RECOVERING NEPAL
Federation of PUD and Drug Service Organization

Annual Narrative report for the period of 2018

"Harm Reduction Advocacy in Asia"

Recovering Nepal
Kumaripati, Kathmandu
2018

Table of Contents

1. General Background:

Recovering Nepal is a National Federation of PUDs and Drug Service Organizations in Nepal. Recovering Nepal was originally founded in 2001 by energetic people who use drugs and PLHA to combat HIV and drugs and works through agreements with the government of Nepal. Recovering Nepal has 85 organizational members and informal individual members.

In 2003, a series of workshops were held where the drug users got an opportunity to share their experiences, reflect their feeling, observations, insights and learn from each other. These interactions led to the legal registration of Recovering Nepal in 2003. Since its establishment, Recovering Nepal has reached out to drug users via various support groups. Since May 2003, this group is serving as a strong network of committed people, who are helping in addressing the stigma discrimination, raising voice to promote basic rights, advocating for policy change and increasing quality access to affordable and comprehensive treatment and care for the PUDs who are living with HIV.

The organization promotes provision of HIV and Harm Reduction services and advocate for the rights of PUDs while focusing on strengthening the capacity of PUDs and their organizations to respond to the HIV epidemic, especially at the grassroots level. It is an organization by PUDs and for PUDs. We seek to increase Participation of PUDs in designing effective policies and programs. RN is committed to Increase Participation of Drug users in Designing Effective Policies & Programs, promoting human rights and public health approach to drug use and HIV/AIDS in Nepal by implementing following broader level interventions as;

Build the leadership and advocacy skills of IDUs so that they are able to participate meaningfully in the policymaking process;

Build support and partnerships between IDUs and district, regional and national policymakers and related bodies to improve their understanding of IDU issues related to HIV/AIDS prevention and care, reform operational policies to improve the policy framework;

Increase understanding of how HIV/AIDS and drug use-related stigma and discrimination impact on the provision of services for drug users and how reduction of stigma and discrimination for IDUs can improve implementation of HIV/AIDS programs.

2. HR Asia Projects:

India HIV/AIDS Alliance is the Principle Recipient (PR) for the Global Fund regional Harm Reduction Advocacy in Asia project (2017-2019), involves 7 countries in Asia (India, Vietnam, Indonesia, Cambodia, Thailand, Nepal and the Philippines), aims to maximize impact of investments that help break the cycle of transmission of HIV among PWID in concentrated

epidemics addressing legal, policy and health system barriers that hinder necessary outreach, coverage and access to core services.

3. Epidemiological situation according to Blue print for Change:

- Size estimate PWID: Minimum 27,248 and maximum 34,487, which is between 0.15% and 0.19% of the adult population.
- The breakdown by gender: 24,573 - 30,561 males and 2,676 - 3,926 females.
- HIV prevalence among PWID: 6.4% ; 8% PWID of the estimated adult population living with HIV (39,397) people living with HIV in 2015)
- HIV incidence among PWID: Data not available.
- HCV prevalence PWID: 87.3 (80.5-94%)
- Hot Spots/ distribution in country: Kathmandu, Kaski, Morang are the three districts with the highest number of PWID hot spots.
- Drug Use patterns: mainly injecting of opioids (buprenorphine) in combination with antihistamines and benzodiazepines (so called South Asian Cocktail)
- Condom use/Use of sterile injecting equipment: 52.5% / 96%

4. National Strategic Plans:

With the National Strategic Plan, Nepal has accepted the challenges of Fast-Tracking towards ending the AIDS epidemic as a public health treat by 2030, through achieving 90-90-90 treatment targets by 2020.

Priority actions recommended in the national HIV strategy are:

- Scale up HIV testing and treatment for key populations: through identify, reach, recommend, test , treat and retain and treatment as prevention
- Scale up evidence informed innovative methods to prevent new HIV infections among key populations: scale up targeted investments and coverage of community led activities and strategies, including strategic behavioural communication, condom programmes and harm reduction services for people who inject drugs.
- While other prevention target (harm reduction services) for PWID are 80-95%, the OST target has been increased in the national HIV Strategic Plan from 4%to 10%.

Relevant indicators to be achieved by 2021 set out in the National Strategic Plan in regards to PWID are:

Key indicator	Baseline 2015	Target 2021
Percentage of PWID living with HIV	6,4%	4%

Percentage of PWID who received an HIV test in the past 12 month	27,9%	90%
Percentage of PWID reporting the use of sterile injecting equipment last time they injected	96%	96%

5. Strategic Goals to Increase Impact of Harm Reduction Interventions:

To reach an 80% coverage of harm reduction services for PWID and the UNAIDS 90-90-90 target the following strategic goals need to be achieved. These goals will require a more consistent and long-term investment of resources, capacity building, advocacy and mobilization. Multiple stakeholders including the Government, Civil Society and the community will have to work together in realizing these goals, which are;

6. Objectives:

- Create an enabling legal and policy environment that supports the implementation of HIV and Harm Reduction interventions
- Strengthen PWID networks to enable meaningful engagement with national governments and regional mechanisms for a sustained HIV and drug use response
- Increase use of strategic information in shaping evidence and rights based HIV and Harm Reduction policies and activities of both previous objectives

7. Major activities under HR Asia project:

Harm Reduction (OST)	HEP C	Policies/Strategies/Guidelines
1. facilitate the revision of the OST guidelines in consultation with TWG formation of the national level task force	1. Facilitate regular meetings- National Hep C committee,	1. Development of the national Hep C treatment strategy
2. Hold National Level Consultation to incorporate the inputs on OST guideline revisions	2. Inclusion of the community and CSOs in the existing National Hep C committee.	2. Development national level treatment guidelines including

3. Facilitation of regular meetings of the TWG for Harm Reduction	3. Gather Advocacy and technical Inputs	3. Community based guidelines on Hep C testing, diagnosis and treatment for mono- and HIV co-infected PWID
Capacity for Advocacy	**Prison**	**HIV & Harm Reduction Policy Advocacy Related Activities.**
1. Advocacy Training Workshops and consultation meetings with national PWID networks (including networks for female PWUD) to strengthen advocacy capacity of CSOs and PWID networks.	1. Assessment of the prevalence, Health, Harm Reduction and HIV needs	1. Identification and development of HIV & harm reduction policy champions among : political leaders, pop stars, prominent journalists, religious leader, etc.
	2. Needs Assessment of the legal barriers to deliver the services within prison settings and	2. Consultations and meetings with Parliamentarians Forums and Sub - Committees of parliamentarians to advocate for drug policy reform and amendments in drug control law
	3. Recommendations for the law enforcement to address the needs and gaps	3. Provincial level sensitization meetings, drug policy meetings for development of evidence based state drug control policy and law
Drug Policy Reform	**Information, orientation and sensitization**	**Working with law enforcement**
1. Development of a task force/working committee under the Ministry of Home Affairs including community, CSOs, and government and civil society stakeholders to review the drug policy and drug control act. to identify specific clauses for amendment and ratification	1. Advocacy and sensitization of key stakeholders (health service providers, law enforcement, district administration, and other stakeholders) to familiarize them with the harm reduction programme on local level.	1. The inclusion of HIV & harm reduction in police training curriculum, Consultations with the police. 2. Development of the HIV and Harm Reduction training curriculum for police. National level consultation with law enforcement and related stakeholders for advocating

		the service delivery in prison setting - based on the assessment recommendations
Advocacy strategy	WUD capacity building activities	Abscess management and overdose management
1. Strategic Activities to Potentiate the Advocacy. Advocacy with Policy Champions, planning commission, ministry of finance, municipality, MoH, NCASC - for sustainable and Increased domestic funding synchronizing the agenda with SDG 3	1. Capacity building for key members of the WWUD network, 7 provincial level trainings on: Documentation and report writing	1. Training for the health service providers for abscess management and overdose management

