (Civil Servant, Interview 11).

The civil servants working within the Ministries of Defence, Justice, Foreign Affairs and the Attorney General's Department influenced the amendments to the Poisons, Opium and Dangerous Drugs Ordinance during the early 1980s and in the creation of the first national policy on drugs in 1994. They had been

influential in establishing the ideology of prohibition in government departments, including the office of the President. This significantly helped the senior police officer who initiated the amendments later made in the Ordinance.

According to interview data and annual reports produced by the CND following meetings with member states, the majority of these civil servants came into contact with epistemic drug policy actors representing the Colombo Plan, UNODC, US and SAARC when attending CND and Colombo Plan meetings on drug control. These international actors, as discussed in Chapter Four, had an influence in channelling aid to Sri Lanka. They held the principal belief of adopting prohibition and punishment for dealing with drug-related offences. The senior civil servants were also aware of some of the pre-conditions for obtaining foreign aid to fund development projects, which also became a priority for the President in office. Applying a punitive paradigm towards managing the drug problem had been beneficial for both external policy actors as well as governments when considering the need for funding poverty-alleviating projects. This was conveyed by a civil servant as:

"I suppose we needed to check the mood of potential international donors when we went to UN and other meetings and this is something we clearly communicated to the President as we had a lot of projects and ideas for poverty alleviation that needed funding. These donors were mainly interested in member states signing up to the UN drug control conventions and implementing them locally" (Civil servant, Interview 12).

According to interview data, civil servants holding the senior post of Secretary at the Ministry of Defence had close contact with the President when the Defence responsibility was included within the office of the President. This was particularly the case when the President had also been the Minister of Defence. Advice on drug law enforcement had been given to the President by these civil servants. Some of them subsequently became presidential advisers, a formal position within the Office of the President. Overall, civil servants adhered to the

principle belief in prohibition as the goal and the causal view that drug use was a barrier to the alleviation of poverty. This belief prevailed throughout all the branches of the government departments and the President's Office (Member of Parliament, Interview 13). The concurrent war in the north and east with its links to terrorism and drug supply can be seen as significant reasons for the Ministry of Defence to retain responsibility for the NDDCB from its establishment in 1984 as it could continue to be closely monitored from the President's office. Furthermore, there were no interest groups or voices that lobbied the President about an alternate approach or about shifting the NDDCB under a different Ministry.

The Moral Framing of the Drug Issue.

A common view amongst those advising the President on drug policy during the period under consideration was their concern with morality, about good citizenship and socially accepted behaviours. Consequently there was a moral underpinning to the policy-making and political concerns at the time. Their moral ideology regarded drugs as dangerous, threatening to cultural values and as evil substances that compromise the values in Sri Lankan culture. State intervention and tough law enforcement were seen as legitimate responses to foster moral and upright behaviour. These presidential advisers believed that state intervention was legitimate to protect Sri Lankan culture and national progress. Public opinion had also been supportive of this approach as drug addiction and dealing were considered to be behaviours compromising the moral values of Sri Lankans. Some of the newspaper articles published on the topic of drug addiction undoubtedly perpetuated these moral crusades. For example, some titles of articles appearing in national newspapers included;

“The scourge of illicit drugs and the insidious socio-economic impacts of drug trafficking” Wickremasinghe (2003) The Island Newspaper, Tuesday 4th November, 2003.

“The twin menace of drug addiction and trafficking” Jayasinghe (2003) Sunday Observer, Sunday 22nd June 2003.

“War on drug menace heightened” Jayasinghe (2005) Sunday Observer, Sunday 4th December, 2005.

Some newspaper articles were written by retired senior civil servants and lay people of prominent standing in Sri Lankan society. The articles used words such as ‘dangerous’, ‘scourge’, ‘evil’, ‘pest’, ‘menace’ to describe the drug problem. Often, the risks associated with drug use were dramatized in the media, how it damages families and familial economy. The suffering in civil society due to drug related crime and moral decay had been blamed for many unhappy conditions and events in Sri Lanka. Significant hostility towards drug dealing and addiction was shown by the morally righteous community who described drug problems as the public enemy. A majority of newspaper articles justified and supported state intervention to eradicate the drug problem against this background.

Presidential Response to Drug-related Crime.

According to the annually published Handbooks of Drug Abuse Information from the NDDCB during the period 1995-2007, a steady growth is seen in the number of people imprisoned for drug-related offences (See table 5).

Table 5: Drug-related prison admissions *(Data not available for the year 1999)*

	1995	1996	1997	1998	2000	2001	2002	2003	2004	2005	2006	2007
Cannabis (n)	608	400	394	574	1002	933	1176	1307	2734	4565	3952	5065
% of drug admissions	11.7	5	5.5	7.1	11.9	11.6	11.9	12.6	26	33.9	38	44.1
Heroin (n)	4565	6949	6742	7625	7345	7066	8637	9076	7772	8861	6423	6386
% of drug admissions	88.1	95	94.4	92.9	88	88.3	88.1	87.4	73.9	66	61.9	55.7
Other (n)	8	0	3	0	4	3	4	5	13	9	9	27
Total drug-related admissions (n)	5181	7349	7139	8199	8351	8002	9817	10388	10519	13435	10384	11478
Total prison admissions (n)	15893	17769	18135	20800	18715	22239	25023	27681	26898	33034	28723	31306
% of all drug admissions	32.6	41.3	39.4	39.4	44.6	36.0	39.2	37.5	39.1	40.7	36.2	36.7

When considering the entire prison population, those admitted for drug- related offences is the largest single category, averaging 38.6% for the years shown. They included both the remand and sentenced population. Although most of the enforcement action initially focused on heroin, there was an eightfold increase in those admitted for cannabis-related offences.

Enforcement action against cannabis had been incremental and strengthened over time, which indicates that equal importance had been given to the arrest and processing of cannabis users and dealers as of heroin users and dealers. However, there had been calls to be even more stringent on drug law enforcement and to exercise capital punishment as a deterrent. Although the death sentence for drug-related offences was introduced by President J.R

Jayawardena in 1984 as part of legislative amendments made towards the Poisons, Opium and Dangerous Drugs Ordinance, its application was symbolic as there have been no executions of drug users or traffickers from 1984 to 2008. However there have been many death sentences passed for drug users and for traffickers during the same period (Gallahue and Lines, 2015). When a death sentence is issued, the presiding judge states that the person should be imprisoned and executed at a time nominated by the President. However, none of the Presidents in office have implemented the order, which in effect suspends the death sentence effectively to one of life imprisonment. In keeping with the line of a tough law enforcement approach, some civil servants have petitioned the President that the death penalty should be implemented for drug traffickers:

"In line with the law of the land judges sentenced people to death. But it has never been implemented since 1976. I also advised (The President) that the death penalty should be restored for drug traffickers. I mean they are the big guys who corrupt our society and without going for the big guys you can't cut the supply of drugs coming into the market. I think that's why we haven't been able to wipe out this evil" (Civil Servant, Interview 11).

Advice provided by civil servants to President Chandrika Bandaranaike Kumaratunga[18] concerning the implementation of the death sentence for drug trafficking took place within the broader context of a rising number of drug-related crimes, violent offences, murder, child abuse and rape within the country (Sri Lanka Police, 2005; Jayasundara, 2004). Mainstream political parties, the media and some Buddhist clergy also lobbied for tough laws to curb the rise of crime and the implementation of the death sentence (Member of Parliament, Interview 13).

[18] President Chandrika Bandaranaike Kumaratunga served as the fifth President of Sri Lanka from 12th November 1994 to 19th November 2005.

There had been unanimous support in Parliament for President Kumaratunga to pass a resolution in 1995 to implement capital punishment. In 1999, President Kumaratunga did implement it by issuing a Presidential Proclamation, so it would become a deterrent to organised and serious criminals in the country. However, in the face of strong opposition from national and international human rights groups, the death sentences have been automatically commuted to life imprisonment (Interview data; Asian Centre for Human Rights, 2004). In January 2001, the government revoked this decision to automatically commute the capital punishment sentence to one of life imprisonment.

Implementing the death penalty was raised again following the assassination of a prominent High Court Judge Sarath Ambepitiya and his bodyguard on 19th November 2004. The deaths were suspected of being an order from a major drug trafficker. Justice Ambepitiya had a reputation for his tough verdicts and had given a life sentence to a woman who had trafficked drugs on the day of his assassination (Asian Centre for Human Rights, 2004). A judge being assassinated for the first time in Sri Lanka and the link to a drug trafficker was a major political concern due to the implications for state security and the independence of the judiciary (Member of Parliament, Interview 13). Afterwards President Kumaratunga seized the opportunity to again try to implement the death penalty for the crimes of murder, rape and drug trafficking (Asian Centre for Human Rights, 2004). Capital punishment for convicted drug traffickers had been a politically charged issue and appears to have been associated with politicians' perceptions of the will of the electorate.

Political Lobbying.

Drug prohibition was one of the few subjects on which all the major political parties in Sri Lanka could all agree as non-partisan government policy. Cabinet Ministers and the majority of Members of Parliament both in government and opposition agreed on all the major legislative changes enacted by Parliament concerning drugs. Although a well-established political party system should

encourage debate on proposed drug policies, there were no strong voices or opposition within or outside government to follow any course other than prohibition. Rather, the President, Cabinet and the Parliament have all concurred to maintain or expand tough law enforcement policies. While the legitimisation of prohibition was inextricably linked to the need to maintain a more moral and secure society, prohibition also served the agenda of politically active groups and the electorate (Civil Servant, Interview 11). As mentioned before, there were economic imperatives to maintaining strict sanctions against drug trafficking and drug use, and attempts to frame the issues in medical terms had little success.

The Public as a Stakeholder.

The public, as a stakeholder in the policy-making process, cannot be overlooked as their demands to take action to curb the drug problem had influenced politicians. Although there is no linear relationship between public opinion and drug policy, politicians had been acutely aware of their constituents' attitudes towards drugs. There had been substantial popular support in the prohibition of drugs whereby the public had exerted influence on the President and some Members of Parliament in maintaining tough law enforcement approaches to manage the drug problem. These electoral requests had been put forward by Buddhist and Christian priests, professional groups and business entrepreneurs whose communities were affected by heroin use and dealing (Member of Parliament, Interview 13). They emphasised that the activities of organised gangs with links to violent crime and drug supply were vices disrupting their local communities. Public requests often carried moral overtones and included social and economic concerns. The rhetoric of law and order occupied a major position within the political agenda due to public requests and might have been used for electoral advantage by politicians. Targeting law enforcement in affected electorates had been the outcome of some of these public requests. A senior civil servant, describing the public demands made on the President stated:

"Now I remember there had been a number of requests from people in electorates when the President visited them. They were really affected by heroin because there was a lot of crime committed by drug addicts. People couldn't even keep their plants or clothes to dry out in their gardens because drug addicts stole them to buy heroin or whatever. Those who sold drugs were part of the underworld and are violent criminals and they made sure that their business was not affected. The President was concerned about her own electorate and I remember after a long discussion she instructed the Police to conduct raids in her own electorate" (Civil servant, Interview 12).

Similarly, religious leaders had also requested politicians to intervene and curb the drug problem. Ananda Dassanayake, Member of Parliament, during the Poisons, Opium and Dangerous Drugs Ordinance Amendment Bill, referring to the views held by the clergy stated:

"Deputy speaker, the Davasa Newspaper on 22nd March 1984 alludes to the views held by Valpola Rahula, Madagama Vajiragnya and Maduluwey Sobitha, Buddhist priests and Father Oswald Gomes on the drug problem. Our clergy says that we need to save our children from this dangerous menace" (Ananda Dassanayake, Hansard, 22 March 1984: 637).

A Member of Parliament who was interviewed also mentioned a more recent request made by some Buddhist monks:

"I remember some Buddhist monks in my electorate coming to see me on my public day to talk about the heroin problem. They were helping some families affected by heroin through their temples. The breadwinners of these families started using heroin and there was no way the families could survive as a result. The family home was no longer a safe place for these people to bring up their children and the entire village was affected by drugs. I brought what these Buddhist monks said to the attention of the local police station" (Member of Parliament, Interview 13).

Buddhist Monks as Stakeholders.

Buddhist monks have maintained close ties with lay people in Sri Lankan society and similarly the state had also kept close ties with the Buddhist monks. Presidents and Members of Parliament had listened to popular public requests as they have the power to reject failed policies by making their voices heard at the polls. Public attitudes towards the drug problem had been utilised by elected officials to legitimise government action on prohibition and strengthen law enforcement from time to time.

In Sri Lanka, some 70% of the population follow the Buddhist faith and the rest are comprised of Hindus, Muslims, and Christians respectively (World Fact Book, 2012). Buddhism and prominent Buddhist monks had often played a significant role in the political affairs of Sri Lanka as political actors employed them to pursue power. As the majority religion, Buddhism had often become a powerful symbol for the Sinhala (ethnic) Buddhist (religious) politicians (Imtiyaz, 2014). Sinhala-Buddhist politicians are divided between the two main political parties, the Sri Lanka Freedom Party (SLFP) and the United National Party (UNP). Analysing the behaviours of these two parties suggest that Buddhism and prominent Buddhist monks had been used by these two parties in their quest for power (Imtiyaz, 2014). In the same way, the role of Buddhist monks, particularly those who were involved in active politics, cannot be overlooked in contemporary drug policy analysis in Sri Lanka.

Buddhist monks' active involvement in electoral politics began as early as 1943 when Migettuvattee Jinananda stood for Colombo Municipality Council election (Deegalle, 2004). It had not however been common for Buddhist monks to be involved in local or national politics, but they had contested some local as well as Parliamentary elections from time to time with little success until 2004. The most radical development in monastic involvement in Sri Lankan politics took place in 2004 when the Jathika Hela Urumaya (JHU), often approximated in English as the National Sinhala Heritage Party, fielded over 200 Buddhist monks to contest the Parliamentary elections. Deegalle (2004) states that this

was a historic event in south and south east Asia whereby a political party led by Buddhist monks were contesting Parliamentary seats. The JHU secured 9 out of the 225 seats in Parliament, or 6% of the vote. The JHU monks became a symbol of Sinhala Buddhist strength within Parliament, gaining an official stake in the making of policies and legislations to address contemporary socio-economic problems.

Although the intention here is not to provide a detailed account on why the Buddhist monks entered politics, the main objectives of the JHU require brief examination before any perspectives on the role of the JHU in contemporary drug policy can be understood. The establishment of a Buddhist state in the context of rising crime and moral decay resulting from breaking the five precepts of Buddhism was the JHU's prime objective (Deegalle, 2004). Peace negotiations with the LTTE at the time were also failing and the JHU was unhappy with party politics of the SLFP and the UNP as both parties were accused of utilising the ethnic conflict for their political advantage in the south of the country. The JHU launched its political manifesto in 2004 in the hope of improving the weakened status of Buddhism, which had strong foundations in Sinhalese nationalism. The JHU utilised the idealised concept of the *dharmarajya* (a righteous state) which had existed in the ancient Buddhist polities of Sri Lanka to their own political advantage (Deegalle, 2004). The righteous society was pledged to be built on the five precepts of Buddhism and as discussed in previous chapters it included abstinence from the use of intoxicants.

Athuraliye Rathana and Dr. Omalpe Sobitha were Buddhist monks who both became firm advocates for the JHU and were elected to Parliament in 2004. They were staunch activists in propagating the righteous society concept. With support from the JHU party members, they strongly believed that intoxicating substances such as drugs, alcohol and tobacco resulted in moral decay, which was an obstacle to achieving the righteous society (NGO Director, Interview 5). The JHU included tobacco due to its resultant health harms, and saw both alcohol and tobacco as gateway drugs for young people progressing to use

drugs such as heroin and cannabis (NGO Director, Interview 5). The JHU commenced a national public campaign highlighting the physical, social and spiritual harms caused by drugs, tobacco and alcohol. They were able to attract the support of organisations such as the Swarna Hansa Foundation[19] and Dharmavijaya Foundation[20], both supportive of temperance and the righteous society ideology. Within this context, the JHU urged the government to take legislative action to regulate both the tobacco and alcohol industries, and to eradicate illicit drugs from Sri Lankan society. This latter point was a prominent part of the JHU's political rhetoric and attracted public appeal.

Lobbying by Alcohol and Tobacco Policy Stakeholders.

Alcohol and tobacco policy development during the 1980s and 1990s involved some individual stakeholders and organisations who were also influential in the development of drug policies. These stakeholders who came into contact with the President occupied prominent positions within Sri Lankan society and were influential in government decision-making processes. The intention here is not to provide a detailed account on the nature of alcohol and tobacco policy development. However, an awareness of the alcohol and tobacco policy-making landscape, the ideologies of stakeholders who had a keen interest in alcohol and tobacco policies is likely to add meaning and perspective in understanding the contemporary drug policy decisions, endorsed or rejected, by the President's office.

During the early 1990s, some temperance supporters believed that the activities of the Temperance Movement were happening too slowly to achieve their goal of abstinence. Consequently, an appeal was made to President

[19] Swarna Hansa Foundation was established in 1979 with the aim of safeguarding the national culture while helping people in a discerned development process. It rejected the use of tobacco and alcohol as they were seen as obstacles for development.

[20] The Dharmavijaya Foundation was incorporated by an Act of Parliament in 1979 with the objective of total development of man, namely, moral, health, education and economic, in accordance with Buddhist principles.

Premadasa, requesting a revival of the Temperance Movement (Nanayakkara et al., 2013). In response, the President established a special committee to inquire into the need for prevention of alcohol and tobacco use in 1992. However, the work of this committee came to an abrupt end when the President Premadasa was assassinated by the LTTE on 1st May 1993 (Nanayakkara et al., 2013). Later, in 1997, President Kumaratunga appointed a new committee to draft a national policy on tobacco and alcohol. According to interview data, this committee consisted of a chair of the NDDCB, some medical doctors who had a keen interest in the development of alcohol policies, and representatives from the Excise Department, PNB, Police, Ministries of Justice, Health, and Education. Its focus was the regulation of the alcohol and tobacco industries due to increases in cardiovascular and coronary heart disease. The committee's report had approval from the Cabinet and concentrated on the elimination of tobacco and alcohol related harm primarily by the banning of alcohol and tobacco in advertising and banning obtaining sponsorship from the industries for social events and the restriction of supply to children and young people under the age of twenty one.

The report produced by the committee pronounced tobacco and alcohol to be major public health problems. It recommended the regulation of the alcohol and tobacco industries through legislative changes as the solution to eliminating alcohol and tobacco related harm. There had been little debate over the care and treatment of those who misused alcohol to form part of any coherent government policy. Although the prevention of illicit drugs was within the remit of this committee, the report stopped short of any different recommendations to address the drug problem. As a policy-maker stated:

"I know that Dr…… was a member of the committee (Committed appointed by the President on alcohol and tobacco) because he had a lot of interest in the alcohol field. At that time he was also the Chairman of the drug control board. As far as I can remember doctors fully supported having a national alcohol policy because of all the health problems associated with it. I don't think

anything came out from that committee for us here at the drug control board" (Policy-maker, Interview, 03).

Although an Act was drafted to enforce the policy directives outlined in the committee report towards the late 1990s, there had been a lack in interest and priority given to the area of alcohol and tobacco regulation due to interference and manipulation by the tobacco and alcohol industries (Nanayakkara, 2013). However, it became topical and a policy priority after the JHU lobbied for tobacco and alcohol regulation in 2004 as part of their wider political campaign to establish a righteous society. It was within this context that the JHU's Buddhist monk Dr. Omalpe Sobita tabled a private member's Bill in Parliament in 2005 (National Authority on Tobacco and Alcohol Bill, 2005) addressing the tobacco and alcohol policy directives outlined in the report produced in 1997. He was backed by the same medical doctors who had assertively campaigned for both tobacco and alcohol regulation in the late 1990s and the two foundations supportive of the Temperance Movement (Policy-maker, Interview 3). These developments led to the passing of the National Authority on Tobacco and Alcohol Act No 27 of 2006 addressing the policy directives previously mentioned. It also paved the way for the establishment of the National Authority on Tobacco and Alcohol (NATA) under the Ministry of Health. These developments in the tobacco and alcohol fields and the policy actors involved set the scene for drug policies developed after 2005.

Alcohol, Tobacco and Drugs becoming Politicised Tools.

Lobbying had been encouraged by the various professional groups such as doctors and lawyers to ensure that their opinions were heard and action could be taken to effect introduction or change in public policy in many areas. The lobbying was mainly aimed at the President who held the power within the Presidency to effect policy change. Political lobbying reached significant levels

during President Mahinda Rajapakse's[21] tenure and there had been demands to additionally enact legislation to control tobacco and alcohol. Consequently, alcohol, tobacco and drugs continued in the political focus during 2004-2008. They had begun to become a political priority primarily due to the JHU's interests in the control and regulation of these substances. The substances were regarded as 'intoxicants', all under this one heading. Politicians argued that use of intoxicants resulted in the compromise of moral values in Sri Lankan society. It was a popular political response by President Mahinda Rajapakse, in both addressing the demands of the JHU and the public to respond with stringent controls. It is considered that political involvement led to 'intoxicants' becoming an important topic and to a paradigm shift. Drugs, tobacco and alcohol were under the political spotlight, forming part of the presidential election manifesto (Mahinda Chinthana, 2005) promising to control them, an approach that had not been rigorously articulated previously by politicians with the electorate.

By 2005, the righteous society ideology had gained momentum and was perceived by the political elites as having a significant impact on the voting public. It had the support of the JHU, prominent Buddhist monks, and supporters of the Temperance Movement and the senior medical doctors who had been part of the committee established by President Kumaratunga to draft the national policy on tobacco and alcohol in 1997. Some of these policy actors also represented the NDDCB, Alcohol and Drug Information Centre (ADIC) and FONGOADA.

President Mahinda Rajapakse formed a coalition with a number of political parties and civil society movements to successfully contest the presidential election in 2005. The JHU was one of these coalition parties who strengthened the righteous society ideology within the political structures in Sri Lanka. Rajapakse had addressed the interests of these coalition parties and utilized their support in attracting the Sinhala Buddhist vote (Member of Parliament,

[21] President Mahinda Rajapakse served as the sixth President of Sri Lanka from 19th November 2005 to 9th January 2015.

Interview 13). This significantly helped him to be elected. The JHU influenced his election manifesto, also known as 'Mahinda Chinthana' (Mahinda's vision), which addressed the establishment of a righteous society and the interests of Sinhala nationalists. Accordingly, 'Mahinda Chinthana' placed a substantial level of importance on establishing a nation free of illicit drugs. Furthermore, areas such as tobacco and alcohol control also gained importance in Mahinda Chinthana. As the election manifesto states:

"I will be dedicated to the task of totally eradicating the drug menace presently experienced in Sri Lanka. I will do so within a period of three years through a co-ordinated effort covering the implementation of laws, the actions of police and other social institutions.

Financial assistance will be extended by the Government to intensify educational and awareness programs against the use of drugs.

Steps will be taken to prohibit consumption of alcohol and cigarettes in common public places.

Government assistance will be accorded to voluntary organisations operating counselling centres to rescue and rehabilitate those addicted to alcohol, drugs and smoking. Towards this aim model rehabilitation centres will be set up by the government covering the entire island" (Mahinda Chinthana, 2005: 4).

This text appeared in the first chapter of Mahinda Chinthana under the title 'Towards a Disciplined Society' whereby the 'physical and spiritual' development of a person was addressed. 'Putting an end to the drug menace' formed part of the righteous society ideology, which signifies the political importance placed on addressing the drug problem within the country. In his election manifesto, President Rajapakse had reiterated the importance of having a moral society where rehabilitation was emphasised as a means to instil lost or deteriorated morals of behaviour in those who not only used drugs but also alcohol and tobacco. The rationale for this blanket approach being applied to all these substances is inextricably linked to them being seen as 'intoxicants' which weaken the morals of Sri Lankans and are contrary to the

Buddhist precepts (Psychiatrist, Interview 4). The goal of total abstinence from 'intoxicants', was a part of the righteous society ideology. It was politically motivated and strengthened by the JHU. As a Member of Parliament explained:

"Athuraliye Rathana's ideas were behind the development of President Mahinda Rajapakse's election manifesto. He was advising the President on the drug issue and he was also behind the 'Mathata Thitha' (full stop to intoxicants) concept. These are just political slogans as they wanted to win the votes of women in villages who were affected by their spouses' alcohol or drug addiction" (Member of Parliament, Interview 13).

'Mathata Thitha' became a popular political slogan used by the United People's Freedom Alliance (UPFA), the coalition led by President Rajapakse. It became a mantra repeated in the workings of his government, public political meetings and messages transmitted to the public by the President's office, the Ministry of Defence, NDDCB and NATA (Member of Parliament, Interview 13). While it addressed the concerns of Sinhala female voters in the south, it was also aimed at Tamil female voters in the country's midlands. Both groups were adversely affected by the influence of the illicit alcohol industry although drugs were also perceived as having a greater role to play in the disruption and income of families. Accordingly, state intervention for the control of drugs and alcohol had public support, particularly from women in rural communities. The Mahinda Chinthana (2005) election manifesto promoted the ideology of abstinence from tobacco and alcohol use and not just from drugs. Government Ministers, the NDDCB and institutions referred to this manifesto message and the slogan of 'Mathata Thitha'. Both had governmental support to be widely regarded as official policy and became the means by which the status quo could be maintained on one hand and on the other, accepted as having populist support.

However, the integrity of the 'Mathata Thitha' policy was questioned as President Mahinda Rajapakse's government and preceding ones relied upon

the legal alcohol industry as a source of additional revenue for the government when there was a shortfall in state financing (Dayaratne, 2011). Similarly governments had raised a significant amount of income through the taxation of tobacco products. Any action that would significantly reduce government income from the legal alcohol and tobacco industries was a major problem which compromised the efficacy of the Mathata Thitha slogan. The continued issuing of liquor licenses or permits for the sale of alcohol had also questioned the sincerity of the government to support its 'Mathata Thitha' slogan (Member of Parliament, Interview 13). Total abstinence from alcohol, tobacco and drugs was merely a political slogan devoid of commitment or action and was merely political rhetoric to attract votes and support. However, the Mahinda Chinthana election manifesto and the 'Mathata Thitha' slogan became the drivers for the introduction of many policies. For example, the Tobacco and Alcohol Regulation Act 2006 and the creation of NATA, the Drug Dependant Persons Treatment and Rehabilitation Act 2007, and the update of the First National Policy on Drugs in 2006.

The Updated National Policy on Drugs 2006.

The updated national policy on drugs was not in stark contrast with the earlier policy published in 1994. It continued to be based on the four pillars; enforcement; preventative education and public awareness; treatment, rehabilitation and after-care; and international coordination. Although these four pillars were slightly different in the updated policy as control over precursor chemicals was inserted due to the external influences. While government ministers and politicians publicly campaigned for the 'Mathata Thitha' slogan whereby eradication of drugs in Sri Lankan society became a political mantra, the revised national drug policy also stated the following:

"The overall goal of the government in relation to the drug problem is to reduce the drug supply and drug use to the barest minimum possibly by 2010" (Revised Sri Lanka National Policy for the Prevention and Control of Drug Abuse, 2006:1).

This drive to reduce illicit drug use had public appeal and was policy at the political level. The inclusion of the above statement in the revised national policy on drugs gives some indication of the political will inherent in the 'Mahinda Chinthana' manifesto to be translated into the national policy document specific to drugs. It is an indication of creating a society nearly drug-free, which again has a political focus in keeping with the promise to the voting public. These factors further strengthened the continuation of law enforcement strategies to control the drug problem and the discourse on abstinence.

The policy update in 2006 can be considered as a hurried response to the prevailing political ideologies concerning drugs, alcohol and tobacco. It reflects the ideologies of doctors and prominent Buddhist monks and the JHU concerns around the establishment of a 'righteous society'. Applying the blanket approach to intoxicants discussed previously, and identifying alcohol as a drug, the updated policy states:

"Licit drug use (licit tobacco products, licit alcohol products) should be discouraged at all levels. Relevant ministries/local government institutions or relevant authorities should discourage licit drug use in public buildings and public places. All forms of drug promotion will be discouraged" (Revised Sri Lanka National Policy for the Prevention and Control of Drug Abuse, 2006:3).

The policy update was led by the NDDCB and had been influenced by the same stakeholders who developed the first national policy on drugs. Additionally, although not formally engaged in policy-making, the views of prominent doctors who lobbied for tobacco and alcohol control legislations and those representing the Temperance Movement influenced the content of the updated policy. Once more, the NGO sector involved in drug prevention, education and rehabilitation work had not been involved or had a role with regards to updating the policy.

In addition to political concerns, the updated policy addressed some of the short-falls related to sentencing procedures for those who are in remand for a drug-related offence. As one civil servant stated:

"The only expert evidence that leads to establish the quantity and that it is a narcotic substance is the evidence of the Government Analyst. There is only a handful of Government Analysts. You will be surprised to hear that sometimes cases are delayed for more than two to three years because the report of the Government Analyst is not available. So, the offender is sometimes in custody until the report is made available" (Civil Servant, Interview 9).

This had been raised on a number of occasions by the legal profession and by middle class families whose relatives had been held on remand for a significant period due to delays encountered in preparing drug analysis reports to the court by the Department for the Government Analyst (Policy-maker, Interview 7). The NDDCB believed it was opportune to address this in the updated policy in the hope of instigating action by criminal justice agencies to resolve the problem.

Public Health Approach.

The means to manage the drug problem had been firmly embedded within the criminal justice system since legislation was amended in 1984 and there was no shift in later policy during the period under investigation. Any paradigm shift away from the criminal justice approach had not been discussed or advocated by politicians or the NDDCB who had been influential and had a role in drug policy-making, in particular by those directly involved in the treatment and rehabilitation of drug users. There are a number of restraining factors which stood in the way of framing the drug problem as a public health issue, and in balancing public health and national security in order to create healthier and safer communities which is a measure of the success of drug policies on drug use and on the public's health. The focus of this next section will be on the

prevailing factors for adopting or rejecting a public health approach to managing the drug problem. Accordingly, the prevailing ideologies, rationale and the role of government and non-government stakeholders who had a keen interest in drug demand reduction is worth exploration.

The previous chapters discussed how external policy actors, government ministries and departments and the NDDCB supported policies and programmes that were managed by the criminal justice system, with abstinence as the only goal of drug treatment. Similarly, the FONGOADA, which represents a significant number of NGOs involved in the area of demand reduction also advocated abstinence. The NGOs falling under the remit of FONGOADA are predominantly involved in prevention, drug education and rehabilitation programmes. According to interview data, the FONGOADA since its inception in 1987 was partly funded and endorsed by the NDDCB and had been recognised by the government as the organisation that represents NGOs working in the field of drugs. The NDDCB periodically consulted and attained support from FONGOADA to implement national drug policies and programmes already endorsed by the NDDCB.

The FONGOADA was led by influential people of prominent social standing in Sri Lanka who had close relationships with elite stakeholders involved in drugs, tobacco and alcohol policy-making. On its executive committee were epistemic community members of the NDDCB who functioned as ex-officio members, including Buddhist monks involved in delivering drug rehabilitation (Policy-maker, Interview 8). The FONGOADA had a principle belief in the prohibition of drugs and a causal belief that drug use is an obstacle to individual development and poverty alleviation. As discussed earlier, these beliefs were initially diffused by external policy actors such as the Colombo Plan, SAARC and the UN and later accepted by the NDDCB. The Colombo Plan funded study tours and awarded scholarships to some members of FONGOADA to learn about drug rehabilitation models in Singapore, Malaysia, Thailand and the USA (Interview data). This led to the development of a network of NGO representatives who later supported the rehabilitation of drug users and the goal of abstinence.

The idea that drug use is a social problem was widely supported by the NGOs falling under the remit of FONGOADA where the prevention of drug use and rehabilitation of drug addicts became the main policy responses. This concurred and helped the government in maintaining the status quo and the continuation of a penal approach to managing the drug problem for over two decades since legislation was enacted in 1984 whilst also supporting abstinence as the only treatment outcome.