8. List of Major interventions conducted in 2018 as per plan:

S. No.	Name of the activities	Remarks
1	Facilitation of regular meetings of the TWG for Harm Reduction	
2	Facilitation of regular meetings of the national HepC committee, Inclusion of the community and CSOs in the existing National HepC committee including advocacy for community based HepC testing, diagnosis and treatment for mono- and HIV co-infected PWID	
3	Hiring expert consultant and community expert for development of the national HepC treatment strategy and treatment guidelines including community based HepC testing,	
4	Provincial level sensitization meetings for drug policy meeting for development of state drug control policy and law	
5	Assessment of the prevalence, Health, Harm Reduction and HIV needs and assessment of the legal barriers to deliver the services within prison settings and recommendations for the law enforcement to address the needs and gaps	
6	Advocacy and sensitization of key stakeholders (health service providers, law enforcement, district administration, and other stakeholders) to	

	familiarize them with the harm reduction programme on local level	
7	Advocacy and Leadership trainings on Human Rights and Harm Reduction Services for Women Drug User Network	
8	Training for the health service providers for abscess management and overdose management	
9	Annual planning and review	
10	Multistakeholder consultation meeting	
11	SAARC Meeting	

9. Major activities conducted during 2018

9.1 Facilitation of regular meetings of the TWG for Harm Reduction:

The meeting about Facilitation of regular meetings of the TWG for Harm Reduction funded by GFATM and under technical support India HIV/AIDS Alliance held in Ministry of Home Affairs, Singhdurbar, Kathmandu on 10 August, 2018. The total altogether 16 authorized level participants were attended in the meeting and discussed on the following agenda as;

Agenda for the meeting:

- Program update
- SAARC level consultation meeting
- Satellite/mobile dispensing sites for OST
- OST site of Recovering Nepal in Chitwan
- Multi stakeholders meeting on OST
- Any Other Business

9.2 Facilitation of regular meetings of the national HepC committee, Inclusion of the community and CSOs in the existing National HepC committee including advocacy for community based HepC testing, diagnosis and treatment for mono- and HIV co-infected PWID:

RN held meeting with HEP C TWG committee in different dates to discuss on development of HEP treatment strategy and guidelines. Therefore Recovering Nepal organized a 'National Hep C Committee' meeting with the inclusion CSO's under the leadership of the National Centre for AIDS and STD Control (NCASC-MoHP), Teku, Kathmandu, under the 'HRASIA Project' to advocate for community

based Hep C testing, diagnosis and treatment for mono-infected and HIV co-infected PWID.

The meeting was co-chaired by Dr. Tara Nath Pokhrel, NCASC Director-Coordinator and Chair of national Hepatitis Steering Committee Dr. Dillip Sharma. The total altogether 26 participants representing from different organizations who attended in the meeting including key members such as :

a. Dr. Tara Nath Pokhrel, NCASC Director-Coordinator
b. Dr Guna Raj Lohani- Representative- Department of Drug Administration-Member
c. Dr. Anup Bastola – STIDTH-Member
d. Dr. Dilip Sharma- Bir Hospital-Member
e. Mr. Anjay KC Technical Advisor of Recovering Nepal
f. Mr. Prabachan KC-SPARSHA -Member
g. Dr. Marie Langrange- Expert France-Member
h. Dr. Rajya Kunwar-Save The Children
i. Mr. Amrit Rai
j. Mr. Raju Joshi

9.2.1 Objectives of the Meeting:

- To update key stakeholders on the HEP C related major activities planned in HR Asia Project implemented by Recovering Nepal
- To generate discussion on the development of 'National Hep C treatment Clinical guideline' and 'Hep C Community based guidelines ' to expedite process of guidelines finalization according to the plan of action.

9.2.2 Presentations:

Firstly, *Mr. Anjay KC Technical Advisor of Recovering Nepal*, presented[1] on overall planned activities under the project HR Advocacy in Asia and highlighted on Major HEP C related activities as follows;

A. Advocacy for community based Hep C testing, diagnosis and treatment for mono- and HIV co-infected PWID.

- Facilitation of regular meetings of the national Hep C committee,
- Inclusion of the community and CSOs in the existing National Hep C committee.

- Gather Advocacy and technical Inputs

B. Development of the national Hep C treatment strategy and treatment guidelines including community based Hep C testing, diagnosis and treatment for mono- and HIV co-infected PWID

- Hiring expert consultant
- Hiring community expert for
- development of the national Hep C treatment strategy and
- development national level treatment guidelines including
- community based guidelines on Hep C testing, diagnosis and treatment for mono- and HIV co-infected PWID

C. Development and Printing of the IEC materials for Hep C treatment literacy and adherence for community members and service providers.

- Development of content of IEC materials on Hep C treatment literacy and adherence for community members and service providers
- Printing of the IEC materials for Hep C treatment literacy and adherence for community members and service providers
- Dissemination of the IEC materials for Hep C treatment literacy and adherence for community members and service providers

D. National consultation/workshop for inclusion of inputs from the community, CSOs and Other Stakeholders on developed Hep C treatment guidelines including community based Hep C testing, diagnosis and treatment for mono- and HIV co-infected PWID.

- National consultation/Workshop
- gathering inputs from the community, CSOs and Other Stakeholders
- incorporating inputs to the developed guidelines.

E. TOT for Medical Officers and Community Leaders for implementation of the national Hep C treatment guidelines including community based Hep C testing, diagnosis and treatment for mono- and HIV co-infected PWID.

- Development, TOT for Medical Officers and Execute Training
- Development, TOT for Community Leaders and Execute Training

Secondly, *Mr. Prawchan KC Program Manager of SPARSHA Nepal*, presented[2] on a community-based, nurse-led service model that links a viral hepatitis service in tertiary hospitals such as TUTH to primary care clinics, such as the Liver Center , and results in hepatitis C treatment

provision in the community[3]through CBOs like SPARSHA Nepal, to increase access to hepatitis C virus treatment for people who inject drugs.

Mr. Prawchan KC said regarding the HCV Scenario in Nepal, 'Little is known about HCV prevalence rates in Nepal. While it is low in the general population, two studies have suggested that the prevalence of anti-HCV antibodies among people with a past and/or current pattern of injecting drug use is around 80% to 85.5% for men and around 15% for women'. In another study, he said, in 1998, the prevalence of anti-HCV was 98% in PWIDs. In Nepal during the period of 2009-2013, few other research has been carried on Co-infection of Hepatitis C Among HIV-infected Population with Different Study Risk Groups focusing in Kathmandu, Nepal which shows that Estimated 50% to 90% of IDUs with HIV also have HCV infection It is estimated that 50% to 90% of IDUs with HIV also have HCV infection. Another study done by HEPA Foundation, UNODC. Prevalence of Hepatitis C in OST Client. Kathmandu, Nepal in the Kathmandu Valley. The prevalence of anti-HCV among IDUs enrolled in opioid substitution therapy (OST) and IDUs who were not in the OST program. In that study, the prevalence of anti-HCV among the OST users and nonusers was 80.5% and 57%, respectively. Co-infection with Hepatitis C Virus among HIV-Positive People in the Kathmandu Valley, Nepal. The prevalence of HCV co-infection was 96.2% among participants with lifetime injection drug use (IDU). Among participants not receiving ART, the co-infection rate was 58.1% compared with 37.8% among those receiving ART.

He talked about Why and How HCV Research was Initiated in Nepal. During the period of 2011 - 2013, many liver complications related deaths were reported among HIV/HCV Co-infected patients as well as HCV mono-infected patients. Among PWID community, fear and confusion related to Hepatitis was increasing. Individual and collective effort was in place and advocacy was ongoing but lack of evidence could not generate enough support to develop prevention and treatment interventions. As the part of ongoing HCV movement, an effort was made to generate evidence by initiating research in 2014 on the Prevalence of HIV, Hepatitis B and C Infections and an Assessment of HCV Genotypes and Two IL28B SNPs among People Who Inject Drugs in Three Regions of Nepal,' mid-western Terrai (Nepalgunj), the eastern region (Dharan, Biratnagar) and the central region (Kathmandu, Lalitpur and Chitwan) by GIZ, SPARSHA And CMDN.

The primary AIM of research work was to establish a Prediction Model for HCV Screening and Treatment Success for Nepal and in light of the new developments in the HCV Treatment arena. As the part of research, we tested the community based screening and treatment model for mono-infected and HIV/HCV co-infected person in Nepal as to tailor community based intervention to address Hepatitis as country's context specific needs. In addition, for strategic

information and education, Treatment Advocate Manual on Viral Hepatitis was also translated in Nepali and disseminated widely to harm reduction service providers in Nepal. Based on the manual, HCV training for treatment advocates were also provided to different service providers as capacity building process. Expert-guided, simple protocal for HCV treatment regimen, laboratory follow up with CB-centered care and triage to medical professionals.