There had been little support and endorsement by the FONGOADA for the introduction of harm reduction policies and programmes which supported a public health approach. Any NGO supporting the adoption of harm reduction policies and programmes had difficulty in obtaining membership of the FONGOADA as a gate-keeping role had been adopted to ensure that harm reduction was kept off the agenda due to ideological differences. As an NGO Director stated:

"In fact quite a number of people asked why we have not been consulted on a number of policies. Although they say that FONGOADA represents NGOs quite a number of NGOs are excluded. So, this is not inclusive policy-making as there has not been a robust consultative approach taken. FONGOADA basically wants to follow the government line of approach, not upset anyone in the drug control board and not include anyone who believes in harm reduction. It is biased towards certain institutions and engages in institutional politics" (NGO Director, Interview 1).

As discussed in Chapter Four, some of the NGO representatives who diffused and advocated for the adoption of harm reduction policies and programmes had observed or worked in methadone prescribing clinics and needle exchange programmes existing in the UK and USA. They later attempted to introduce these practices within the context of a lack of any medical conceptualisation of the drug problem in Sri Lanka and the country's medical profession rejection of the inclusion of addiction treatment as part of its health service. Their voices

were not heard as they were located on the margins of policy-making. In general, those who advocated for a harm reduction approach believed that drug addiction is a relapsing condition and eradication of drugs in Sri Lanka was an unrealistic goal. They believed in applying a more humane criminal justice policy which looked at the needs of the drug user:

"We know that with so much of law enforcement over so many decades in many different countries, none of the countries have been able to wipe out the availability of drugs. Every year in Sri Lanka we have more drugs being seized, more drug related prison admissions and more drug addicts reported despite all our efforts. So, we have to be realistic with what we can do with the drug problem, help drug addicts who are really the victims here and their addiction rather than just locking them up in prison or in rehab and think the problem will go away" (NGO Director, Interview 1).

The proponents of a drug-free society stated that a harm reduction approach would help a drug user retain their addiction through opioid substitute prescribing and would send a contradictory message against the prevailing prohibitionist policy and goal of total abstinence (Civil Servant, Interview 6). It would also conflict with the causal belief that drug use, even in smaller quantities, would have a detrimental effect on development and poverty alleviation. The official view was that a tough law enforcement approach would both reduce the size of the drug market and amount of illicit drug use. In this context, the NDDCB and FONGOADA as authoritative groups in drug policy-making and implementation, united to reduce the influence of interest groups who advocated a different drug policy response which would potentially threaten the abstinence ideology and status quo. It minimised the opportunities for interest groups who advocated on harm reduction to enter the existing power and decision-making structures of drug policy-making.

The political and religious environments in which drug policies emerged and intensified during President Rajapakse's tenure, appear to have limited the

debate about a harm reduction approach. Of particular importance are the policies of the JHU and the coalition government led by President Rajapakse, where a righteous society was propagated based on abstinence from all intoxicants and how this would conflict with the principles of harm reduction. Some policy-makers believed that any proposal on harm reduction in this context would result in immediate rejection by the political leadership as it would be contrary to the revised national policy on drugs and the 'Mahinda Chinthana' manifesto:

"I don't think it would have been possible to introduce things like needle exchange schemes or even methadone prescribing in Sri Lanka in this very sterile religious environment. I can imagine hissy fits thrown by some of our clergy involved in politics taking their protests to the streets for something like this. This will immediately get the backs up of our politicians. Also, harm reduction would be totally against what's said in the election manifesto and the recently revised national policy" (Psychiatrist, Interview 2).

Less harmful ways of drug use were regarded as promoting evil, illegal and immoral activities. Any message against abstinence and an introduction of harm reduction policies and programmes would be routinely rejected in particular by powerful Buddhist monks who were staunch supporters of abstinence. The principles inherent within a public health approach to managing the drug problem were not compatible with the prevailing moral, political and religious ideologies that were endorsed by the coalition government. Additionally, there was no significant, legitimate and sufficiently strong opposition able to enter into the existing power structures to advocate on an alternative approach such as harm reduction.

Politics of Evidence and Information on the Drug Problem.

There is little robust scientific evidence regarding the extent and nature of the drug problem and policies in Sri Lanka. Hence, this makes it difficult to report

on the use of valid data which would inform the development of drug policy. However, official use is made of what data is collected and it is argued that this paucity serves to sustain the existing policy and practices. Of particular significance is how the evidence and information published in national documents such as the annual Handbook of Drug Abuse Information (Handbook) and national HIV/AIDS Strategy documents frame the drug problem and how this changes or endorses the continuation of prevailing policies.

The Handbook has been published annually by the NDDCB since 1991. Significant data it collects and publishes includes:

- Prevalence of drug use
- Figures of the legal consumption of opium and cannabis by Ayurveda Drug Corporation;
- Drug related arrests;
- The amount of drug seizures, price and purity;
- Drug related prison admissions;
- Numbers of admissions to rehabilitation centres;
- Reported cases of HIV and AIDS.

Additionally, the Appendix of each Handbook contains:

- Basic socio-economic details of Sri Lanka;
- Up-to-date national drug policy;
- A summary of legislation pertaining to drugs;
- The role of government agencies involved in drug control;
- The international drug control conventions Sri Lanka had signed;
- A list of the drug reports submitted to the INCB or CND by the NDDCB on a monthly, quarterly or annual basis.

Although the Handbook contains some information on the characteristics of those who underwent rehabilitation, it lacks comprehensive information on the outcomes of rehabilitation, any adverse consequences related to drug use such as overdoses, drug related deaths, hepatitis C and the sharing of needles and syringes.

The Handbook functions as the main source of information related to the subject of drugs that is endorsed by the government and available to the public. It has a wide circulation; a copy is distributed by the NDDCB to government departments and ministries (Policy-maker, Interview 3). On application to the NDDCB, copies are also sent to NGOs working in the field of drugs. Considering the limited amount of information published on the drug problem by parties outside of the NDDCB, the public regarded the Handbook as a credible source of information that accurately describes the country's drug problem, particularly as it is published by the government (NGO Director, Interview 1). However, there has been contention with regards to some of the information published in the Handbook particularly concerning the prevalence of drug use within Sri Lanka.

Disagreement over the number of drug users existed within professional groups who represented penal and medical agencies and had a keen interest in drug control, some having represented the NDDCB in an ex-officio capacity (Psychiatrist, Interview 4). As discussed previously, a Colombo Plan expert from Malaysia estimated 133,060 to 164,940 people using cannabis in 1980 (Spender and Navarathnam, 1981). At that time heroin had not entered the local drug market to a level that concerned policy-makers. Later, the PNB estimated there were 100,000 heroin and 200,000 cannabis users in 1999 (Xinhua News Agency, 1999). An outreach study conducted jointly between the NDDCB and UNDCP estimated 40,000-50,000 heroin users in 2001 (UNDCP, 2001). It is believed that the number of cannabis users in the country far exceeds the figure quoted by the government (Police officer, Interview 14). There had been no attempts to estimate the number of cocaine and other stimulant users in the country as this was considered to be small and not

requiring a response (Policy-maker, Interview 3). Analysing the data contained in the Handbook from 1996 until 2004, a figure of 40,000 heroin and 200,000 cannabis users has been maintained as a constant figure. A psychiatrist who disagreed with the government's endorsed recurring figures on prevalence estimates stated that:

"For so many years the Handbook of drugs has been saying that there are only 40,000 heroin users and 200,000 cannabis users in the country. We have been challenging that there's more drug users in the country. I think the police narcotics bureau claims a much higher figure. That is based on the number of arrests and drugs being confiscated. But neither the PNB nor the NDDCB have an idea about epidemiology. If you really add up all the people who are in treatment centres, and then all the people who are in prison, because they say half the prison population are drug addicts, I think the figure will be much higher. Then, how about drug addicts who don't come into prison or treatment or those who don't get arrested? There must be a formula that can be used to do this in a more scientific way. I think the drug using population is much higher than the figure quoted. The drug control board has always downplayed this aspect may be because they didn't want to send a bad signal to the UN and foreign organisations who are thinking of investing in Sri Lanka" (Psychiatrist, Interview 4).

Similarly, there had been discrepancies in the prevalence of injecting drug use. The World Bank estimated that 2% of drug users injected drugs in Sri Lanka (World Bank, 2000). The Handbook had always maintained that less than 1% inject drugs and that there are no HIV cases related to injecting drug use. The medical profession working in HIV and AIDS and the national HIV/AIDS policy-makers both believed that HIV arising from injecting drug use is a non-existent phenomenon due to a low prevalence of injecting (National STD/AIDS Control Program, 2001; Interview data). Later in 2007, the National HIV/AIDS Strategic Plan stated that 4% of drug users inject drugs (National HIV/AIDS Strategic Plan 2007), which is double the WHO estimate and four times more than what had been estimated by the NDDCB. Overall, the conclusion arrived at by the

NDDCB on the prevalence of injecting drug use and HIV had been based on anecdotal evidence and from investigating the patterns of drug use among those admitted to drug rehabilitation centres. A police officer who disagreed with the above stated:

"They (NDDCB) have been saying that there's only 1% of the drug using population who inject drugs for the last 15 odd years. How can it be 1% when there has been an increase in the number of drug addicts and fluctuating prices of a gram of heroin? Figures from rehab centres are not representative of all drug users. I don't think there are a lot of people who inject drugs in Sri Lanka like in India or Pakistan. But, surely you can't keep saying it's less than 1% for many years?" (Police officer, Interview 14).

A study conducted about heroin users in the early 1990s, which included drug users not attending treatment centres, found that the prevalence of injecting drug use had increased from 1% in 1988 to 13% in 1992 (Kandiah, 1994). The same study revealed that injecting drug users were having unprotected sex with multiple partners, had high rates of needle and syringe sharing and used multiple drugs, such as benzodiazepines and alcohol. The conclusion of this study was that injecting drug users were at high risk of contracting HIV. Although this study was supported by the NDDCB, it did not feature in the Handbook or receive any public response. Policy-makers continued to believe that injecting practice in the drug using population was an insignificant number during the period under investigation.

In addition to discrepancies in the prevalence data, drug usage was described in the Handbook as a relatively small and reasonably well-contained problem compared to most other countries in the south Asian region. There were no other credible or legitimate documents or research produced by agencies outside of the NDDCB to dispute this picture. Concerns were voiced by some professionals such as doctors but did not attract significant attention (Psychiatrist, Interview 4). The perceived absence of any crisis or any growth in

the number of opioid users, coupled with an absence of many injecting drug users were factors which refuted the need to introduce opioid substitute prescribing and needle and syringe exchange programmes:

"The heroin problem in the country is not a major issue as we have a small number of heroin addicts and a very tiny group of injecting drug addicts. Therefore, we are not interested in introducing methadone or syringe exchanges here. But in the future if we are faced with an injecting heroin problem, then we may have to consider these. The current problem can be addressed by rehabilitation and counselling programmes" (Civil Servant, Interview 6).

Hence it was believed that the existing policies were sufficient and a radical shift in policy was not required. Framing the drug problem in this light at national level had also helped relations with external parties such as the INCB. A policy-maker who had an interesting view on measuring the success of existing drug policies stated:

"As required we have produced our country reports to the INCB on a regular basis. Once the legislation is in place they are concerned about looking at our arrest figures, drug seizure figures, number of people in prison and in treatment and so on. We collated all these stats and sent them to the INCB using the standard templates we use for reporting. It was important to show that we had a handle on this through our reporting. The INCB is pleased with our progress. So to that extent, the current drug policy is working" (Policy-maker, Interview 8).

It had been important for national policy actors to describe the drug problem as being both well contained and managed so as to satisfy external organisations. This success was chiefly based upon information reported by drug law enforcement agencies (Interview data). The success of drug treatment outcomes had been limited to reporting on the number of drug users entering treatment, without any inclusion of information on those successfully completing treatment, follow up studies and relapse rates.

The content of the Handbook had helped maintain the continuation of existing policy and the ideological view of the NDDCB and the influential policy actors. Similarly, information submitted to the INCB, in describing the drug problem as a well-managed one also helped maintain the status quo, as a reported drug epidemic could potentially attract pressure on Sri Lanka to respond accordingly. Maintaining this position was favourable for attracting foreign funds for the country's developmental work and so as not to deter investment. It was believed that any uncontrolled drug problem would have an enormous negative impact on development and poverty alleviation funding programmes (Civil Servant, Interview 9). Statistics and information used on the nature of the drug problem helped the NDDCB and the government to maintain the prevailing drug policies at national level without any denunciation from external policy actors.

Conclusion

Civil servants, prominent Buddhist monks, alcohol and tobacco lobby groups and the public are identified as key stakeholders in drug policy. Their influence with the President and the legislature has been significant in determining the nature and course of drug policies which emerged during the study period. Stakeholders framed the drug problem within security, economic and moral perspectives. Drugs were an important subject for both the national interest and the elite decision-makers, and by implication both determined the course and outcome of policies. The divergent interests of stakeholders and their advice provided to elite decision-makers on the management of the drug problem were contextualised within a normative framework whereby drugs were seen as a threat to national security, socio-economic development and morality. The proximity of stakeholders to elite decision-makers and their political interests had a significant impact on determining policy outcomes.

Chapter Eight: Conclusion

Introduction.

Sri Lankan drugs policy has adopted a punitive approach based on a criminal justice response model as opposed to treatment, social welfare or a public health orientated model. The approach to managing the drug problem shifted from a *laissez-faire* system that existed prior to the study start date to one that is based on stringent law enforcement. This policy response resulted in a large number of drug users and traffickers being incarcerated in prison and has largely been consistent over the period studied. Attempts have been made to challenge the criminal justice model with limited success. A number of economic, political and social factors have combined to sustain the criminal justice model and ward off attempts to introduce a system with a stronger focus on treatment and public health.

This final chapter will synthesise and analyse the findings and key issues discussed previously with a particular focus on drug policy origin and development, the key stakeholders and the role of international organisations and epistemic communities. Some of the themes discussed overlap due to their inter-connectedness and the presence of cross-themes. The usefulness of the conceptual framework applied to explore drug policy development will be revisited, particularly in regard to the integration of epistemic community theory with stakeholder analysis in order to understand the dynamics of decision-making and policy transfer. Documents become actors in the policy-making process and the researcher explains how they influenced policy change and have helped to maintain a penal approach. The chapter then discusses the study limitations, contributions of this research, policy developments subsequent to the study period and future directions for drug policy and research in Sri Lanka.

Stability in Policy Approaches.

The stability in policy approaches and a lack of innovation underpinned the continuation of the criminal justice model. As discussed in earlier chapters, drug policies were developed by a small group of policy actors who had simultaneous responsibility for defence, economic, health, foreign, criminal justice, tobacco and alcohol policies. Generally these actors have been from elite groups and individuals linked to the political arena and to international networks. They established effective working relationships with the Presidents, were influential in framing and defining the drug problem, and legitimising policies and practices for its management. Membership of this group has generally remained stable throughout the period of this study. This, coupled with their high level of interest in the subject of drugs and their connections with international epistemic communities, explains the development of their consensual knowledge-base over time, despite members also moving between government offices and occupying many roles. This consensual knowledge-base was not limited to actors occupying positions within the NDDCB. As stated by Haas (1992:10), epistemic actors are located across different organisations and this is based on 'where they stand' as opposed to 'where they sit'; in other words, their beliefs and knowledge of the drug problem mattered more than any organisational position they occupied. Their working was dominated by a penal agenda focusing on legal and penal reforms relating to drug control and with a health sector displaying limited interest and accepting little responsibility to help manage the drug problem.

According to Haas (1992), epistemic communities are networks of professionals or expert individuals with shared analytical and normative beliefs about a particular issue. Its application to the study of drug policy in Sri Lanka helps to explain how consensual knowledge can influence policy during uncertain times. As discussed in Chapter Five, the advent of narco-terrorism and a new heroin epidemic raised uncertainties. The decision-makers turned to experts for help to deal with the drug problem. The experts were a knowledgeable group of professionals, initially instigated by international

epistemic communities. The national experts later went on to become a part of an international epistemic undertaking that had a principle belief in prohibition and shared consensual knowledge on drugs being a threat to national security and socio-economic development. This shared knowledge was imperative for providing the rationale for the subsequent development of policy, creating and maintaining a normative framework for policies to emerge, particularly the decisions on drug policies which needed the support of the Presidents and other major decision-makers.

The stability in the approaches to drug treatment also supported the maintenance of the criminal justice model. Rehabilitation had popular support as it did not conflict with the principle belief in prohibition or the causal belief that drug use was an obstacle to socio-economic development and a drug-free society. Any opportunity for the development of alternative treatment models and the growth of a variety of treatment providers was limited. Drug demand reduction programmes were limited to drug education and rehabilitation. The collective power of the NDDCB and the NGO sector through coalition and consensus building ensured the continuation of this whole approach. Chapter Seven argued how the NDDCB and FONGODA were mutually supportive in the maintenance of the established normative framework and rejected any other drug treatment policies emerging.

Chapter Six discussed that any national stakeholders who confronted the existing abstinence-based treatment model had little success in introducing a public health approach. Similarly, Chapter Five discussed that international epistemic communities' influence to introduce harm reduction programmes were also rejected. Primarily, both groups of stakeholders believed in prohibition and drugs becoming an obstacle to socio-economic development. Although a general world-view of the drug problem was shared, divergent views existed between the national and international epistemic communities concerning drug control. The activities of the national epistemic community occurred within a circumscribed context as prohibition was the core belief and any challenges to it resulted in non-policy transfer. In these circumstances the

country's drug problem was often re-framed as being well contained, as not reaching crisis levels and it did not have a significant number of injecting users in comparison to neighbouring countries. This representation of national consensus mitigated against external influences on harm reduction and their policy transfer.

Policy Actors and their Dynamics.

The thesis argued that individuals and groups involved in the policy and decision-making processes, the development of institutional structures and the dynamics between national and international policy actors also served to sustain the penal approach and status quo. The individuals, who formed the first national committee on drugs in 1973, adopted a common policy enterprise. The majority of individuals from this group continued to engage in drug policy making throughout the study period, although legal and law enforcement professionals dominated the policy-making landscape. Existing legislation needed amendment in order to add penal sanctions and ensure that the long-standing lenient system that resulted in a high acquittal rate for drug related offences ended. As previously discussed, the focus of international epistemic communities had been to establish international co-operation to curb the illicit trade in narcotic drugs and cannabis and encourage Sri Lanka to adopt UN drug control conventions, in agreement with other countries. The continued involvement of legal and law enforcement professionals in policy-making is inextricably linked to the problem being framed by national and international epistemic actors within the responsibility of the criminal justice system with requirement for an enforcement response and changes to legislation.

Haas (2001) argued that new ideas and knowledge in addressing social problems can provide new systems for the understanding and interpretation of policy, which then can create new institutional processes and frameworks. Amendments made to the Poisons, Opium and Dangerous Drugs Ordinance of 1929 in 1984, marks the political legitimisation of the UN drug control conventions Sri Lanka had agreed to. Subsequently, law enforcement

professionals were placed at the forefront of implementing drug legislation as they met many drug users by virtue of their new role. This significantly enhanced their professional competence and authoritative claim to define the drug problem and acquire policy-relevant knowledge particularly with the arrival of the new heroin epidemic in the 1980s. The links and proximity of law enforcement elites to the Presidents determined their level of influence in decision-making processes and partly explains the continuation of the criminal justice model.

The establishment of the NDDCB in 1984 marks the attempt to depart from *ad hoc* policy-making and place it within a focal organisation as this was imperative for epistemic communities and the Sri Lankan government. The Board's initial responses to the drug problem largely consisted of some legal and penal reforms. Although their remit included policy formulation and co-ordination of all drug control activities, their scope was extended to include drug treatment and rehabilitation in community and prisons and the regulation and inspection of drug treatment facilities. The continued legitimacy of the NDDCB and expansion of its scope is associated with it becoming the 'expert national organisation' concerning drug control. The inclusion of multi-agency representation on the Board acknowledged that law enforcement alone was unable to provide a total solution to the drug problem and underlined the need to work in partnership.

The reputation of the NDDCB was high as it was usually led by lawyers, reputed personnel from law enforcement backgrounds or doctors, all highly regarded. They had access to elite decision-makers as well as the political system to legitimise and authorise their activities. Additionally, social and political support given to the NDDCB was closely linked to the idea that their activities would enhance human welfare rather than any sectional interest. With growing expertise, the NDDCB was accepted as having authority by national and external organisations, due to the liaison role the NDDCB had with external stakeholders in ensuring conformity of drug control activities with other countries. The official role awarded to the NDDCB from its publication of

various national and international drug reports meant that knowledge about the problem and possible solutions clustered around this focal organisation. It existed within the context of limited information and research being published by parties outside the NDDCB and the lack of any sufficiently strong and legitimate organisation to challenge its authority.

Another important area is the Presidents' keen interest and control over drug policies as discussed in Chapter Seven. This indicates the importance drugs had in the heart of the political, social and economic decision-making. Drug policies also emerged when national interests such as security, socio-economic development and political welfare were involved, and by implication again became a concern for the Presidency. Civil servants and legal and law enforcement personnel who worked closely with the Presidents endorsed the ideology of drugs being a threat to national security, socio-economic development and moral hygiene. They also acted as conduits between the Presidents, government and other nations' governments on matters related to drugs, foreign and defence policies, including the workings of SAARC. Their importance and proximity to the President determined their influence on drug policy.

The normative framework presented by the national epistemic community legitimised Presidential involvement and state intervention to adopt a tough law enforcement approach to the drug problem. Whilst this was largely in congruence with international interests and addressed national concerns, drugs were also used as a political tool in balancing the political power structures. Prohibition served the agenda of politically active groups and the electorate thus maintaining keen interest from the Presidents. This can be argued as a political exercise in pursuit of power. The politicisation of drugs peaked during President Rajapakse's tenure as political stakeholders propagated the 'righteous society' concept which re-endorsed the criminal justice approach. The centre of power lies with the Presidency so the effect of public policy change has largely been important in sustaining the penal approach.

Consensus Policy.

Overall there had been strong consensus among Presidents, political parties, government ministries and departments, the NDDCB, and prominent Buddhist monks on the responses of drug prohibition and stringent law enforcement. The prohibition ideology was strong where it had been used in arguments over the implications for national security, socio-economic development and moral hygiene. Consensus policy-making is partly grounded in the truth tests or consensual knowledge epistemic communities diffused in framing the drug problem and in the establishment of the normative framework for policies to emerge. This knowledge became accepted belief among the majority of stakeholders, extending beyond the small group of drug policy experts and elite decision-makers.

Consensus in drug policy approaches was also reinforced by Buddhist precepts. Abstention from intoxicants was key to policy stakeholders who advocated on the path to a righteous and developed society. Moral values drawn from Buddhism strongly influenced this consensus formation. This was also noted in the history of drug policy-making, especially during the British colonial period when national stakeholders lobbied against the government's policy on opium in a predominantly Buddhist society. Similar sentiments peaked towards the 2008 period due to political coalitions and consensus formed between prominent Buddhist monks, those in government office and political parties. The religious-moral model of drug policy-making was further solidified during this period and had consensus across government and non-government organisations. This was also partly influenced by policy-makers who coincidentally happened to be staunch Buddhist devotees who occupied influential and insider positions in policy-making. Furthermore, the temperance ideologies were promoted by the same stakeholders who influenced consensual formulation of contemporary drug policies.

While gaining consensus inside the country, the national epistemic community additionally built strong agreement with external stakeholders based on the

interpretation of the prohibition aspects of the UN drug control conventions. At south Asian level, the principle belief in prohibition and the causal belief in drugs becoming an obstacle to socio-economic development underpinned this consensus formed with SAARC. It occurred against the background of securing funds for the country's developmental work from external organisations or their affiliates. The economic, political and social context was important not just for Sri Lanka but for SAARC membership countries in their development of drug policies.

As discussed in Chapter Five, one significant legitimising factor for countries in the SAARC region to endorse prohibition and the SAARC convention on drugs was narco-terrorism and the threat it posed to nations. The Sri Lankan delegation to SAARC successfully framed the drug trafficking problem as a threat to national security based upon its experience with narco-terrorism. As Haas (1992:23) argued 'epistemic communities focus on reaching consensus within a given domain of expertise and through which the consensual knowledge is diffused to and carried forward by other actors'. This partly shows the social construction of the drug problem in Sri Lanka had an influence on SAARC member countries with the diffusion of consensual knowledge. It demonstrates the political influence that an epistemic community can have on collective policy-making, in this instance, in the SAARC region. The consensus emerging from new knowledge ensured cooperation among member states to deal with the trafficking problem as efforts at policy coordination were successful. However, it is argued that the exposure of national stakeholders to this regional consensus through the workings of epistemic communities, helped the SAARC to retain the criminal justice model in Sri Lanka through the influences of collective policy-making.

External Influences.

The thesis argues that external influence has played a significant role in the development of drug policies in Sri Lanka. Chapter Four described the historical external influences and use of knowledge experts to legitimise and

support policy decisions taken by colonial administrators to regulate opium and cannabis. The resultant policy decisions were the outcome of the interaction between the external influences and the moral, economic, social, cultural and political debates which prevailed in framing the drug problem and its solutions within Sri Lanka.

The development of contemporary drug policy has not been dissimilar as governments have used universal norms and principles on drug control to address national concerns and legitimise policy decisions. However, ideas diffused by international epistemic communities were not rapidly embraced to become national policy. International epistemic networks propelled the problem of controlling drugs onto the national political and policy agenda, eventually influencing the development of subsequent policies and their outcomes throughout this study period. Delays in enacting legislation to give effect to the UN drug control conventions Sri Lanka was a signatory to is an example of a cumulative impact following external pressure. External practices were translated into national policy only when the 'conditions were right' and legitimised with national interests and primacies.

In their study of external influences of national drug policies in four European countries, Beccaria et al., (2015) stated that their examples were unable to prove direct imposition of policy or legislation by external stakeholders. In contrast, analysis of Sri Lankan drug policy provides evidence of external pressure and coercion applied to enact UN drug control conventions. The amendments to the Poison, Opium and Dangerous Drugs Ordinance of 1929 in 1984 and the introduction of the Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act No 1 of 2008 were, undoubtedly, the outcomes of external pressure and coercion. This highlights that different dynamics might apply in non-western settings as financial and other resources granted to a developing country can be made subject to the implementation of a number of UN conventions.

In this context, the criminal justice approach to managing drug problems was partly determined by external pressures. Epistemic communities help define national interests with a particular focus on security and development. This became relevant and acceptable only as a result of evidence emerging on the link between ‘narco-terrorism’ and its threat to national security and sovereignty. The continued acceptance of this threat discourse due to the long-standing civil war solidified and strengthened the continuity of drug policies primarily located within the criminal justice system.

As discussed before, the epistemic community theory attempts to explain the role played by knowledge experts in articulating the cause and effect relationships of uncertainties and complex problems. It helps governments identify their interests, frame the issues for collective action, recommend specific policies and ideas for negotiation to advance human welfare. The uncertainty-reducing role that is distinctive to an epistemic community was executed by the UNCND and Colombo Plan as evidence emerged over the link between drug trafficking and terrorism, and the growing heroin epidemic as a result of leakage into the local drug market. Against this background, the international epistemic community diffused the idea that drugs are a global problem and that international cooperation is a more effective decision to deal with the trafficking problem, particularly considering Sri Lanka’s strategic geographical location. Drug trafficking as a threat to national security had been propagated as a causal idea arising from the lack of sufficient controls. Epistemic actors helped engage and achieve consensus with the Sri Lankan government in order to address a number of areas identified in UN drug control conventions, although national stakeholders initially believed that the ownership of the drug trafficking problem should belong to opium producing nations.

Exposure to international epistemic communities helped civil servants, legal and law enforcement professionals agree that the management of a new heroin threat needed more enforcement and international cooperation. As part of this exposure and learning, consensual knowledge about the drug problem developed. Similarly, the Colombo Plan's well-established role in helping

member-states with socio-economic development was crucial in diffusing the idea that drug use is an obstacle to socio-economic development. Acknowledging the benefits of this learning, Cabinet Ministers and Members of Parliament who had been working closely with civil servants claimed in Parliament that drugs were a threat to security, sovereignty and socio-economic development. This led to stringent law enforcement having unquestioned political legitimacy.

The recent shift to include treatment and rehabilitation, which is somewhat more inclusive of health issues can also be attributed to external influences. It arose out of national policy actors' interaction with international epistemic communities. This prompted the development of drug treatment and rehabilitation policies and programmes when there had been internal and moral debates on the care and treatment of drug users. The responses emerged within an established dominant penal framework and in the absence of any binding international instrument to guarantee the nature and type of drug treatment service provision. Thus, the country kept its freedom to adopt its own approach to treatment and rehabilitation. As discussed in Chapter Five, the main criteria to obtain foreign aid was only restricted to giving effect to the UN conventions on drug control, particularly enforcement aspects and reporting of data on supply-reduction initiatives to the INCB. Only recently did the implementation of human rights conventions and the establishment of good governance frameworks become additional pre-conditions for grant aid.

The CPDAP's authority was further approved with its provision of help to develop drug demand-reduction policies and programmes in addition to the usual supply reduction initiatives. Their knowledge brokering role and support with organising and funding study tours, conferences and workshops on drug control for national policy stakeholders significantly contributed towards the development of a group of informed national experts on drug treatment and rehabilitation. However, the continuing development of only abstinence-based drug treatment systems in Sri Lanka, including compulsory treatment, is partly explained by CPDAP exercising a conservative approach, exposing and

socialising national stakeholders to abstinence-based treatment systems as opposed to other treatment models. This gate-keeping and knowledge-filtering role demonstrates the dependency and drawback of a prohibitionist-only framework.

There has been a less significant role for external knowledge experts or epistemic communities in shaping drug control policies towards the latter part of the chosen study period. This was linked to the view that the drug problem was reasonably controlled, prevailing policies were able to address the drug problem, and the absence of any crisis warranting the involvement of external experts. By this time, a small group of national knowledge experts in drug control policies existed and represented legal, penal, medical and non-governmental organisations. In other words, the level of uncertainty in managing the drug problem was significantly reduced due to the growth and presence of a national epistemic community when compared to the early 1980s when heroin was new to the Sri Lankan drug market and drug trafficking was extensive. National experts involved in contemporary drug policies believed that stringent law enforcement and the rehabilitation of drug users should be the main policy responses.

Although the role for external epistemic communities was less significant around the 2008 period, external influence on national drug policies continued. Unlike the 1980s and 1990s, drug policies were influenced and co-located with a number of international instruments that Sri Lanka had been party to, namely human rights and good governance conventions. Granting of foreign aid and trade concessions on exports to the European Union had been subjected to the implementation of the recently internationalised human rights and good governance frameworks at local level. Coercive methods of policy transfer took place, particularly when the beneficiary status of the GSP tax concession scheme was subjected to the ratification and implementation of core international conventions related to human and labour rights and good governance. The 1988 United Nations Convention on Illicit Traffic in Narcotic Drugs, which had not been implemented by the Sri Lankan government, was

co-located with the above mentioned non-drug specific international conventions. During this time, economic debates prevailed at national level whereby the GSP scheme was considered a significant contributor towards Sri Lanka's economy, by increasing exports to the EU market. These economic concerns had implications both for the national economy and formed part of the international relations agenda. They combined and significantly influenced coercive forms of policy transfer, distinct from the negotiated forms of policy transfer that took place in earlier phases of drug policy development.

Documents as Actors.