Mr KC said that the Research Findings indicated that the prevalence rates of HBsAg, anti-HIV antibodies and HCV-RNA were 3.5%, 13.8% and 41.9%, respectively and spontaneous HCV clearance was evident in 16% of all of those who tested positive for anti-HCV antibodies. Also, he said, overall, 59.8% of HCV infections were caused by HCV genotype 3 and 40.2% by HCV genotype 1. No other HCV genotypes were identified in this study. The IL28B SNP rs12979860 and rs8099917 were identified in 122 patients, and 75.4%of all participants had both favorable genotypes rs12979860 C/C and rs8099917 T/T

In low resource settings, pegylated interferon α plus ribavirin (pegIFN/RBV) used to be and still is the standard treatment. However, the response to treatment with pegIFN/ RBV depends on the viral genotype (HCV-GT) and viral load. In addition to viral factors, host factors also determine the likelihood of achieving a sustained virologic response (SVR) when treating chronic hepatitis C with pegIFN/RBV. Two single-nucleotide polymorphisms (SNP)— IL28B rs12979860 and rs8099917— determine the likelihood of spontaneous viral clearance and SVR with pegIFN/RBV-treatment. Homozygote carriers of cytosine (CC) at position rs12979860, and thymin (TT) at position rs8099917 have a much higher likelihood of spontaneous clearance and achieving SVR with pegIFN/RBV treatment. The higher rate of SVR in Asian patients correlates with high rates of IL28B rs12979860-CC and rs8099917-TT in this part of the world.

He said " Initially Treatment was planned with Pegylated interferon and Ribavirin.The treatment was upgraded to include all of the available DAAs (Sofo/Ledi, Sofo/Dac). We modified our AIMS to achieve 80% SVR with available regimens (sofosbuvir, ledipasvir, daclatasvir, ribavirin, peg-IFN) and to identify "best practices" for optimal screening, HCV viral detection and treatment cure in Nepal. Till date we have treated 600 patients and for HIV related services , more than 60% client accessing services are from outside Kathmandu valley.

He said that the Service domain starts from HIV Testing and Counselling (HTC) as an entry point to Community Based Anti-retroviral Treatment (CBART), including Community and Home Based Care (CHBC), Community Care Centre (CCC) , Hepatitis Counselling and Referral Centre, Directly Observed Treatment Short Course (DOTS). The Service domain of SPARSHA Nepal is based on the assessment of key populations, communities and with their involvement in planning and designing that caters the services based on true needs of target community.

Thirdly, *Mr. Amrit Bickram Rai, Advocacy Officer from NAP+N*presented[4]his presentation. He shared the activities of the Key Population Research And Advocacy (KPRA) Project, *[with the Support from Save the Children].*

He gave a project Description of the project as Evidence based Advocacy on community based testing and monitoring of quality services for key populations Implementedthrough Save the Children International in Nepal as Principal Recipient with NAP+N as Sub Recipient, supported by The Global Fund from April 2018- December 2020 in Kathmandu, Kaski &Chitwan for PWIDs & PLHIVs

He said it was to strengthen community capacity to improve access to quality HIV prevention, testing, treatment, care and support services among key populations in Nepal. With the objective of building evidence and engaging in strategic advocacy for the purposes of improved quality of HIV prevention and care services for People Who Inject Drugs (PWID) in Nepal it also focuses on building evidence and engaging in strategic advocacy for the purposes of improved quality of health services and HIV prevention and care services for transgender people in Nepal, he said.

He talked about the Hep C committee with NCASC, NPHL, SCI, Hepatitis-specialist, community representative and NAP+N formation for technical guidance. Also the review and preparation of SOP for Hep C Treatment by National Consultant in close coordination with high level committee by Consultant for review and preparation of Standard Operating Procedures for Hep C Treatment was mentioned.

There were plans for Hepatitis C medicines to be procured through Government soon after development of Hepatitis C testing and treatment guidelines with Plans to treat tentatively 300 Hepatitis C Co-infected PLHIVs and Treatment of Hepatitis C for People who inject drugs. Her said treatment process will be started with those already having a positive HCV screening test so 150 PWID with HCV can be enrolled in treatment n the initial phase. There is provision to provide social support for treatment of Hepatitis C which will be provided to the clients enrolled in the HCV treatment process as per the need.

9.2.3 Topics discussed/decisions made/way forward:

The meeting decided to form a technical committee for Hepatitis C, min which there was the inclusion and participation of neither the community based key population networks, such as RN or NAP+N nor the participation of community based service providers working in Hep C such as SPARSHA. The meeting has decided that the community will advocate for three seats each to the TWG from each organization RN , NAP+N and SPARSHA respectively to represent the interest of the community, under the coordination and leadership of NCASC Director and following members of technical committee as;

Dr. Tara Nath Pokhrel, NCASC Director-Coordinator

- Representative- Drug Administration-Member
- Dr. Anup Bastola – STIDTH-Member
- Dr. Dilip Sharma- Bir Hospital-Member
- Mr. Prabachan KC-RN-Member
- Dr. Marie Langrange- Expert France-Member
- Dr. RajyaKunwa-NCASC-Member

The meeting has decided that the draft HEP C treatment guidelines would be prepared by 15 November, 2018 and will be submitted to HEP C steering committee on 16 November, 2018.

NAP+N has a plan to treat 1000 with DAAs for those who need them the most. However, currently there are no formal national guidelines for clinical or community settings for Nepal. SPARSHA Nepal Has been Piloting the treatment through CBT setting,

There is a need/ requirement to develop 4 types of technically complementary thematically inter-lapping Modules

- National Hep C (Clinical) Guidelines and Diagnostic Algorithms
- Community Based Hep C (Operational) Guidelines and follow-up CB monitoring
- Training Module for Hep C treatment for Physicians
- Training Module for Hep C treatment for Community Health Professionals

There is a need/ requirement to hire 2 qualified consultants (Physicians) to draft the Nation Level Clinical Guidelines, TOR's with Common requirements will be discussed and pooled to procure the candidate. It was agreed that SPARSHA would take the lead on the Community Based Guidelines since they have the expertise and experience in the community setting.
The Trainings C and D, as mentioned in point [3.], will be scheduled for 2019, since A and B must be developed and finalized before as a prerequisite dependent activity.

Nepal has still not added Hep C antivirals to its essential drugs list and though prices are decreasing to affordability in other countries, in Nepal the cost is still relatively expensive. Pan genotypic drugs can reduce the cost of genotyping. (There is some sofosbuvir in stock which will expire if do not provide diagnostics and treatment for about 70-80 patients-SPARSHA) . Anti-retroviral are not subject to the same licensing. Antivirals for Hep C are allowed only one time permit which has disrupted treatment over and over again. Government has plans to treat 300 per year till 2021 but no operational provision on the ground (Except CBT SPARSHA)

Delays in HIV V/L is causes a major problem for maintaining timelines. NPHL test results for HIV V/L usually arrive 4-6 weeks later adding up to a potential 8-12 weeks delay for each co-infected patient requiring regimen change. Switching ARVs for Co-infected patients causes

delays in treatment commencement. Although it usually does not have any clinical drawbacks patients must wait 4-6 weeks to confirm continued viral suppression.

Because Ledipasvir increases Tenofovir levels, when given as Tenofovir Disoproxil Fumarate (TDF), concomitant use mandates consideration of creatinine clearance (CrCl) rate and decrease of TDF for those on Sofosbuvir/Ledipasvir. All patients creatinine must be assessed before the onset of treatment. The potential for renal toxicity is very important to follow-up and monitor closely.

- Community Based Monitoring Tests need to be ascertained
- CBT follow-up blood testing ??
- Fibro scan data of patients ??
- $SVR_{12,}$ $SVR_{12,}$ SVR_{24} needs to be determined ??