References had frequently been made to international drug control conventions by the legislature, NDDCB and other government departments and ministries, which suggest that they formed part of governmental social life. As discussed in Chapter Three on research methodology, Prior (2008) argued that documents extend beyond being only a source of data and can be viewed as actors becoming part of organised activities instigating further action. The thesis argues that international documents on drug control performed a quasi-actor role alongside the epistemic workings of human policy actors and instigated national action to determine the direction of drug policy. International drug control documents linked people together and promoted policy coordination. New relationships were created within and between national and international policy actors where conformity to UN drug control documents became one of the founding principles.

The UN and the SAARC conventions on drug control had often been referred to in Hansard as instruments that the country has an obligation to comply with. Similarly, when considering inter-textuality between drug policy documents, the first national policy on drugs in 1994 followed by the updated policy in 2006 refer to the UN conventions and the CMO in a manner that demonstrate the need for national action to ensure compliance with international norms. Another example is the inter-textuality between the Drug Dependants (Treatment and Rehabilitation) Act 1983 of Malaysia and the Drug Dependant Persons

Treatment and Rehabilitation Act 2007 in Sri Lanka, which contains legislative provision for compulsory treatment. However, it is difficult to ascertain whether it was the influence from the human actors, Malaysian documentation or a combination of both which was prominent in the development of Sri Lankan drug policy. This difficulty applies to the contents of UN documents studied. However, it was clear that international drug control documents did play a role and influenced the direction of drug policy in Sri Lanka.

This inter-textuality of documents as discussed by Atkinson and Coffey (2004) has been proven when analysing the content meaning and role of national and international documents selected for study in this thesis. Documents and epistemic actors cannot be separated when analysing the development of drug policy in Sri Lanka. The degree to which international drug control conventions (as documents) represent the principles, causal beliefs and consensual knowledge shared by epistemic actors requires further research. The inter-textuality and study of national and international documents demonstrates some consensus on the prohibition paradigm and unity in establishing the previously discussed normative frameworks for drug policies to emerge. Further research is also required, and would be interesting, to explore in depth the role of documents as either part of epistemic activity or as epistemic actors.

Epistemic Communities, Stakeholder Analysis and Policy Transfer.

The epistemic community theory coined by Haas (1992) has been useful in terms of studying external and internal influences on Sri Lankan drug policies and the role it plays in the transfer of global drug policy to a non-western setting. As discussed before, of particular use has been its application to identifying the principle beliefs and consensual knowledge in framing the drug problem and in setting the national policy agenda. However, the explanatory power of the epistemic community theory is limited to setting the policy agenda. While the theory is able to explain how drug problems become recognised by decision-makers, it stops short of explaining the dynamics of epistemic activity and decision-making in order to understand policy outcomes. In other words,

the theory is unable to establish a causal link between consensual knowledge and actual policy change.

Unlike the majority of previous research, this study demonstrates that the actions of the international epistemic community can help to develop a national epistemic community, which shares similar principle and causal beliefs and a common policy enterprise that has been previously adopted by an international epistemic community. Some members of the international epistemic community overlap when national epistemic actors functioned in an ex-officio capacity or when they were later appointed as members of the CPDAP and SAARC technical committees on drug control. Over time, national epistemic actors became part of an international epistemic undertaking as they were held together by the various national and international workshops, seminars and study tours on drug control.

This thesis argued that although members of an international epistemic community on drugs have a general world view of the drug problem and a common policy enterprise to address it, some members may have divergent views when innovative ideas are contested. This study was unable to demonstrate all innovative ideas becoming part of the consensual knowledge of the national epistemic community. Hadii et al., (2011) also argued that the global tobacco control epistemic community's innovative ideas were sometimes contested by the tobacco control epistemic actors or eventually became part of the consensual knowledge. In the case of Sri Lanka, the national epistemic community re-framed the drug problem as being different from other countries to justify the rejection of harm reduction ideas forming part of the consensual knowledge of the national epistemic community. However, the adoption of a stakeholder analysis explains that stakeholder interests on socio-economic development, a drug-free and righteous society concepts were more influential and legitimate interests over harm reduction policies and programmes.

Furthermore, in a similar comparison to Balch (2009), one of the main drawbacks in applying the epistemic community theory into the study of drug policy in Sri Lanka was the difficulty in separating the role of ideas from interests. For example, national security, sovereignty and socio-economic development were all at the heart of elite decision-making in Sri Lanka. Separating them from consensual knowledge on drugs diffused by epistemic communities from the interests of decision-makers is challenging in terms of providing an account on the motivation for policy change. However, when the theory is integrated with stakeholder analysis where an interest-based approach to drug policy analysis is combined, stakeholder interests reveals the impact of consensual knowledge on national interests.

The apolitical nature of the epistemic community theory as stated by Haas (1992) can be challenged at national and international levels. At national level, drug-knowledgeable government officials moved between government departments and ministries and continued to be involved in generating consensual knowledge on drug control. They were consulted by elite decision-makers in times of uncertainty for advice on how to manage the drug problem. For example, some epistemic actors who occupied a marginal position in decision-making structures were located later at the core of government decision-making systems. They were significantly influential when they functioned as Presidential advisers, senior Presidential advisers and senior civil servants. The President sought advice from these epistemic actors when the drug trafficking problem was rife and when drug market activities disrupted local communities. The examples provided in Chapter Seven on advice given by civil servants in regards to stringent law enforcement were closely related to political interests and suggest that epistemic actors have access to the political agenda. Although epistemic community theory is unable to explain the dynamics and intricacies between knowledge and political interests, political stakeholder analysis reveals that electoral interests and balancing the power structures were influential drivers for acting on epistemic advice. They operated behind and in congruence with consensual knowledge of epistemic actors.

The Chairs to the NDDCB were appointed by the President and in the majority of cases they formed part of the national epistemic community. Although lawyers, senior police officers and doctors occupied this position they were political appointees and to a certain extent challenge the apolitical nature of the epistemic community theory. The distinction between political interests and consensual knowledge propagated by epistemic actors requires further understanding when epistemic actors occupy an insider position in policy-making. The application of stakeholder analysis to understand the wider political context in which drug policies emerged, provided new insights on the strength and influence of the national epistemic community on drug control in Sri Lanka. The potential of consensual knowledge became influential and realised through the involvement of elite decision-makers. In other words the strength of the Sri Lankan epistemic community on drug control lies in the alliance and proximity between epistemic actors and elite decision-makers.

Most epistemic activity was funded by UN organisations, Colombo Plan and the USA. Chapter Five discussed the funding sources of epistemic communities, the pressure and coercion applied by external stakeholders in the transfer of global norms and principles on drug control, often tied to aid and other incentives granted to Sri Lanka. External influence to enact drug legislation in Sri Lanka questions the independence of consensual knowledge diffused by international epistemic communities as they cannot be considered distinct from those who fund their epistemic activity. International epistemic communities on drug control were part of an international donor community and there exists little bargaining power for developing nations when confronted with external influences. Further research is required to investigate the dynamics between international epistemic communities and their donor organisations in explaining the independence of consensual knowledge on drugs and their impact on policy transfer.

Stakeholder analysis incorporates a much broader role for policy actors, and permits examination of how their ideologies, beliefs and interests are brought to the policy agenda, as opposed to limiting drug policy analysis to expert

knowledge generated by epistemic communities. As discussed, drug policies in Sri Lanka affect, and are affected by, many different actors both directly and indirectly. This was also shown by Houborg et al., (2015) in their study of stakeholders in addictions policy in Europe. The continuation and stability in policy approaches partly explains this. The thesis was able to identify government and non-government organisations, epistemic communities, individuals and professional groups, Buddhist monks, tobacco and alcohol policy actors, political parties, the public and other interests groups as stakeholders in drug policy. As noted, external stakeholders significantly influence the activities of national stakeholders in the developing world. Stakeholder activities were located within the broader economic, political and social contexts in which policies emerged in the history of Sri Lanka. Analysis of stakeholders discloses information about their power, interests, influence and legitimacy of action in the area of drug control. Against this background, stakeholder analysis is a useful tool for the analysis of drug policy and is able to provide a much broader narrative on the drug problem and its policies in time and place. Stakeholder analysis is also able to provide an understanding of how the policy agenda is set and add further meaning to the consensual knowledge produced by epistemic actors, their influence, salience and legitimacy based on stakeholder interests.

Similar to Thom et al., (2013) this thesis was able to demonstrate that some stakeholders occupy a core position and others are on the margins of policy-making. Those who occupied a core position and had close working relationships with elite decision-makers were more influential in drug policies than those who occupied a marginal position. The public is also an important stakeholder group and ensured that their interests are heard in the policy process, particularly when drugs disrupted local communities which gained the interest of politicians. The alliances the public had with Buddhist monks and Parliamentarians ensured the legitimisation of their local agenda and relevance to policy outcomes.

As we have seen throughout this thesis, drug policy innovation and reform in Sri Lanka originated from external influences. The thesis argued that policy transfer takes place across time, based on the economic, political, social interests and ideologies of national stakeholders. Of particular interest is the examination of policy learning from other jurisdictions in relation to the development of drug policy in a developing country. International epistemic communities are agents of policy transfer when considering their role in the diffusion of drug-policy knowledge. National policy makers' engagement with epistemic activities resulted in policy learning. This study identifies the policy beliefs of epistemic communities and their common policy enterprise, the resources they bring into the process of policy orientated learning and identifies the nature of policy transfer epistemic actors were seeking to make in Sri Lanka.

There exists a mixture of policy convergence and translation as opposed to straight-forward copying of international policy and legislation on drug control. As discussed in Chapter Two, policy transfer and translation are action-orientated intentional learning mechanisms. However, policy convergence differs and is concerned with unintentionality where human agents are not actively involved in the transfer of policies but other forces such as industrialisation, globalisation and regionalisation are at play when policies in two or more countries become more alike over time (Knill, 2005; Evans, 2009; Stone, 2012). The introduction of the death sentence for drug related offences in Sri Lanka is an example of policy convergence as there is a lack of any evidence to denote that this was transferred from human actors. As discussed in Chapter Six, parliamentary debates at the time on the introduction of the death sentence revealed that harmonising macro-economic forces and legislation in the region under a new capitalist government became relevant and important. The government emulated an Asian approach to managing some aspects of the drug problem due to geographical proximity to countries such as Malaysia, India, Bangladesh, Pakistan, Singapore, Taiwan, Thailand and Indonesia, which explains policy convergence of the death sentence.

The majority of drug policies translated can be located in the norms and principles identified within international drug control conventions, policies and practices. As discussed, negotiated and coercive forms of drug policy transfer existed in the history of Sri Lanka. The idea of compulsory treatment, suggested as far back as the 1980s, was translated into national policy in 2007 with national policy actors' learning through exposure to Malaysian treatment models. While the legislation concerning compulsory treatment between the two countries has a number of similarities in terms of its content and identical text, there had been modifications from the Malaysian legislation, adapting it to suit a Sri Lankan context.

This thesis also highlighted that the epistemic consensus on the drug problem and the need for policy innovation was adequately framed but insufficient for translation into policy as stakeholder interests and legitimacy are important factors that ensure a successful translation. Nevertheless, policy transfer analysis contributes significantly to the study of drug policy-making in nation states, helping to understand how decision-makers acquire knowledge and legitimate policy transfer based on national interests and a host of other factors.

Limitations and Contributions of this Research.

As discussed before, where perspectives are limited to a group of elite individuals whose activities were located within government decision-making processes, this means that only a relatively small number of stakeholders were interviewed. Although confidentiality was guaranteed and key informants were reassured that information they supplied would not identify them, their position, or the organisation they currently or previously represented, data generated through interviews may have either restricted or amplified information.

Similarly, the researcher's background in mental health and addiction treatment services in the UK with familiarity of international treatment approaches and

sponsorship to gain access to key informants for interview through known elite individuals may also have influenced the data in unknown ways.

Stakeholders such as those involved in the delivery of drug treatment services, particularly front-line staff, were not interviewed. Similarly, drug users, often the objects of drug policy and who can be considered as an important stakeholder group (Houborg et al., 2016) and the media who also have a role in framing the drug problem also did not form part of this study. They could have provided valuable insights into the study of the drug problem and policy development from a different perspective.

Due to practical reasons this thesis was unable to interview and capture the lived experiences of international stakeholders representing organisations such as the UNODC, INCB, WHO and Colombo Plan. Policy actors who represented or currently represent these organisations are likely to be a geographically dispersed population and would prove difficult to access for interview. Although national stakeholders were able to provide an account on the role and influence of international epistemic communities and other stakeholders, the value of interviewing these groups is acknowledged.

There were some shortcomings from the available documents which could affect their analysis. For example, internal inconsistencies existed in terms of style, content and comprehension. A very few were written in Sinhalese and its translation into English might have led to misinterpretation or misrepresentation of the actual content meaning. However, the researcher's ability to read Sinhalese and cross-checking with key informants mitigated this short-coming to a certain extent. The researcher is also unable to state that the transcript of workshops and conferences on drug control are free from error and distortion.

This study constitutes a number of contributions to knowledge. Considering the limited research on public policy-making and the lack of research on contemporary drug policy-making in Sri Lanka, the findings are of pivotal

importance as they provide new insights and meanings to the drug problem and policy development in Sri Lanka and from the perspective of a developing nation. The thesis also generated insights on how, why and by whom drug policies were developed, and it contributes to the literature in identifying the epistemic communities and other stakeholders involved with drug policies in non-western countries. Furthermore, the thesis analyses and contributes to the understanding of the expert-role and its influence on policy transfer, the dynamics of such transfer in a non-western setting, the conditions by which the transfer occurs and the role of political structures in accepting or rejecting ideas diffused by epistemic communities.

The adoption of a historical-social science approach to carrying out the work provided new insights and understanding of the narratives of the drug problem and drug policies in time and place. Contextualising drug policy in the history of Sri Lanka through a chronological approach facilitated the analysis of political, economic and social factors in exploring the emergence, maintenance and shifts in drug policies, their associated epistemic communities, other stakeholders, and particular discourses, all of which are embedded in time and in particular historical situations. This approach also enabled the tracing of epistemic and other stakeholder activity, their ideologies, interests, alliances and if they were located within the core or margins of decision-making structures. Given the lack of drug policy research in Sri Lanka, attention to history offered a rich reservoir of information and sufficient material with which to further analyse policy preferences, current policy issues, events and their inter-relatedness.

Future Directions for Drug Policy and Research in Sri Lanka.

Drug policies continued in the political focus after 2008, the end of this analysis of Sri Lankan drug policies. No new policy or legislation emerged after 2008, and the context of stability and consensus in policy approaches has continued without any major divergence. The penal approach has been kept as the subject of drugs has become increasingly used as a political tool. After the war

in 2009, stakeholder action, influence and their dynamics explain this as opposed to any knowledge driven model in explaining policy development.

The LTTE was militarily defeated in May 2009 by the Mahinda Rajapakse government ending almost three decades of civil war. There was immense popular support for him from large political groups, particularly prominent Buddhist monks and the JHU who previously advocated on a righteous society and drug policies. As argued by Zuhair (2016), the initial post-war support was based within Sinhala-Buddhist nationalism, a deliberate traditional political strategy to consolidate the majority vote. Soon after the war ended, national newspaper articles were printed stating drugs were in the political limelight as President Rajapakse declared war on drugs. President Rajapakse stated that the next challenge of the nation is the 'eradication of the drug menace'. Drugs continued to be framed as a threat to economic growth and political stability in post-war Sri Lanka. Issuing a special press release to mark the International Anti-Narcotics Day on 26th June 2009, President Rajapakse stated:

"The nation is now facing the challenge of ensuring the country's development, which has been set back due to the terrorism. The drug menace makes this task rather challenging. Each and every day from this moment should be used to defeat the drug war" (Colombo Page, Friday 26 June 2009).

Against this background, the "Mathata Thitha" or full stop to intoxicants campaign intensified and gained more traction from the JHU and other stakeholders. The campaign continued to feature in government activities and had popular public support. As the historical accounts showed, drug policy continues to be located within economic, political, social and moral debates with the hope of achieving a drug-free society. A chair of the NDDCB, in a public interview, echoing these post-war aspirations stated:

"The NDDCB believe that we will be able to reduce the drug circulation in the country at a considerable rate by the year 2015 and ultimately we will be able

to achieve the goal of drug-free Sri Lanka by the year 2020" (Sunday Observer, Sunday 11 May, 2014).