9.2.4 Discussion and Decisions

Program update: Dr. Purushottam Shedain from NCASC shared updates on OST program. There were issues related to coverage of program, enrolment in the service, retention in the service and quality of service. The TWG meeting decided to conduct an impact assessment of OST program. NCASC will take the lead and form committee to conduct impact assessment.
SAARC level consultation meeting: Bishnu Sharma will share a concept note on regional level consultation meeting with NCASC and MoHA. They will then decide about the conduction of regional level consultation meeting.

- Satellite/mobile dispensing sites for OST: This will be discussed in next meeting with further preparation.
- OST site of Recovering Nepal in Chitwan: Discussed
- Multi stakeholders meeting on OST: TWG discussed on the need of multi stakeholders meeting and agreed to conduct the meeting. TWG suggested to align the activities related to drug use in National HIV Strategic Plan 2016-21 and Drug Control Work Plan while implementing such activities as a single plan.
- AOB: MoHA is in a process of conducting National Drug Survey for which a core team is formed. NCASC and other partners were urged to provide support in terms of technical expertise and resources.
- Next meeting will be conducted on the 2nd week of September and exact date will be decided later.

C. Hiring expert consultant and community expert for development of the national HepC treatment strategy and treatment guidelines including community based HepC testing:

Recovering Nepal with the recommendation of HEP C TWG Committee recruited Dr. Dilip Sharma, Senior Hepatologist of National Association of Medical Science, Bir Hospital to prepare draft national HEP C treatment guideline. The work is progressively going on and process of

incorporating feedbacks, recommendations and inputs going on in developing guideline. Once the draft will be prepared, the consultation meeting is planned to conduct immediately.

9.3 Provincial level sensitization meetings for drug policy meeting for development of state drug control policy and law:

The different province level organizations affiliated with Recovering Nepal organized one day Provincial level sensitization meetings for drug policy for development of state drug control policy and law in their respective provinces. The program was organized with the objective of providing information regarding national HIV & AIDS strategic documents and it's prioritized comprehensive program particularly targeted to PWID and existing law and policies that enable access to different program and health services.

The presentation by president of different provinces highlighted on drug use and possession of drugs are criminalized by Narcotic Drugs (Control) Act, section 4. Penalties include imprisonment. People charged for the first time with drug use or possession involving cannabis or medicinal opium may not be convicted / charges may be dismissed if the quantity of drugs was small (section 19). Section 19 A provides that people undergoing treatment or rehabilitation in a centre established or recognized by Government of Nepal shall not be subject to punishment under the Act.

It was discussed on the major problems in harm reduction program identified as although harm reduction is a priority area of the HIV programme, the coverage of services is low; Quality and effectiveness of services varies; No appropriate service delivery and quality monitoring in place; Services are not comprehensive; referral systems are often weak; Skills and knowledge of some harm reduction service provider (including OST) in reaching and providing quality comprehensive services needs to be improved; Capacity of new service providers needs to be build.

9.3.1 Objectives of events:

The event particularly tried to concentrate with the following objectives as;

- To inform on current PWID targeted programs in accordance with national HIV&AIDS Strategy
- To sensitize on drug policy for development of state drug control policy and law
- To advocacy on favorable policies and laws in state level in order to create enabling different human right and health services

9.3.2 Held events in different provinces as;

S. No.	Name of the province	Name of the events	Date	No. of participant	Contact person
1	1	Provincial level sensitization meetings for drug policy meeting for development of state drug control policy and law	10/11/2018	11	Mr. Deepak Chapagain
2	2	Provincial level sensitization meetings for drug policy meeting for development of state drug control policy and law	10/12/2018	11	Mr. Nabin Mallik
3	4	Provincial level sensitization meetings for drug policy meeting for development of state drug control policy and law	10/25/2018	11	Mr. Shiva Kumar Neupane
4	6	Provincial level sensitization meetings for drug policy meeting for development of state drug control policy and law	10/10/2018	11	Mr. Lalit Bhattarai
5	7	Provincial level sensitization meetings for drug policy meeting for development of state drug control policy and law	10/14/2018	10	Mr. Navraj Pandey

9.3.3 Major discussed agenda:

The number of drug abusers in Nepal has been swelling even though sound and subtle narcotic drug policies and strategies have been in place for more than a decade. According to a national drug survey conducted in 2012, there were 91,534 hard drug users in the country. It has also been revealed that many drug abusers are addicted to pharmaceutical drugs. The main reason is that they are easily available on every street corner, and they can be bought without a prescription. Even pharmacists are sometimes unaware that a certain medicine can be misused as a drug. While law enforcement agencies have traditionally been focusing on controlling regular narcotics and psychotropic substances, the abuse of pharmaceutical drugs has emerged as a big issue in recent years.

Male and female IDUs are not only at risk for acquiring and transmitting HIV through the sharing of drug injection equipment, but also through high-risk sexual behaviors, including but

not limited to unprotected sex and engaging in sexual behaviors under the influence of drugs or in exchange for drugs. This vulnerability underscores the need for responsive programming so that we can better meet the specific and comprehensive needs of both male and female IDUs. Of additional concern is the potential bridging effect, whereby an epidemic, initially fueled by the sharing of contaminated injecting equipment, is spread through sexual transmission from IDUs to non-injecting populations and through perinatal transmission to newborns.

As per presentation by president of different provinces, the main highlighted issues are national HIV&AIDS strategy 2016-2021 including current laws and policies with regard to PWIDs. The key person of the different provinces presented on importance of harm reduction program targeted to PWID it's major challenges and gaps. They pointed out mainly on community involvement, conditions of female PWID and barriers created by existing laws. Similarly, they focused on innovative, well-coordinated and integrated services towards primary HIV prevention for and with key populations.

With consideration to harm reduction policies and philosophy, the presenters emphasized on promoting and facilitating referral to public health services, primary health care and mental health and substance use services, Increase activities to reduce stigma and discrimination against people who use drugs, and raise public awareness and understanding of harm reduction principles, policies and programs among professionals in the health, social and criminal justice systems, officials in all levels of government, and the general public. It was focused on to ensure full and equitable reach to all vulnerable who use drugs, to provide education about health promotion and illness prevention to inform decision-making. They briefed on major interventions targeted to PWID as;

- Community-based outreach;
- NSPs;
- Opioid substitution therapy (OST) and other drug dependence treatment;
- HIV counseling and testing (HCT);
- ART for IDUs living with HIV;
- Prevention and treatment of sexually transmitted infections (STIs);
- Condom programs for IDUs and their sexual partners;
- Targeted information, education and communication (IEC) for IDUs and their sexual partners;
- Vaccination, diagnosis and treatment of viral hepatitis27; and
- Prevention, diagnosis and treatment of tuberculosis.

During the program, it was mainly insisted to six pillars of policies strategies of Narcotic drug control national policy 2063. With highlighting, the State of Laws and Policies on Harm Reduction related to IDUs in Nepal, the primary concerns defined as the Narcotic Drugs

(Control) Act, 2033 B.S. (1976) governs most of the issues related to drugs users. At the time of its enactment, the Act was basically focused on punitive approach; it includes relevant definitions, crime and penalties etc. However, in its amendment in 1993, it incorporated the principles of major international instruments and widens the scope of the Act beyond criminal justice system. The major instruments incorporated through the amendment was the SAARC Convention of 1992 on Narcotics Drugs and Psychotropic Substances; Single Convention (including the 1972 Protocol amending that Convention) 1961 and the UN Convention on Illicit Trafficking of Narcotic Drugs and Psychotropic Substances, 1988. The amendment introduces the concept of legalization of controlled delivery, and corrective measures for drugs user and diversion from criminal justice system. In addition, it also increased the penalties for drug offences.

The national drug policy 1995 highlighted as the National Drug Policy, which also contributes for the effective implementation of Drug Act, 1978, has been promulgated a) to maintain, safeguard and promote the health of people by making the country self- reliant in drug production; b) ensuring the availability of safe, effective, standard, and quality drugs at affordable price in quantities sufficient to cover the need of every corner of the country; and c) to manage effectively all the drugs-related activities including production, import, export, storage, sale, supply and distribution.

Some of the major objectives of the policy are:

- To evolve a suitable mechanism to ensure the availability of safe, effective and quality medicines at reasonable price throughout the country.
- To supply adequate quantity of essential drugs at each level of government health institutions.
- To include drug industries as priority sector by all concerned ministries of GoN in order to make the nation self-reliant in production of essential drugs.
- To promote rational use of drugs and to establish a drug information system.
- To set up a well equipped quality control laboratory with trained staff under the Ministry of Health and Population to carry out the testing, analysis and standardization of drugs.

To improve the existing infrastructure of the Department of Drug Administration (DDA) and provide sufficient qualified and trained personnel for strengthening the drug administration mechanism and effective enforcement of the Drug Act.

The program focused on National narcotic drug policy highlighted as;

9.3.4 Powers and Procedures :

The Act empowers the Narcotic Drugs Control (NDC) Officer to issue warrants and search any person or place if s/he has a reason to believe that such person has committed or is about to commit an offence that is punishable under the Act. The NDC Officer or a police officer of the rank of Assistant Sub-Inspector is empowered to enter, search, seize and arrest without a warrant the offender may escape or the evidence would be erased. However, such an entry,

search, seizure shall be made in the presence of a member of the Municipality or the Village Development Committee or a Ward Committee or a respected person of the locality or an employee of any other government office.

9.3.5 Diversion from Criminal Justice System:

Provisions under the Act allow the court to divert drug addicts to treatment programmes. In case a person/institution takes a responsibility of a cannabis addict and made a bond for his/her treatment for up to one month in the treatment centre, the judicial authority may not punish the person on submission of fortnightly reports of such treatment. In case a person is addicted to opium, coca or any other narcotic drugs made from it, a person/institution is required to take responsibility for treatment of up to three months. Submission of fortnightly reports of the treatment to the court is also necessary. Similarly, in case of a person who is addicted to any natural or synthetic narcotic drugs or psychotropic substances, as notified by the government, a person/institution has to take responsibility for her/his treatment for 3 months and the court may not punish such a person on the condition of fortnightly reports of his treatment being submitted to it.

Furthermore, immunity from the punishment is provided to a narcotic drug addict/consumer who is undergoing treatment in a treatment/rehabilitation centre established or recognized by the government for offences committed under section 14 (a) and (e) i.e. consumption of cannabis and opium.

Similarly, the discussion has been made on National Policy and strategy on Narcotic Drugs Control, 2006 as;

With the realization that the eradication of drug addiction in Nepal is a complicated task and even in the presence of plenty of agencies to control it, there is an emerging trend of Nepal being a transit point of drugs smuggling through golden triangle and golden crescent, the National Policy on Narcotic Drugs Control was formulated in 2006 with a vision of "narcotic drugs user free healthy and prosperous society". This policy has identified the increasing trend of youth involvement on drugs addiction, use of multi drugs, injecting drugs and also increasing trend of STI including HIV and crime rate as major issues to be addressed. At the same time it internalizes the increasing trend of human rights violations of drugs user and also admits that the Nepal are not able fulfilling its obligations under international instruments.

9.3.6 Major objectives of this policy are:

- To reduce drugs related crime by prevention and control on illegal farming, production, transport and sell of narcotic drugs.
- To reduce incidence of drug abuse of vulnerable group.
- To increase access to standard, reliable and dependable treatment and rehabilitation service of drugs user.

- To control and reduce vulnerability of drug users, their family and society from infection like HIV, hepatitis, and sexual diseases.
- To make coordination between other policies that directly or indirectly relate to the prevention and control of narcotic drugs.
- To promote wider collaboration and partnership on prevention and control program of narcotic drug.

9.3.7 Conclusion and recommendations:

The meeting concluded that it requires wider collaboration and partnership to enhance PWID related interventions based on strategic evidence and close monitoring with effective implementations. It was felt need of discussion on current existed policies, laws and strategies to promote the accessibility and availability of different services with the objective of transforming PWID into productive citizen of nation.

10. Assessment of the prevalence, Health, Harm Reduction and HIV needs and assessment of the legal barriers to deliver the services within prison settings and recommendations for the law enforcement to address the needs and gaps:

With fulfilling entire official requirements, Mr. Rishi Ojha has been recruited as consultant for assessment of prevalence, Health, Harm Reduction and HIV needs and assessment of the legal barriers to deliver the services within prison settings and recommendations for the law enforcement to address the needs and gaps. The progress is moving ahead.

11. Advocacy and sensitization of key stakeholders (health service providers, law enforcement, district administration, and other stakeholders) to familiarize them with the harm reduction programme on local level:

India HIV/AIDS Alliance works with PWID community to build networks that engage with national and state-level governments, state and local law enforcement officials as well as health care workers to expand their understanding for the delivery of a comprehensive harm reduction package of services. As the Principle Recipient (PR) for the Global Fund supported regional Harm Reduction Advocacy in Asia (HR Asia) programme, It is a three year, seven country Asia programme (2017-2019) that includes Cambodia, India, Indonesia, Nepal, Philippines, Thailand and Vietnam.

Recovering Nepal is the National Federation of PUDs and Drug Service Organizations in Nepal, and it is the in country partner for the implementation of the HR Asia programme in Nepal, which aims to maximize impact of investments that help break the cycle of transmission of HIV

among people who inject drugs (PWID) in concentrated epidemics by addressing legal, policy and health system barriers that impedes access to services. The programme also aims at strengthening community systems and increasing the evidence for advocacy.

11.1. Purpose of the HR Asia Grant:

The HR Asia project aims to Create a platform for strategic engagement with regional mechanisms as well as national governments on legal and policy reform to support harm reduction interventions.

11.2. Advocacy and Sensitization Meeting and its Objectives:

On the 12th October 2018 in Province No. 6 and on 15th October 2018 in province No. 7, Recovering Nepal organized a meeting for the Advocacy and Sensitization of key stakeholders at the District Development Committee Venue. Participants were present from local governance bodies, health service providers, law enforcement, district administration, and other stakeholders) to familiarize with them the harm reduction program on the local level. The total no. of participants representing from different organizations have attended in the province no. 6 is 49 and in province no. 7 is 40. The Key objectives of this meeting were:

To share with key stakeholders (health service providers, law enforcement, district administration, and other stakeholders) Recovering Nepal's engagement in the HR Asia Project and its major project activities to conduct advocacy and sensitization on the harm reduction programme in Nepal.

To establish a harmonious relationship with government and all stakeholders for active support, create solidarity and bring forth political; commitment for the future programs related with PWID

S. No.	Name of the province	Name of the events	Date	No. of participant	Contact person	Contact No.
1	6	Advocacy and sensitization of key	12 Oct. 2018	49	Mr. Lalit Bhattrai	9858052677

		stakeholders (health service providers, law enforcement, district administration, and other stakeholders) to familiarize them with the harm reduction programme on local level				
2	7	Advocacy and sensitization of key stakeholders (health service providers, law enforcement, district administration, and other stakeholders) to familiarize them with the harm reduction programme on local level	15 Oct. 2018	40	Mr. Navraj Pandey	9848724718

11.3. Major issues presented as:

The National HIV Strategic Plan 2016-21, Nepal HIV vision 2020 articulates a vision to ending the AIDS epidemic as a public health threat in Nepal by 2030. The Targets and indicators for Fast-Tracking the response by 2020 are as follows;

- Identify, recommend and test 90% of key populations.
- Treat 90% of people diagnosed with HIV.
- Retain 90% of people diagnosed with HIV on antiretroviral therapy.
- Eliminate vertical transmission of HIV and keep mothers alive and well.
- Eliminate congenital syphilis.
- Reduce 75% of new HIV infections.

11.4. Risk of HIV infections:

Male and female IDUs are not only at risk for acquiring and transmitting HIV through the sharing of drug injection equipment, but also through high-risk sexual behaviors, including but not limited to unprotected sex and engaging in sexual behaviors under the influence of drugs or in exchange for drugs. This vulnerability underscores the need for responsive programming so that we can better meet the specific and comprehensive needs of both male and female IDUs. Of additional concern is the potential bridging effect, whereby an epidemic, initially fueled by the sharing of contaminated injecting equipment, is spread through sexual transmission from IDUs to non-injecting populations and through perinatal transmission to newborns.

Goals of Harm Reduction Strategies and Services Policy:

- Reduce incidence of drug-related health and social harms, including transmission of blood-borne pathogens through equipment sharing by promoting wellness practices
- Promote and facilitate referral to public health services, primary health care and mental health and substance use services
- Increase activities to reduce stigma and discrimination against people who use drugs, and raise public awareness and understanding of harm reduction principles, policies and programs among professionals in the health, social and criminal justice systems, officials in all levels of government, and the general public.
- Ensure full and equitable reach to all vulnerable who use drugs, to provide education about health promotion and illness prevention to inform decision-making.