Economic debates over the high prison cost of accommodating drug-related offenders increased as funds were being diverted away from the country's socio-economic development (Sunday Observer, Sunday 11 May, 2014). A past President of the Colombo Plan International Society stated:

"The upkeep of drug addict prisoners also costs the state over Rs. 8000/- a day. The Colombo Plan International Society has campaigned vigorously for the establishment of separate prisons for drug offenders, who amount to about 35% of the prison population. The drug addicts should be separated from common criminals as the drug addicts find ingenious ways to smuggle drugs inside the Prisons and induce other inmates to their habit. The state announced some time ago that they will establish separate prisons at Pallekelle, Talduwa and Wirawila exclusively for drug offenders. We urge the state to immediately act on these measures which are vital for arresting the spread of this scourge to our society" (Island, Friday 26th June 2009).

The Drug Dependant Persons Treatment and Rehabilitation Act 2007 was implemented after the war with some prisons operating and dedicated for compulsory drug treatment. This implementation is a result of the socio-economic debates and the moralised policy agenda that continues to exist. Drugs again became a political tool during and after the Presidential election in 2015. 'Yahapalanaya' or Good Governance, "the slogan upon which Mathiripala Sirisena was elected President, augured well as a cross-cutting theme, which resonated well with all the communities united in their dejection of the Rajapaksa regime's extensive corruption, nepotism and other excesses" (Zuhair, 2016: 6). Drugs remained a contentious subject that was included into this 'good governance' policy agenda. The same stakeholders who propagated the righteous society concept, the JHU and prominent Buddhist monks, formed a coalition with President Sirisena to claim that the implementation of their 'full

stop to intoxicants' campaign had been hampered by the Rajapakse administration. The new Minister of Public Administration, Local Government and Democratic Governance, Karu Jayasuriya stated that The Mahinda Chinthana Election Manifesto promised to totally eradicate the drug problem by 2008 but an opposite result has occurred (Ada Derana News, July 30th, 2015).

President Sirisena established a Presidential Task Force on Drugs soon after his election as President.

"The Presidential Task Force for Drug Prevention is committed to pave way for economic, social and cultural development through making Sri Lanka a drug-free nation in accordance with the manifesto of President Maithripala Sirisena; 'Compassionate Government, a Stable Country" (President's Media Division, 2016).

The same stakeholders as before continued to feature in drug policy development although a substantial number of prominent Buddhist monks are members of the Presidential Task Force for Drug Prevention. The Buddhist monks in the JHU political party who supported the newly elect President to come into office under the cross-cutting theme of 'good governance' appear to have a significant stake and influence on drug policy-making. Law enforcement also continues its central role as senior legal and penal representatives feature in the Presidential Task force, particularly with a focus on dealing with major drug traffickers. For these stakeholders, 'good governance' also means ensuring stringent law enforcement for those major drug traffickers who allegedly had not been dealt by the law under the previous administration. The aspiration of a drug-free society is perceived to be hampered by these large scale drug traffickers.

Additionally, and similar to debates on the drug problem during the study period, drug trafficking continues to be framed as a matter that has an adverse impact on political stability, socio-economic development and of a 'righteous

society'. The religious-moral model to policy-making has gained traction within the recently established Presidential Task Force for Drug Prevention whereby aspiration towards becoming a drug-free society continues to prevail with little debate on the public health aspects of the drug problem. Drug, tobacco and alcohol use continue to be regarded as intoxicants that compromise development and moral values of Sri Lankans.

Presidential involvement on matters concerning drug control signifies the continued importance placed on the subject of drugs with the economic, political and social decision-making in post-war Sri Lanka. Recently, the continuation of the penal approach and the ways in which the drug problem has been framed has arisen from political struggles and continues to sustain the criminal justice model.

The role for external epistemic communities on drug control continues to be less noticeable after 2008, as the drug problem is perceived as stable with no uncertainties in relation to its management. Today's drug policies should be viewed and contextualised from the point of the 2015-elected government having a deep desire to repair its international relations and restore membership with various external organisations. This includes the desire to secure foreign aid and multi-million dollar finance for the country's developmental work which had been hampered by the long civil war. To this extent, the dynamics of international relations have changed in the recent past and dialogues between the Sri Lankan government and external organisations have re-commenced following a period when the international community had shown its dissatisfaction over the country's regard for human rights.

The Sri Lankan government appears to be keen on re-engaging with international policy coordination, particularly with regards to coming into line with the previously mentioned international conventions on human and labour rights and good governance. They occur in the backdrop of national interests, particularly with regards to the country's economic development under a new

government that places an increased emphasis on good governance. For the government, particular importance is placed on the re-negotiation of the GSP beneficiary status that was withdrawn by the European Commission in 2010. Institutionalising the international conventions that Sri Lanka had acceded to in earlier years would be the priority both for the government and for external organisations such as the United Nations, European Commission and countries such as the USA and UK. National drug policies are likely to be influenced by these events as drug policies are co-located alongside a large number of international conventions when re-negotiating the GSP beneficiary status.

There is a complex relationship between people, power and politics in the development of drug policy in Sri Lanka and that seems likely to endure. Evidence from the steady rise in drug seizures, arrests, drug-related incarcerations, drug use and relatively stable drug prices suggests that the nation's policy on drugs needs re-thinking. While there exists consensus on the prohibitionist paradigm for drug control, a debate needs to begin to ensure a public health agenda is incorporated into policy-making. Stakeholders with divergent views, including the knowledge experts whose views on the drug problem had not been heard should be included in this debate so that consensual knowledge on the drug problem expands.

There is a need for investment in robust scientific research into the nature and prevalence of drug problems, the outcomes of the available demand reduction programmes, including compulsory treatment in Sri Lanka. The study of Sri Lankan drug policy in general also requires investment. This should inform future policy debate and development. The historical analysis of drug policies suggests that any new consensual knowledge on the drug problem needs to be re-framed as being of national interest and has legitimisation from powerful elite decision-makers and Buddhist monks to ensure policy innovation. Attention should be paid to successive shifts in drug policies of other countries, from which Sri Lanka has previously learned and from which policies have been transferred or translated. For example, Malaysia has moved from solely having harsh punitive measures to include a public health approach in the wake of an

HIV epidemic (Tanguay, 2011). The cessation of compulsory treatment and the establishment of voluntary drug treatment facilities indicate that Malaysia's response is beginning to include a health-oriented approach as part of its overall drug policies. The perceived absence of a current crisis situation, particularly the continuing low prevalence of an injecting drug problem, should not underestimate vulnerability to an HIV epidemic in Sri Lanka.

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Appendices

Appendix A

Interview questions around amendments made to the Poisons, Opium and Dangerous Drugs Ordinance in 1984

1. What are some of the reasons to amend the law in relation to drugs in 1984?

   Prompts:

   - National concerns
   - International concerns

2. Who was mainly involved in making those changes?

   Prompts:

   - Institutions, people and international actors

3. How was the drug problem perceived at the time?
4. What were the main reasons to create the NDDCB?
5. Can you please tell me about the nature of the drug problem in early 1970s?

   Prompts:

   - How big was the drug problem?
   - Was it a crime issue, medial issue, social issue, legal issue?

6. Who was most affected by the drug problem and why?
7. Can you please tell me about the reasons behind the establishment of a National Narcotics Advisory Committee in 1973?
8. Can you please tell me about the membership of the NNAC?
9. Who was influential in policy decisions at the time?
10. Why have they been most influential?
11. Can you describe some of the work carried out by the first NNAC?

Appendix B

Sri Lankan National Policy for the Prevention and Control of Drug Abuse

The government of Sri Lanka being conscious of the illicit drug problem especially in relation to heroin and cannabis and its far reaching and destructive socio-economic implications, reaffirms its political will and determination to combat the problem by developing effective strategies based on:

(a) Enforcement:
(b) Preventative education and public awareness;
(c) Treatment rehabilitation and after care; and
(d) International and regional co-operation

Strategies and Mechanisms of Implementation of the National Drug Policy

1.0 Introduction to the drug problem in Sri Lanka

Since the early 1980's Sri Lanka has had to face a growing problem of drug abuse, mainly heroin amongst the youth, introduced originally by tourists. It is estimated that there are about 50,000 users of heroin and about 200,000 users of cannabis in Sri Lanka today. To a nation which firmly believes that its citizens have a right to decent life with moral, humanitarian and spiritual values in a healthy and safe environment, this matter is of grave concern specially as it involves the youth who are the wealth of the nation.

The causes of drug addiction are many and include increased availability of drugs, expansion of communication, socio-economic factors, migration and rapid urbanisation, changes in attitudes and values toward society, community, family, religion, morality etc. and the ruthless exploitation of fellow human beings by drug traffickers. Social costs are heavy and are due to the drug crime and disease, increasing poverty among addicts,

overcrowded prisons, social and family disruption, human suffering and the like. Since the group at risk is primarily in the 15-35 years category the loss of productivity and manpower is enormous.

2.0 The role of the National Dangerous Drugs Control Board

To combat the growing problem of the drug abuse effectively, it is vital that all agencies of the government, provincial councils and non-governmental organisations join in a cooperative endeavour. The board will coordinate the implementation action based on the policies and guidelines approved by the government. To this end the NDDBC Secretariat will be expanded and will consist of the following sub divisions.

(1) Enforcement
(2) Preventative Education and Public Awareness
(3) Treatment Rehabilitation and after care

The Board will, in addition also have the following divisions

(4) Research and Training
(5) Drug Analytical (to facilitate law enforcement, treatment, and research)

Each division will have a suitable and permanent staff in order to engage in these activities more fully and to co-ordinate and monitor implementation strategies.

The short term and long term action plans developed will be based on national priorities and would be formulated keeping in mind the local needs and suitably adapting the strategies which are outlined in the United Nations Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control (CMO). The CMO is the compendium of practical action for combating drug abuse and illicit trafficking. The UN General Assembly has on several occasions urged the governments to use the CMO in the formulation of their own programmes.

3.0 Strategy Outline

The Strategy for implementation will be presented under the following policy subject headings which will also contain appropriate lists of relevant government and other agencies.

(a) Enforcement,
(b) Preventative Education and Public Awareness
(c) Treatment, Rehabilitation and After care
(d) International and Regional Co-operation

4.0 Enforcement

It is necessary to ensure vigorous enforcement of the law in order to reduce the illicit availability of drugs, deter drug related disease and to create an environment favourable to drug abuse prevention.

Thus, enforcement will be made more effective through the following:

4.1 Building- up intelligence on trafficking, effective interdiction at all points of entry and strengthening operational capabilities of all enforcement agencies and personnel.

4.2 Extend scope of existing legislation to deal effectively not only with carriers but also more importantly with traffickers and financiers with maximum penalties and deprivation of the proceeds and their crimes.

4.3 Taking necessary steps to (1) expedite the hearing of drug cases (2) establish standard procedures for the safe handling of court productions of drugs.

4.4 Tightening controls over legal drugs prescribed in Sri Lanka to prevent “leakage” to the illicit market.

4.5 Stressing alternatives to imprisonment such as treatment and rehabilitation programmes for the dependants wherever appropriate.

4.6 Giving adequate resources to the enforcement agencies at all times and facilitating maximum use of specialised personnel.

4.7 Monitoring the effectiveness of present enforcement agencies island-wide to assess the extent of their impact on the trafficking and availability of drugs at street level. If it is found necessary that a combined enforcement thrust should be wielded by a new single agency establishing such an agency under the NDDCB.

4.8 Supporting international efforts to curb the production, transiting and trafficking of drugs.

4.9 Entering into treaties with other states to cover exchange of prisoners, mutual legal assistance, extradition and controlled delivery.

4.10 Government and other Implementing agencies.

(a) Ministry of Defence (Police, Armed Services, Immigration and Emigration, NDDCB)
(b) Ministry of Finance (Customs, Excise)
(c) Ministry of Foreign Affairs
(d) Ministry of Health
(e) Ministry of Justice and Parliamentary Affairs (Courts, Prisons, Attorney Generals Department)
(f) Ministry of Public Administration and Home Affairs (Provincial Councils)

5.0 Preventative Education and Public Awareness

Accepting that prevention is more efficient and cost effective than either enforcement and/or treatment, the government will facilitate better use of all preventative educational opportunities. Focus will be on formed curricula, informal and non-formal education activities and the use of mass media.

Awareness and educational programmes will utilise all mass media. Measures will also be taken to impact relevant, facets of knowledge, positive attitudes coping skills, particularly to young people.

5.1 The role of mass media

5.1.1 A multi-media approach will be taken, paying attention to allocation of media space/time, supplementary media inputs, appropriate material selection and effective presentation of material.

5.1.2 Each media will be promoted to have specialised preventative education cells and personnel.

5.1.3 The board and other appropriate organisations will facilitate dissemination of relevant knowledge to media specialised in skills is presentation of material, conduct and update training programmes and where possible play and monitoring role on media effectiveness.

5.1.4 Guidelines and ethical codes will be evolved with regard to the portrayal o drug abuse related incidents in the media.

5.2 Prevention through Education

5.2.1 Modules pertaining to drug abuse will be included where possible in programmes of formal and non-formal education.

5.2.2 Extracurricular activities will be carefully planned and organised in order to supplement the class room learning

5.2.3 All educational institutions will have access to a functional counselling service which also will have the capability of dealing with drug related problems. Access will where necessary be made available for the testing or the presence of drugs in the body and for treatment and rehabilitation.

5.3 Prevention in the work place

5.3.1 Employers will publicise among the work force the information regarding consequences of peddling or the use

of drugs. Employers “and workers” organisations will develop joint action programmes for this purpose.

5.3.2 Testing for the presence of drugs in the body will be recommended where necessary.

5.3.3 Employee assistance programmes will be initiated.

5.4 Leisure time activities

5.4.1 The provincial councils and local authorities will have community based programmes to cater to a wide range of interests of persons at risk, especially the school drop outs and the unemployed. These programmes will act as viable alternatives and discourage deviant behaviour such as drug abuse.

5.5 Development of employable work skills

5.5.1 Relevant institutions will provide vocational training for youth with a view to opening up avenues of appropriate employment.

5.6 Government and other Implementing Agencies

(a) Ministry of Defence (NDDCB)

(b) Ministry of Education, Cultural affairs and Information (Institute of Higher Education, NIE, Department of Information, SLBC, SLRC, ITN, Lankapuwath)

(c) Ministry of Labour and Social Welfare

(d) Ministry of public administration and Home Affairs (Provincial Councils, Municipal Councils)

(e) Ministry of Youth Affairs and Sports (NYSC, NAB)

(f) NGO’s

6.0 Treatment, Rehabilitation and After Care

In order that the process of treatment to be completed, the phase of treatment and detoxification must be integrated with the phases of rehabilitation and after care.

Treatment, rehabilitation and after care will be through the following measures:

6.1.1 In the view of the large number of persons voluntarily seeking treatment, a short term Action Plan will be drawn up by the Ministry of Health to deal with the immediate problem.

On the long term basis the Department of Health will be responsible for coordinating and giving guidance to the development and maintenance of the comprehensive national treatment programme for drug dependants.

6.1.2 The active cooperation and collaboration of the non-governmental sector will be encouraged.

6.1.3 Treatment facilities will be made freely available. Where possible it will be encouraged.

6.1.4 Appropriate health care professionals cadres will be given training in the treatment and care of drug abusers.

6.1.5 Treatment/ Detoxification will be supported with counselling, educational and other social measures.

6.1.6 Legislation will be enacted and facilities will be provided for compulsory treatment where appropriate.

6.1.7 Government and other Implementing Agencies

(a) Ministry of Defence (NDDCB)
(b) Ministry of Health
(c) Ministry of Justice and Parliamentary Affairs (Prisons)
(d) Ministry of Labour and Social Welfare (Department of Probation and Child Care)
(e) NGO's

6.2 Rehabilitation and After-care

The objective of rehabilitation and after-care will be the integration of former dependants into society.