11.5. Core interventions:

- Community-based outreach;
- NSPs;
- Opioid substitution therapy (OST) and other drug dependence treatment;
- HIV counseling and testing (HCT);
- ART for IDUs living with HIV;
- Prevention and treatment of sexually transmitted infections (STIs);
- Condom programs for IDUs and their sexual partners;
- Targeted information, education and communication (IEC) for IDUs and their sexual partners;
- Vaccination, diagnosis and treatment of viral hepatitis27; and
- Prevention, diagnosis and treatment of tuberculosis.

11.6. The State of Laws and Policies on Harm Reduction related to IDUs in Nepal:

The current constitution of Nepal, 2072, which was promulgated, guarantees various fundamental rights, including right to equality and non-discrimination. According to the constitution, all citizens of Nepal are equal before the law and no person is to be denied equal protection of the law. It further encompasses that no citizen shall be discriminated on grounds of religion, race, sex, caste, tribe, origin, language or ideological conviction or any of these. However, it allows the State to make special provisions for the protection and empowerment or advancement of women, *dalit*, indigenous ethnic tribes, *madeshi*, or peasants, labourers or those who belong to a class which is economically, socially or culturally backward, or children, the aged, disabled and those who are physically or mentally incapacitated.

The constitution also guarantees freedom of (a) opinion and expression, (b) assembly, (c) forming unions and associations, (d) movement and residence throughout Nepal and (e) practice any profession or occupation. However, these freedoms are subject to reasonable restrictions provided at proviso clauses. It further recognizes the right to privacy of a person and information relating to her/him. Moreover, it recognizes the right to get free basic health

services from the State as provided in the law. According to the Constitution, the State is also responsible to enact law to provide free legal aid to indigent persons.

Part 4 of the Constitution which encompasses directive principles and policies for the State; require the State to pursue a policy of establishing the rights of all citizens in matters relating to education, health, shelter etc.

11.7. Drugs Act, 2035 B.S.:

Drugs Act governs pharmaceutical drugs inside the country. The regulation of narcotic drugs also falls in the jurisdiction of this Act. Various drugs are classified in Schedule A, B & C by the Department of Drug Administration (DDA) under the Drug Act. Schedule A contains narcotics, psychotropic and poisonous drugs, Schedule B contains antibiotics, hormones and general therapeutic agents i.e. prescription drugs and Schedule C lists common drugs.
"Government of Nepal, Ministry of Health and population, Department of Drug Administration DDA identified Methadone/Buprenorphine (Narcotics and Psychotropic Substances) for Import and Use and listed under essential drug (Methadone Buprenorphine) list ".

During meeting the major highlighted issues are as follows;

- Legislative and Policy change
- Capacity Building in Service delivery setting
- Sensitization for policy makers(Both central and provincial level)
- Update of SOP for PWID services
- Neglected FIDU
- Neglected drug users street children
- Lack of impact study/research on services for PWID

11.8. Major interactions and conclusions:

local governance bodies, government level stakeholder, health policy decision makers, law enforcement, district administration, and other local level stakeholders recognize the importance of intervention among IDUs and the implementation of the NGO-run 'Harm Reduction Programme' including needle-exchange for IDUs. The discussion revolved around the harm reduction approach which gives drug users options to reduce the risk of HIV infection and hence espouses positive/affirmative rather than punitive strategies. There were a number of doubts where participants from local governance bodies, government level stakeholder, health policy decision makers, law enforcement, district administration, and other local level stakeholders felt that Harm reduction would encourage drug use; however that fact was refuted according to international research that NSEP's and OST do not increase intake of drugs or frequency of drug use.
NSEP are one of the hallmarks of public-health innovation for AIDS prevention among IDU. These programs not only provide sterile injecting equipment to active IDU, they also offer sex education and prevention materials, referrals to medical care, legal and social services, and

drug treatment. And, by reducing the marginalization of drug users, they increase the likelihood that IDU who continue to use drugs will do so more safely. Since NSEP do not recruit nonusers, the total number of users does not change.[5]

In this context, Opioid Substitution Treatment (OST) has proven effective to treat opioid dependence and prevent transmission of HIV - in terms of retention in treatment, reduction of drug use, improvement of psychological and social functioning, and reduction of high risk injecting and sexual behaviors. OST involves the administration of an opioid medication (like methadone or buprenorphine) to an opioid dependent drug user under medical supervision, along with psychosocial support, which helps the client in weaning off drugs. In case of opioid dependent individuals who are already living with HIV, OST contributes to minimize the risk of further transmission of the virus and stabilizes their condition.[6]

Though elimination of drug use is the ideal and final goal, the Strategy identifies intermediate goals of safer injection techniques and drug substitution therapy as the means to stop HIV transmission in IDUs.

12. Advocacy and Leadership trainings on Human Rights and Harm Reduction Services for Women Drug User Network:

RN organized capacity building events of Networks of WWUD to under the funding support of India HIV/AIDS Alliance as Principle Recipient (PR) for The Global Fund HR Asia project. This Training is aimed at building the capacity of Networks of WWUD to advocate for themselves and it includes enhancing evidence based advocacy skills through capacity building activities, through an inclusive consultative, interactive and hands on instructional process. The Female Drug User Network are an important part of the local system contributing to improving the lives of communities of people considered most at risk for HIV. They represent women drug users living with HIV and/or Hep C ; Female Drug Users and/or engaged in female sex workers (FSWs); Female Injecting Drug Users (IDUs), including Transgender Women

who use drugs. RN has charted out a capacity building approach where the key strategy for capacity building is through '*evidence-based advocacy skills enhancement*[7]', because of their specific roles as discussed previously.

12.1. Rationale and Justification for the Evidence based Advocacy Training:

Globally, civil society networks have played a pivotal role in supporting and developing key services required to respond to the HIV epidemic. The networks that represent communities that are central to the dynamics of HIV transmission are particularly important, specifically in their involvement in decision making and programming around HIV. These communities commonly experience high levels of stigma and discrimination, are routinely denied services, and are disproportionately infected with and affected by HIV.

The United Nations, governments, civil society and other global and national stakeholders are involved in a series of processes that determine new development goals, public health and punitive drug policy and these processes often evolve quickly without the strong participation of HIV/AIDS groups or stakeholders and especially network organizations representing the key affected populations.

In Nepal's context, NGOs and civil society have had a relatively short history compared with other countries, including South Asian, such as Bangladesh and India. The aftermath of the democratic and political changes in the 1990s saw the rise of civil society and the NGO sector. The history of Network NGOs representing people affected by and/or considered most at risk for HIV is even shorter.

Funding for HIV in the next decade will focus more on cutting edge research, innovations in HIV prevention and service integration, and addressing stigma and discrimination, among other critical issues including Human rights based interventions. Only the value-addition and centrality of civil society for effective HIV response have been among the main rationales for continuing to support all forms of civil society working on HIV.

The implications are that the networks will need to step up their commitment and be more resourceful to sustain their collaborative capacities and social impacts. Because of the high level of stigma and discrimination attached to HIV in the first place, being a sex worker, a sexual minority, or a drug/injecting drug user places these people further outside the margins. Their capacity to advocate with evidence on their structural vulnerabilities and biological/behavioral

risks is therefore limited as compared with other groups of civil society organizations historically operating in Nepal.

12.2. Overview of the Training:

Through an inclusive process, **RN** has been engaging and where possible assisting women's PUD networks in preparing themselves to participate in the ongoing discussions on how civil societies working for and with HIV affected and MARP communities can position themselves for the new Federal Public Health scenario in Nepal.

In this connection, a three-day "Evidence Based Advocacy Skills Enhancement Training"[8]was conducted by **Recovering Nepal (RN)** from the 21st – 23rd of November 2018 at the Hotel Kanchenjunga, Dhahran, Sunsari Nepal for the WWUD Network, with the purpose of developing, strengthening and enhancing the evidence based advocacy skills of among them to advocate for themselves and their health and human rights more effectively.

in line with the focus of greater community involvement, the training also enabled the training participants to get an overview of issues on health, harm reduction, human rights, WUD, drug treatment as well as drug policy reform and to engage with the other networks through involvement in the decision-making process for topic setting, and identification of areas for evidence based advocacy for both policy and program implementation.

It is hoped that through the training, the WWUD Network will be able to contribute to National Health System Strengthening, Harm Reduction, Human Rights and Social Policy Reform in a meaningful way. It is also expected that the network will develop the ability to advocate for themselves more effectively, through better inter-networking, cohesiveness and technical know-how of different evidence based advocacy skills that will help increase their access to health, including prevention, treatment and care related to Viral Hepatitis, TB, HIV and AIDS and the equitable allocation of health resources for harm reduction and other evidence based interventions specific to them such as Sexual reproductive health and Maternal and Child healthcare issues as well as pregnancy related issues.

The overall objectives of this training were to engage the WWUD to share past and planned network advocacy efforts with respect to key advocacy issues related to the networks and to familiarize each other with cross cutting issues to facilitate alliances and build the capacity of the participants to advocate more effectively through evidence based approaches. The main deliverable or output per say, of this training was to create a Strategic Advocacy Action Plan through consultative mechanism for each of the respective networks.

The core of the training curriculum focused on the concept of evidence based advocacy, its methods and approaches to incorporating core human rights principles into evidence based

advocacy. The training also covered practical guidance on generating and documenting evidence and good practices, analyzing stakeholders and how to target advocacy for policy reform.

The training focused on learning to develop a strategic advocacy action plan in order to address their own specific issues as well as identify related cross cutting issues, challenges and gaps of their own communities with the other networks. The rationale that adults learn through doing and mentoring was integrated into step by step practical exercises throughout the course of the training each building upon its predecessor, evolving into final documented evidence based advocacy action plan to support the - issues/agendas of each of the relevant networks.

An added bonus outcome of this training, were the sharing sessions where identification and documentation of common and other cross cutting issues with other WWUD and common agendas were discovered and a need to collaborate in solidarity as opposed to acting individually was generally felt by the participating , thus instilling a spirit of cohesiveness amongst the WWUD network members.

12.3. Training Objectives:

Broadly speaking, the objectives of this training were to engage the WWUD network through an interactive process to:

- Share the experiences of network's advocacy efforts with respect to key advocacy issues related to the networks.
- Familiarize the participants with cross cutting issues and facilitate alliances for advocacy jointly.
- Build the capacity of the participants to advocate more effectively through evidence based approaches.
- Develop a low threshold doable Strategic Advocacy Action Plan.

The specific objectives of this training related to evidence based advocacy were focused on developing different skills at:

- Defining the issue
- Collecting Data
- Identifying target audience and allies
- Setting goals objectives and targets
- Developing an Action Plan
- Implementing the plan
- Tracking monitoring and evaluating the plan

12.4. Expected Training Outcomes and Deliverables:

It was expected that by the end of the training, participants would be able to:

- Identify common and other cross cutting issues with other networks and discover common agendas to collaborate in solidarity as opposed to acting individually.
- Explain the concept of evidence based advocacy
- Explain the process and list steps of evidence based advocacy
- Explain some core human rights principles important for advocacy
- Generate and document evidences and good practices for advocacy.
- Explain the importance of policy advocacy, targeting policies, decision makers, stakeholders, allies including other key audiences and mediums.
- Develop a step by step strategic advocacy action plan for each Network.

12.5. Participants:

A total of 27 participants were invited to the training, however some of the participants were unable to participate at the last minute. 2 Participants discontinued after the first day of the training due to illness.

12.6. Methodology:

The workshop was conducted from the from the 21st – 23rd of November 2018 at the Hotel Kanchenjunga in Dhahran of Eastern Nepal, facilitated by using a combination of participatory approaches and presentations. Various participatory exercises were used to engage participants and raise the enthusiasm including presentations, illustrated lectures and reflection, plenary discussions, oral questioning, modeling and group work activity exercises through PPT presentations, Handouts, Flipchart Sheets, Group activity exercise matrixes, Laptop, White Board newsprint and meta-cards.

The workshop consisted of presentations on core human rights principles to provide a solid theoretical foundation. The session introduced the participants to the rationale for evidence based approaches to advocacy in a shrinking global HIV funding scenario where networks needed to begin preparing themselves for a more evidence driven and information resourced HIV response.

Participatory sharing exercises were followed to identify and share key issues specific to each of the networks. The participants, then, worked on defining and a strategic advocacy action plan to guide their advocacy activities. The instructor provided a list of issues of each of the networks identified through preliminary community consultation process where the initial workout of appropriateness of issues and availability of data was done. The workshop involved extensive group work and stock-taking and inventorying of available information and evidence, as well as documenting generating and communicating their work as evidence through project processes and qualitative and quantitative research methods including targeting policy reform

according to different policy document types, prioritizing and dealing with stakeholders and policy decision makers and different advocacy mediums.

Based on step by step practical exercises throughout the course of the training, the participants then learned to develop an 'evidence based advocacy'-'action plan' to support their -issues/agendas.

12.7. Proceedings:

The 3 day Evidence Based Advocacy Training for the WWUD Network was scheduled at Hotel Kanchenjunga and commenced with the attendance of the participants for breakfast from 8:30 a.m. After the breakfast the training program formally started at 9 am.

12.8. Opening Session:

The Opening session was conducted with welcome speech by Ms. Sharmila Vaidya – RN WOMEN Chairperson . Then Introduction session was conducted by Mr. Anjay KC with an introduction game. Each member around the table was to introduce themselves according to the five following questions:

- What is your name?
- What network are you from?
- Why are you attending this workshop?
- What do you hope to get from the workshop?
- Name two good things that happened to you in the past year?

Each person stood up, summarizing their main information in less than one minute. Following the Introduction game geared towards exposure and building alliances and facilitating cohesive internetworking among the six networks, the overall training Objectives were shared by Mr. Anjay Kumar KC- as the Instructor. Then the participants were asked to set the ground rules for the training themselves in a participatory way. Some other rules were also such suggested by the facilitator. The ground rules that were agreed upon by the participants for the training are summarized as follows

- Arriving on time for each session and after each break;
- Asking questions freely at any time, However one person should speak at a time
- Comments should be made to the whole group – not to have side conversations.
- Keeping your mobile phones in silence mode
- Everyone can express their opinions so that we can learn from each other
- To follow the timeline agreed upon

After the Opening Session the whole group adjourned for a tea break after which the actual training curriculum was commenced.

12.9. Evidence based advocacy Training Day 1 - 21st, November 2018:

Mr. Anjay KC started off the training curriculum with sessions on what advocacy entailed by exploring "what advocacy is" and "what advocacy is not". He explained the details of the purpose for advocacy and summarized advocacy as changes in policy and practices, reforming institutions, altering power relationships and changing attitude and behavior of people. Put simply, the session summarized advocacy as a means for fighting for people's rights. Mr. KC mentioned that demanding for funding, keeping people uninformed of their rights controlling them instead teaching them and taking over or making decisions for others, avoiding political action and linkage with others was not advocacy. He also mentioned about how independent advocacy was focused on empowering people to express their own needs and help make their own decisions as opposed to telling or advising someone what they should do or making decision for others.

After the session Ms. Pasang Waiba RN WOMEN Coordinator refreshed the participants with a motivational lecture before the lunch break.

The session was resumed after lunch by sharing the concept of Evidence based advocacy and the role of knowledge in advocacy. He stated" we should not only change the mindset of people but also their hearts" and this is only possible with evidence based advocacy, a process based on data and information and scientific evidence. He also explained the steps in advocacy. He then discussed in detail about core Human rights principles its history and the key characteristics. The participants were briefed about the "Articles" contained in Human Right act 1998.

The differences and relationship between Issues and Problems were also discussed. During intermittent discussions, the participants felt encouraged to learn about these differences as they expressed that their prior understanding was that both issues and problems in advocacy were identical in nature. The participants learned that generally, solutions to issues could be readily identified and were of smaller scale and not life threatening while Problem could larger in scale in such a way as to alter our life either temporarily or permanently. He also discussed about addressing the Issue vs. Problem through advocacy.