Rehabilitation and after-care will consist of regular follow up, giving social support and training and channelling into appropriate vocations. Trained personnel of the implementing government agencies listed below will take part in this process. If the magnitude of the problem warrants it the NDDCB may engage in a coordinating or catalyst role.

6.2.1 Government and other Implementing Agencies

(a) Ministry of Defence (NDDCB)
(b) Ministry of Health
(c) Ministry of Justice and Parliamentary Affairs (Prisons)
(d) Ministry of Labour and Social Welfare (Department of Probation and Child Care)
(e) Ministry of public administration and Home Affairs (Provincial Councils, Municipal Councils)
(f) NGO's

7.0 International and Regional Co-operation

It is accepted that no country could tackle its drug problem in isolation. The government will encourage the relevant agencies to actively engage in formal international co-operation through bilateral, regional and international collaboration as follows:

7.1 Sri Lanka government has been a party of the 1961 Single convention on Narcotic Drugs and the Amendment protocol of 1972. Expeditious action will be taken to accede to the 1971 Convention on Psychotropic Substances and the 1988 Convention on Illicit Trafficking in Narcotic Drugs and Psychotropic Substances. In pursuance of this undertaking the NDDCB will take appropriate action and will assist the relevant Ministries to do likewise.

7.2 International cooperation will also be encouraged through NGOs which have international connections or dealings and collaborative mechanisms.

Appendix C

Interview questions around the first Sri Lankan National Policy for the Prevention and Control of Drug Abuse (1994)

1. What are some of the reasons for the government to introduce a national policy on drugs in 1994?
2. Why was it important to produce a national policy on drugs at the time?
3. Who was mainly involved in formulating the first national policy on drugs?

   Prompts:

   Key individuals/people, departments/organisations, interest groups, contribution of stakeholders in the production of initial national policy
4. Who was influential in the entire process?
5. Why have they been most influential?

   Prompts:

   - The role of the Chairman and Executive Director
   - The relationship with the Defence Minister who was also in-charge of all drug related activities in the country.
6. Can you give me some examples on how they (identified people) influenced policy?
7. Who were the religious leaders who may have influenced policy?
8. Can you please tell me the role of religious leaders when formulating the policy?
9. What were some of the differences/tensions between departments or people when formulating the first national policy?
10. Can you please give me some examples on how these differences were managed?
11. In general, how were issues raised and discussed during policy formulation?
12. What are some of the barriers to the development of a national treatment programme for drug users?

13. Were there any political issues that had to be taken into consideration when formulating the first national policy on drugs? If so, what were they?

    Prompts:

    - Local and international issues
    - New left wing government coming into office (broad alliance/coalition government)

14. How were these political issues managed?
15. What were some of the statistics or data used when drafting the first national policy on drugs?
16. Can you give me some examples on how this data or information was used in the policy?
17. Finally, can you please identify someone who shares your perspective and another person who may have a different perspective?
18. Who else should I interview?

Appendix D

Interview questions around the role of different stakeholders in policy formulation and implementation

1. Looking at available literature, am I right to say that there has been a shift in drug policies since mid-1980s?
2. Can you please tell me about those changes?
3. Why was it necessary to bring these changes?
4. What was your involvement in response to the drug problem in the 80s?
5. Can you please tell me about your involvement prior to 1980s?
6. How did the medical profession respond to the drug problem at the time?
7. Can you give me some examples on how the medical profession was involved in policy-making?
8. How did the medical profession perceive the drug problem at the time?
9. Did the drug problem require a medical response at the time?
10. If so, why? And if not, why not?
11. Which groups or individuals were more powerful or influential in drug policy in the 1980s?
12. Can you give me some examples on how the medical profession influenced drug policy?
13. Have you noticed a change in those people who advocated on drug policy over the last twenty years?
    - Groups
    - Organisations
    - Individuals
    - Other professional groups (E.g. lawyers)
14. Are there any particular reasons for these changes? *(only if identified)*
15. At any point, has the medical profession worked closely with either the legal profession or any religious leaders in the creation of drug policy?
16. If so, can you give me some examples?
17. How has the medical profession implemented the national drug policy?
18. How have others implemented the national drug policy?

Can you please provide some examples

19. Is the current drug policy working? Please give examples.
20. How could we improve drug treatment in Sri Lanka?
21. How could we improve drug control in Sri Lanka?

Appendix E

Interview questions around the President's Election Manifesto 2005

1. The President's election manifesto 2005, in its first chapter titled "towards a disciplined society" looks at the drug problem in the country. Why was it important to include a section titled "an end to the drug menace"?
   Prompts:
   - The government's/President's view on the drug problem
   - Public views on the drug problem known to the government/president
   - Previous election manifestos
2. Who was mainly involved in formulating the section on "an end to the drug menace"?
   Prompts:
   - Key individuals, organisations, interest groups
   - The role of the NDDCB
3. Who influenced the content of the section "an end to the drug menace" and why have they been influential?
4. Can you please give me some examples on how they (identified people and organisations) influenced the content of this document?
   Prompts:
   - Power and why have they been powerful
5. What was the role of religious leaders when formulating the section on "an end to the drug menace"?
   Prompts:
   - Buddhist views on abstinence
   - Buddhist support for the election being based on this policy
6. How was this pledge different from the opposition?
   Prompts:

- UNP opposition leader's views on the drug problem and his pledge

7. What are some of the political issues that had to be taken into consideration when formulating this pledge?
   Prompts:
   - Coalition views and opinions
   - Public/interest group views and demands
   - International interests

8. How were these political issues managed?

9. What were some of the differences between people, parties or organisations when formulating this pledge?

10. The Presidential election pledge states "I will be dedicated to the task of totally eradicating the drug menace presently experienced in Sri Lanka. I will do so within a period of three years through a co-ordinated effort covering the implementation of laws, the actions of police and other social institutions". Why was it important to make this pledge to the public?

11. Can you give me some examples of evidence or information that was used when this pledge was made?
    Prompts:
    - Examples from neighbouring countries
    - Election manifestos from other countries
    - Information/data from the NDDCB or any other organisation

12. To what extent has this pledge been delivered so far and what are some of the lessons learned?
    Prompts:
    - Availability of drugs and its use at present
    - Rehabilitation for drug users

13. How has this election pledge had an impact on policy developments?

    Prompts:

    - Introduction of the Treatment & Rehabilitation Act in 2007
    - Revision of the first master plan

14. Finally, can you please identify someone who shared your perspective and another person who may have a different perspective?

15. Who else should I interview?

Appendix F

Interview questions around the Drug Dependant Persons Treatment and Rehabilitation Act No. 54 of 2007

1. What are some of the reasons for the government to introduce a Drug dependant Persons Treatment & Rehabilitation Act in 2007?
   Prompts:
   - The rationale for compulsory treatment
   - Overcrowded prisons
   - Regulating treatment & rehabilitation in the country (rationale for implementing a licensing system)
   - Political vision outlined in the President's election manifesto

2. Compulsory treatment as an alternative to imprisonment was identified as far back as 1994. Why do we see its introduction in 2007, 13-years later?

3. Who was mainly involved in formulating this Act and why?
   Prompts:
   - Key individuals/people, international organisations, national departments/organisations, interest groups, contribution of stakeholders in the creation of this Act
   - The role of the medical profession/Ministry of Health
   - Role of NGOs (FONGOADA)
   - Any new stakeholders/players entering the policy arena

4. Who was influential in this entire process?

5. Why have they been most influential?
   Prompts:
   - The role of the Chairman and Executive Director
   - The relationship with the Defence Minister who was also in-charge of all drug related activities in the country.

- The role of international organisations- e.g. UNODC, Colombo Plan, WHO
- Role of other countries and their knowledge experts
- Role of religious leaders (if appropriate)

6. Can you give me some examples on how they (identified people/organisations) influenced the creation of this Act?

7. Have you or any other person attended any national or international workshops or conferences on compulsory treatment for drug users?
   Prompts:
   - Who facilitated them/where/which country?
   - What did you/they learn from it?
   - Did Sri Lanka follow any models/policies from another country?

8. What were some of the differences/tensions between departments and national/international organisations when formulating this Act?

9. Can you please give me some examples on how these differences were managed?

10. In general, how were issues raised and discussed during policy formulation?

11. Were there any political issues that had to be taken into consideration when formulating this Act? If so, what were they?
    Prompts:
    - Election manifesto/Mathata thita
    - Local and international issues/interests

12. How were these political issues managed?

13. What sort of information/data have you used to support/formulate this Act?

Prompts:

- Treatment and rehabilitation statistics
- Outcome data (from rehab centres, prisons, treatment centres)
- Crime/prison statistics

14. Were there any other policies that influenced the development of this Act?

    Prompts:

    - Mathta Thita election manifesto
    - Policies at international level (UN Policies)

15. Finally, can you please identify someone who shares your perspective and another person who may have a different perspective?

16. Who else should I interview?

Appendix G

Information Sheet for Research Participants

Study Title

Drug Policy-making in Sri Lanka: an exploratory study

What is the purpose of the study?

The research is a study on drug policy in Sri Lanka. It will involve key person interviews and a review of the literature. The aim of the study is to explore and analyse strengths and weaknesses of drug policies in Sri Lanka.

Do I have to take part?

It is entirely up to you to decide whether or not to take part. However, your decision to take part in this study can make an important contribution to the research. If you decide to take part, you are free to withdraw at any time without having to give a reason.

How do I take part?

If you are happy to take part in this research, you will be requested to sign a consent form and take part in a face-to-face interview. This can be arranged at your convenience. The interview lasts 45-60minutes. With your permission, it will be tape recorded. The interviews are tape recorded because I can capture all the details for analysis at a later stage. Recorded tapes are stored safely and destroyed after they have been analysed.

What are the possible benefits of taking part?

Whilst there may be no personal benefits to your participation in this research, the information you provide can contribute to the future development of policy and practice.

Is this confidential?

Information provided by you will be kept strictly confidential at all times. Your responses to interview questions and information you provide will be anonymous. For example, no personal details relating to you, your position or where you work will be recorded anywhere.

What will happen to the results of the research study?

The results are likely to be published upon successful completion of this research. Your confidentiality will be ensured at all times. Your name, position or where you work will not be identified in any publication. At the end of the study, the results can be made available to you should you wish.

For further information contact:

Nimesh Samarasinghe
Tel 0044 1895 258 130 (U.K) or 0777 106 867 (Mobile in Sri Lanka)
Email: nimesh.samarasinghe@nhs.net

Your help is greatly appreciated. Thank you for taking part in the study.
You will be given a copy of this sheet and a signed consent form to keep.

Appendix H

Research Consent Form

Study title: Drug Policy-making in Sri Lanka

(The volunteer and researcher should complete this sheet)

Have you read the information sheet for research participants?

Yes No

Have you had the opportunity to ask questions and discuss the study?

Yes No

Have you received satisfactory answers to all your questions?

Yes No

Have you received enough information about the study?

Yes No

Do you understand that you are free to withdraw from the study at any time without having to give reason

Yes No

Do you agree for the interview to be tape-recorded?

Yes No

Would you like a copy of the transcribed interview so you can add or change anything you have said?

Yes No

Do you agree to take part in the study?

Yes No

YOUR NAME IN BLOCK LETTERS:.....

YOUR SIGNATURE:.....

Date:.....

NAME OF PERSON OBTAINING CONSENT

NIMESH SAMARASINGHE

Signature:..... Date:.....

Appendix I

SAARC CONVENTION ON NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES

THE MEMBER STATES OF THE SOUTH ASIAN ASSOCIATION FOR REGIONAL COOPERATION (SAARC)

MINDFUL of the principles of cooperation enshrined in the SAARC Charter;

RECALLING that at the Islamabad Summit on December 29-31, 1988, Heads of State or Government of the Member States of SAARC expressed grave concern over the growing magnitude and the serious effect of drug abuse and drug trafficking and recognised the need for urgent and effective measures to eradicate this problem including the possibility of concluding a Regional Convention on Drug Control;

RECOGNISING that a regional Convention on Narcotic Drugs and Psychotropic Substances would be a step forward in augmenting SAARC efforts to eliminate drug trafficking;

ALSO RECOGNISING the need to re-enforce and supplement, at the regional level, the measures provided in the Single Convention on Narcotic Drugs, 1961, as amended by the Protocol of 1972, the Convention on Psychotropic Substances, 1971, the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, taking into account concerns which are specific to the SAARC region;

DESIRING to eliminate the root causes of the problem of abuse of narcotic drugs and psychotropic substances, including the illicit demand for such drugs and substances and the enormous profits derived from illicit traffic;

TAKING COGNIZANCE of the links between illicit drug trafficking and other related organised criminal activities, which undermine the economies and threaten the stability, security and sovereignty of States;

CONVINCED of the importance of strengthening and enhancing effective legal means for regional cooperation in criminal matters for suppressing international criminal activities of illicit traffic in narcotic drugs and psychotropic substances;

HAVE AGREED AS FOLLOWS:

Article I
DEFINITIONS

Except where otherwise expressly indicated or where the context otherwise requires, the following definitions shall apply throughout this Convention:

(a) "Cannabis plant” means any plant of the genus Cannabis;

(b) "Coca Bush" means the plant of any species of the genus Erythroxylon;

(c) "Confiscation" which includes forfeiture where applicable; means the permanent deprivation of property by order of a court or other competent authority;

(d) "Controlled delivery" means the technique of allowing illicit or suspect consignments of narcotic drugs, psychotropic substances, substances listed in Table I and Table 11 annexed to the 1988 UN. Convention, or substances substituted for them, to pass out of; through or into the territory of one or more countries, with the knowledge and under the supervision of their competent authorities, with a view to identifying persons involved in the commission of offences established in accordance with Article 3, paragraph 1 of this Convention;

(e) "1961 Convention" means the Single Convention on Narcotic Drugs, 1961;

(f) "1961 Convention as amended" means the Single Convention on Narcotic Drugs, 1961 as amended by the 1972 Protocol amending the Single Convention on Narcotic Drugs, 1961;

(g) "1971 Convention" means the Convention on Psychotropic Substances, 1971;

(h} ”1988 UN Convention" means the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988;

(i) "Freeze” or "Seize" means to temporarily prohibit the transfer, conversion, disposition or movement of property or temporarily assuming custody or control of properly on the basis of an order issued by a court or a competent authority;

(j) “Illicit traffic" means the offences set forth in Article 3, of this Convention;

(k) "Narcotic Drug" means any or the substances, natural or synthetic, listed in Schedules I and II of the 1961 Convention and the 1961 Convention as amended;

(l) "Opium poppy” means the plant of the species Papaver Somniferum L;

(m) "Proceeds" means any property derived from or obtained, directly or indirectly, through the commission or an offence established in accordance with Article 3, paragraph 1 of this convention;

(n) "Property" means assets of every kind, whether corporeal or incorporeal, movable or immovable, tangible or intangible, and legal documents or instruments evidencing little to, or interest in, such assets;

(0) "Psychotropic Substance" means any substance natural or synthetic or any natural material listed in Schedules I, II, III and IV of the 1971 Convention;

(p) "Secretary-General" means the Secretary-General of the South Asian Association for Regional Cooperation (SAARC).

Article 2
SCOPE OF THE CONVENTION

1. The purpose of this Convention is to promote cooperation among Member States, so that they may address more effectively the various aspects of prevention and control of drug abuse and the suppression of illicit traffic in narcotic drugs and psychotropic substances, which are specific to the SAARC region,

2. Member States in carrying out their obligations under this Convention shall take necessary measures, including legislative and administrative measures, in conformity with the fundamental provisions of their respective domestic legislative systems.

3. Member States shall carry out their obligations under this Convention in a manner consistent with the principles of sovereign equality and territorial integrity of States and that of non-intervention in the domestic affairs of other States

4. A Member State shall not undertake in the territory of another Member State, the exercise of jurisdiction and performance of functions, which are exclusively, reserved for the authorities of that other State by its domestic law.

Article 3
OFFENCES

1. Each Member State shall adopt such measures as may be necessary to establish as criminal offences tinder its domestic law, when committed intentionally:

(a) the production, manufacture, extraction, preparation, offering, offering for sale, distribution, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation or exportation of any narcotic drug or any psychotropic substance contrary to the provisions of the 1961 Convention, The 1961 Convention as amended or the 1971 Convention;

(b) the cultivation of opium poppy, coca bush or cannabis plant for the production of narcotic drugs contrary to the provisions of the 1961 Convention and the 1961 Convention as amended;

(c) the possession or purchase of any narcotic drug or psychotropic substance for the purpose of any of the activities enumerated in (a) above;

(d) the manufacture, transport or distribution of equipment or materials, or of substances as listed in Table I and Table II of the 1988 UN. Convention, knowing that they are being or are to be used in or for the illicit cultivation, production or manufacture of narcotic drugs or psychotropic substances;

(e) the organisation, management or financing or any of the offences enumerated in (a), (b), (c) or (d) above;

(f) the conversion or transfer of property, knowing that such property is derived from the proceeds from any offence or offences established in accordance with sub-paragraph (a), (b), (c), (d) or (C) of this paragraph, or from an act of participation in such offence or offences, for the purpose of concealing or disguising the illicit origin of The properly or of assisting any person who is involved in the commission of such an offence or offences to evade the legal consequences of his actions;

(g) the concealment or disguise of the true nature, source, location, disposition, movement, rights with respect to, or ownership of property, knowing that such property is derived from an offence or offences established in accordance with sub-paragraph (a), (b), (c), (d) or (e) of this paragraph or from an act of participation in such an offence or offences;

(h) the acquisition, possession or use of property, knowing, at the time of receipt, that such property was derived from an offence or offences established in accordance with sub-paragraph (a), (b), (c), (d) or (e) of this paragraph or from an act of participation in such offence or offences;

(i) the possession of equipment or materials, or of substances listed in Table I and Table II, of the 1988 UN. Convention knowing that they are being or are to be used in or for the illicit cultivation, production or manufacture of narcotic drugs or psychotropic substances;

j) publicly inciting or inducing others, by any means, to commit any of the offences established in accordance with this Article or to use narcotic drugs or psychotropic substances illicitly;

(k) participation in, association or conspiracy to commit, attempts to commit and aiding, abetting, facilitating and counselling the commission of any of the offences established in accordance with this Article.

2. Subject to its constitutional principles and the basic concepts of its legal system, each Member State shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention.

Article 4
SANCTIONS

1. Each Member State shall make the commission or the offences established in accordance with Article 3 punishable by appropriate penalties, which take into account their grave nature.

2. The Member States may provide in addition to conviction or punishment for an offence established in accordance with Article 3, paragraph 1 that the offender shall undergo measures such as treatment, education, after-care, rehabilitation or social re-integration.

3. Notwithstanding anything contained in the preceding paragraphs, in appropriate cases of a minor nature, the Member States may provide, as alternatives to conviction or punishment, measures such as education, rehabilitation or social re-integration, as well as, when the offender is a drug abuser, treatment and after-care.

4. The Member States shall ensure that their courts and other competent authorities having jurisdiction can take into account factual circumstances which make the commission of the offences established in accordance with Article 3, paragraph 1 particularly serious, such as

(a) the involvement in the offence of an organised criminal group to which the offender belongs;

(b) the involvement of the offender in other international organised criminal activities;

(c) the involvement of the offender in other illegal activities facilitated by commission of the offence;

(d) the use of violence or arms by the offender;

(e) the fact that the offender holds a public office and that the offence is connected with the office in question;

(f) the victimisation or use of minors;

g) the fact That the offence is committed in a penal institution or in an educational institution or social service facility or in their immediate vicinity or in other places to which school children and students resort for educational, sports and social activities;

(h) prior conviction, particularly for similar offences, whether foreign or domestic, to the extent permitted under the domestic law of a Member State.

5. The Member States shall also ensure that their courts or other competent authorities bear in mind the serious nature of the offences established in accordance with Article 3, paragraph 1 or the circumstances enumerated in paragraph 4 of this Article, when considering the eventuality of early release or parole of persons convicted for such offences.

Article 5
JURISDICTION

1. Each Member State shall take such measures as may be necessary to establish its jurisdiction over the offences established in accordance with Article 3, paragraph 1 when:

(a) the offence is committed in its territory;

(b) the offence is committed on board a vessel flying its flag or an aircraft, which is registered under its laws at the time the offence, is committed;

(c) the offence is committed by one of its nationals or by a person who has his habitual residence in that territory;

(d) the offence is one of those established in accordance with Article 3, paragraph 1(k) and is committed outside its territory with a view to the commission, within its territory, of an offence established in accordance with Article 3,. paragraph 1.

2. Each Member State may likewise take such measures as may be necessary to establish its jurisdiction over the offences established in accordance with Article 3, paragraph 1, in cases where the alleged offender is present in its territory and it does not extradite him to another Member State.

3. This Convention does not exclude the exercise or any criminal jurisdiction established by a Member State in accordance with domestic law.

Article 6

PROVISION OF INFORMATION

1. The Member State in which any or the offences established in accordance with Article 3, paragraph 1, has been committed shall, if it has reason to believe that, an alleged offender had fled from its territory, communicate to all other States concerned all the pertinent facts regarding the offence committed and all available information regarding the identity of the alleged offender.

2. Upon being satisfied that the circumstances so warrant, the Member State in whose territory the alleged offender is present shall take appropriate measures under its domestic law so as to ensure his presence for the purpose of prosecution or extradition. Such measures shall be notified, without delay to:

(a) the State where the offence was committed; and

(b) the State or States of which the alleged offender is a national or if he is a stateless person in whose territory he permanently resides.

Article 7
PROSECUTION

The Member State in whose territory the alleged offender is present shall, if it does not extradite him, submit, without exception whatsoever and without undue delay, the case to its competent authorities for the purpose of prosecution through proceedings in accordance with the laws of that State.

Article 8

EXTRADITION

1. To the extent that the offences established in accordance with Article 3, paragraph 1, are not listed as extraditable offences in any Extradition Treaty existing between Member States, they shall be deemed to be included as such therein.

2. Member States undertake to include the offences established in accordance with Article 3, paragraph 1, as extraditable offences m every future Extradition Treaty to be concluded between them.

3. If a Member State which makes extradition conditional on the existence of a Treaty receives a request for extradition from another Member State with which it has no Extradition Treaty, the requested State may, at its option, consider this Convention as the basis for extradition in respect of the offences established in accordance with Article 3, paragraph 1.

4. Member States which do not make extradition conditional on the existence of a Treaty, shall recognise the offences established in accordance with Article 3, paragraph 1, as extraditable offences between themselves.

5. Extradition shall be subject to the law of the requested State.

Article 9
NON-FISCAL AND NON-POLITICAL OFFENCES

The offences established in accordance with Article 3, paragraph shall not be regarded as fiscal offences or as political offences or as offences connected with a political offence or as offences inspired by political motives, without prejudice to the constitutional limitations and the fundamental domestic law of the Member States.

Article 10
CONFISCATION

1. Each Member State shall adopt such measures as may be necessary to enable the confiscation of:

(a) Proceeds derived from offences established in accordance with Article 3, paragraph 1, or property the value of which corresponds to that of such proceeds;

(b) Narcotic drugs and psychotropic substances, materials and equipment or other instrumentalities used in or intended for use in any manner in offences established in accordance with Article 3.

2. Each Member State shall also adopt such measures as may be necessary to enable its competent authorities to identify, trace and freeze or seize proceeds, property, instrumentalities or any other things referred to in paragraph 1 or this Article for the purpose of eventual confiscation.

Article 11
MUTUAL LEGAL ASSISTANCE

1. The Member States shall afford one another pursuant to this Article, the widest measures of mutual legal assistance in investigations prosecutions arid judicial proceedings in relation to criminal offences established in accordance with Article 3, paragraph I.

2. Mutual legal assistance to be afforded in accordance with this Article may be requested for all or any of the following purposes:

(a) Taking evidence or statements from persons;

(b) Effective service of judicial documents;

(c) Executing searches and seizures;

(d) Examining objects arid sites;

(e) Providing information and evidentiary items;

(f) Providing originals or certified copies of relevant documents and records, including bank, financial, corporate or business records;

g) Identifying or tracing proceeds, property, instrumentalities or other things for evidentiary purposes.

3. The Member States may afford one another any other forms of mutual legal assistance allowed by the domestic law of the requested State.

4. Upon request, the Member States shall facilitate or encourage, to the extent consistent with their domestic law and practice, the presence or availability of persons, including persons in custody, who consent to assist in investigations or participate in proceedings

5. A Member State shall not decline to render mutual legal assistance under this Article on the ground of bank secrecy.

6. The provisions of this Article shall not affect the obligations under any other treaty, bilateral or multilateral, which governs or will govern, in whole or in part, mutual legal assistance in criminal matters

7. The Member States shall designate an authority, or when necessary authorities, which shall have the responsibility and power to execute requests for mutual legal assistance or to transmit them to the competent authorities for execution the authority or the authorities designated for this purpose, shall be notified directly to each Member State and to the Secretary-General. Transmission or requests for mutual legal assistance and any communication related thereto shall be effected between the authorities designated by the States; this requirement shall be without prejudice to the right of a State to require that such requests and communications be addressed to it through diplomatic channels and, in urgent circumstances, where the States agree, through channels of the International Criminal Police Organisation, if possible.

8. Requests for mutual legal assistance shall be made in writing. In urgent circumstances, and where agreed to by the States, requests may be made orally, which shall he confirmed in writing forthwith.

(a) The identity of the authority making the request;

(b) The subject matter and nature of the investigation prosecution or proceeding to which the request relates and the name and the functions of the authority conducting such investigation, prosecution or proceeding;

(e) A summary of the relevant facts, except in respect of requests for the purpose of services of judicial documents;

(d) A description of the assistance sought and details of any particular procedure the requesting State wishes to he followed;

(e) Where possible, the identity, location and nationality of any person concerned;

(f) The purpose for which the evidence, information or action is sought.

10. The requested State may request additional information when it appears necessary for the execution of the request in accordance with its domestic law or when it can facilitate such execution.

11. A request shall be executed in accordance with the domestic law of the requested State and where possible, in accordance with the procedure specified in the request.

12. The requesting State shall not transmit nor use information or evidence furnished by the requested State for investigations, prosecutions or proceedings other than those stated in the request without the prior consent of the requested State.

13. The requesting State may require that the requested State keep confidential the fact and substance of the request, except to the extent necessary to execute the request. If the requested State cannot comply with the requirement of confidentiality, it shall promptly inform the requesting State.

14. Mutual legal assistance may be refused:

(a) If the request is not made in conformity with the provisions of this Article;

(b) If the requested State considers that execution of the request is likely to prejudice its sovereignty, security, public order (ordre public) or other essential interest;

(c) If the authorities of the requested State would be prohibited by its domestic law from carrying out the action requested with regard to any similar offence, had it been subject to investigation, prosecution or proceedings under their own jurisdiction;

(d) If it would be contrary to the legal system of the requested State relating to mutual legal assistance for the request to be granted.

15. Reasons shall be given for any refusal of mutual legal assistance.

16. Mutual legal assistance may be postponed by the requested State on the ground that it interferes with an ongoing investigation, prosecution or proceeding. In such a case, the requested Slate shall consult with the requesting State to determine it the assistance call still be given subject to such terms and conditions as the requested State deems necessary.

17. A witness, expert or other person who consents to give evidence in a proceeding or to assist in an investigation, prosecution or judicial proceeding in the territory of the requesting State, shall not be prosecuted, detained, punished or subjected to any other restriction of his personal liberty in that territory in respect of acts, omissions or convictions prior to his departure from the territory of the requested State. Such safe conduct shall cease when the witness, expert or other person having had, for a period of fifteen consecutive days, or 0 for any period agreed upon by the States, from the date on which he has been officially informed that his presence Is no longer required by the judicial authorities, an opportunity of leaving, has nevertheless remained voluntarily in the territory or, having left it, has returned of his own free will.

18. The ordinary costs of executing a request shall be borne by the requested State, unless otherwise agreed to by the States concerned. If expenses of a substantial or extraordinary nature are or will be required to fulfill the request, the States shall consult to determine the terms and conditions under which the request will be executed as well as the manner in which the costs shall be borne.

Article 12
MEASURES TO ERADICATE ILLICIT CULTIVATION OF NARCOTIC PLANTS AND TO ELIMINATE ILLICIT DEMAND FOR NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES

1. Each Member State shall take appropriate measures to prevent illicit cultivation of and to eradicate plants containing narcotic or psychotropic substances, such as opium poppy, coca bush and cannabis plants, cultivated illicitly in its territory.

2. The Member States may cooperate to increase the effectiveness of eradication efforts. Towards this end, Member States shall also facilitate the exchange or scientific and technical information and the conduct of research concerning eradication.

3. The Member States shall adopt appropriate measures aimed at eliminating or reducing illicit demand for narcotic drugs and psychotropic substances, with a view to reducing human suffering and eliminating financial incentives for illicit traffic.

4. The Member States may also take necessary measures for early destruction or lawful disposal of the narcotic drugs, psychotropic substances and substances listed in Table I and Table II of the 1988 UN. Convention, which have been seized or confiscated.

Article 13

SUPPRESSION OF OFFENCES

1. The Member States shall cooperate closely with one another, consistent with their respective domestic legal and administrative systems, with a view to enhancing the effectiveness of law enforcement action to suppress he commission of offences established in accordance with Article 3, paragraph 1. For this purpose they may establish and maintain channels of communication between their competent agencies to facilitate the secure and rapid exchange or information concerning all aspects of such offences.

2. The Member States may take necessary measures to allow for the appropriate use or controlled delivery on the basis of bilateral agreements with a view to identifying persons involved in offences established in accordance with Article 3, paragraph 1, and to taking legal action against them.

Article 14

COOPERATION AND INFORMATION

The Member States shall furnish information to each other and lo the Secretary-General on the implementation of this Convention in their territories and in particular;

(a) The texts of laws and regulations promulgated in order to give effect to the Convention;

(b) Particulars of cases of illicit traffic within their jurisdiction, which they consider important because of new trends, disclosed, the quantities involved, the sources front which the substances are obtained or the methods employed by persons so engaged.

Article 15

APPLICATION OF STRICTER MEASURES

A Member State may adopt more strict or severe measures than those provided by this Convention, if in its opinion, such measures are desirable or necessary for the prevention or suppression of illicit traffic.

Article 16

SIGNATURE AND RATIFICATION

1. The Convention shall be open for signature by the Member States of SAARC at the Fifth SAARC Summit at Male' and thereafter, at the SAARC Secretariat at Katmandu.

2. It shall be subject to ratification. Instruments of Ratification shall be deposited with the Secretary-General.

Article 17

ENTRY INTO FORCE

This Convention shall enter into force on the fifteenth day following the day of the deposit of the seventh Instrument of Ratification with the Secretary-General.

Article 18

DEPOSITORY

The Secretary-General shall be the depository of this Convention and shall notify the Member States of signatures to this Convention and all deposits of Instruments of Ratification, The Secretary-General shall transmit certified copies of such instruments to each Member State. The Secretary-General shall also inform Member States of the date on which this Convention will have entered into force in accordance with Article 17.

IN WITNESS WHEREOF, the undersigned being duly authorised thereto by their respective Governments, have signed this Convention.

DONE AT Male' on this Twenty Third day of November One Thousand Nine Hundred and Ninety, in Eight originals, in the English Language, all texts being equally authentic.

ANISUL ISLAM MAHMUD

Minister of Foreign Affairs

People's Republic of Bangladesh

VIDYA CHARAN SHUKLA

Minister of External Affairs

Republic of India

DEVENDRA RAJ PANDAY

Minister for Finance

His Majesty's Government of Nepal

DAWA TSERING

Minister of Foreign Affairs

Kingdom of Bhutan

FATHULLA JAMEEL

Minister of Foreign Affairs

Republic of Maldives

SAHABZADA YAQUB-KHAN

Minister of Foreign Affairs

Islamic Republic of Pakistan

HAROLD HERAT

Minister of Foreign Affairs

Democratic Socialist Republic of Sri Lanka