After the afternoon tea break group discussion were held among participants to identify their issues and sharing it among the other network participants. The participants felt that many cross-cutting issues with other networks were identified and common agendas were discovered along with a need to collaborate in solidarity.

12.10. Summary of Day-1:

The summary of day 1 was conducted by each of the networks having 1 participants summarizing the objectives of the training as well as what they had learned Advocacy, Evidence and its roles, concept of evidence based advocacy and the difference between issue and problems.

They were also asked to identify the issues of their own Network organization with the help of Network Sharing Support Handouts which contained excerpted example issues identified by other networks themselves during community consultations for the development of the curriculum of this training.

12.11. Evidence based advocacy Training Day 2 - 22rd, November 2018:

The second day of the training also started after breakfast with a Review of the Day 1 training summarized by a Ms. Pratibha Thapa who volunteered. She expressed her thanks and said that she was happy with the training, mentioning that she was able to learn about the difference between issue and problems. Ms. Thapa also helped facilitate group work sessions with as white board writer during the ensuing discussions.

12.12. Discussion Outcomes:

Those who advocate might have to take risks as well. We have to support facts with valid data and information and evidence to advocate effectively. Other participants have learnt about the issues of different DU networks and are happy to get connected with issues of other DU networks. Issues about passports, same sex marriages, police harassment to FSWs, Birth registration and citizenship issues to PLHAs and that discussion on such topics are very effective. Effective voice of articulation and presentation in advocacy is necessary and the difference between 'issues' and 'problems' had a noteworthy impact on the participants. The participants mentioned that the statement that "We had the task of changing the heart and not only the mindset of people through advocacy" was very touchy. While concluding the review session Mr Anjay KC shared the examples of Fact and Truth as there are facts behind every truth and that there are many truths and explanations that ore often indicated by facts.

The next session continued on Collecting Data and gathering evidence based information by the facilitator who shared the session's objectives and provided Tips for collecting data. He also mentioned that the hardest part in advocacy was collecting information due to that fact that it was a time intensive and labor intensive effort. He emphasized the importance of training the people who will be collecting information as untrained staff could influence or affect the data or information gathered. It should be ensured that the information is collected ethically and should give the credit to the source. The importance of Research in Evidence based advocacy was also discussed. The trainer pointed out that Evidence based advocacy was about people

and not just about science, and that we have to remember that our key resources are the people we are involved with in our advocacy work, service provision and in our projects. The difference between Qualitative and Quantitative research methods were also discussed and explained clearly. Then before lunch Ms. Sharmila Vaidya from Recovering Nepal Women, held an energizer session and entertained the participants with a game geared towards highlighting the importance of teamwork and coordination.

The session after the lunch was resumed with a review on qualitative and quantitative research methods. The trainer elaborated on qualitative research techniques and the research tools through recording sheet/forms, matrixes, questionnaires, video and audio media. Participants learnt the value of generating evidence based information through sharing their learnings.

The next session was on Policy advocacy and focused on how to target advocacy for policy reform. He indicated that effective policy advocacy was required to change the heart and mindset of law makers to bring about favorable policy change. Practical consideration of the policy environment and policy issues were touched upon. As a general rule, participants were made aware that it was poor practice to advocate for issues contradicted by scientific evidence or not having any evidence. Pragmatic guidance on dealing with policy makers and other stakeholders through face to face meeting were also explained as the most effective way to deal the policy makers. The third session of the day covered the topic – Identifying your target audience and your allies. A stakeholder analysis was shown through a graphic diagrammatic chart and explained. Practical Limitations about targeting all stakeholders equally and prioritizing with whom we want to work more effectively were also touched upon. Finally the advantages and disadvantage of a highly structured stakeholder analysis were also presented.

12.13. Summary of Day-2:

Finally after the discussions on Identifying primary, secondary target audience, mediums and allies, a group activity exercise was held to define and analyze important and influential stakeholders as well as dealing with stakeholders. The day 2 the sessions were then concluded and the second day of the training was concluded.

12.14. Evidence based advocacy Training Day 3 - 23rd November 2018:

The 3rd day of training began after breakfast with the reflections on the learnings of the previous day sessions. After the review was over the formal session on the Importance of documentation and communication in evidence based advocacy was initiated by the trainer.
A three pronged approach to identifying Strengths, Weakness and Gaps were also elaborated with examples. The Sample examples of documentation and communication products how to develop them, such as Case studies, Newsletters, Photo-story books, Websites, Policy reports,

Workshop reports, Presentations, Abstracts , Annual reports , Radio programmes, Videos and IEC materials flipcharts and leaflets were demonstrated.

After the lunch break group activity exercises on developing the action plan of their identified issues was conducted.

Ways to construct a good advocacy message were also explained. The points entailed were making the message clear and compelling, avoiding jargon, highlighting the perspectives of target populations, using clear facts and numbers creatively and using information that is local which is relevant to the people. The session also discussed strategic action planning and how it is a dynamic document that needed to changes accordingly to the context, circumstances and other peripheral factors. The analogy was made to a live and changing dynamic document as opposed to a dead or static one was illustrated. The participants were explained about importance and ways of the Implementing the Plan as well as monitoring, evaluating and modifying the action plan according to the changing circumstances was highlighted.

12.15. Summary of Day-3:

During the final part of the training group work activity exercise was held where the participants practiced developing a strategic action plan of their identified issues and they shared their action plan among the other DU network participants.

12.16. Conclusion:

The 3 days training was successfully conducted with full participation and interactive sessions. Altogether 27 participants from the WWUD Networks were present in all day's sessions. Participants expressed a high level of satisfaction with and thanked the trainers and facilitators for their dedicated facilitation of the training.

13. Training for the health service providers for abscess management and overdose management:

Recovering Nepal organized two days training on abscess management and overdose management for health service providers on 15-16 November, 2018 at Hotel Orchid, Tripureshwor, Kathmandu. The program was inaugurated by Executive Director, Mr. Bishnu Fueal Sharma of Recovering Nepal with expressing welcome and thanks to all the RN team members, NCASC representative Mr. Bir

Bahadur Rawal and participants coming from different provinces of Nepal. He stressed on to be update about abscess management and mentally prepare to provide health service to PWID community people. He told that such type of training will make capacity and skills of health service providers and will benefit to PWID community people. Similarly, he identified major gaps as to make capacitated health personnels and low coverage of such training in the context of local areas to provide abscess management and overdose management services in local areas of different provinces.

13.1. Objectives:

- To enhance capacity of health service providers and equip with knowledge and skills on abscess and overdose management;
- To bring changes and perceptions of health service providers toward PWID community and provide health services regardless of PWID identity
- To make available competent health service providers on abscess and overdose management in local areas of different provinces

13.2. Major topics day 1 and day 2:

This program was conducted on 15th and 16th November at hotel orchid. There were health worker as participants from different parts of Nepal working on OST and ART centers. The session was started with introduction of the program objectives of the program. Then there was short presentation on National HIV response to PWID, Epidemic situation, major issues, way forward by Mr. Bir Bahadur Rawal from NCASC.

We started program with definition of abscess, how intravenous drug users with abscess presented to health care center, what signs and symptoms we should aware of while diagnosing abscess and how they can be management. We focused on surgical and medical management of abscess and when to operate in local facility and when to refer to higher center. Participant share about their experience on how they used to deal with such cases and realized what they could have done in those cases. They were taught about step by step procedure of Hiltons method of incision and drainage of abscess.

There was one section regarding universal precaution explaining what was universal precaution what are key elements, how they can follow universal precaution and what are advantages of following universal precautions. They learned about proper hand washing technique.

We also focused on which antibiotic to be given in abscess cases and when to upgrade antibiotics in case of complicated cases. We also shared our knowledge of different complicated cases and how they were managed. They were happy to know about which antibiotics to be prescribed during infections and knew the importance of sending pus culture and sensitivity. We also share knowledge about precautions to be applied during operations and other procedures to prevent from surgical site infections. They were happy to get such knowledge.

One section was drug overdose management. On that section we focused on signs and symptoms of drug overdose and mainly opioid drug overdose how they could be identified and what should be done in emergency situation and how they should be managed. Participant who were from OST sector were happy to get knowledge on antidote naloxone.

Participant were happy to get knowledge regarding abscess management and drug overdose management which was reflected on pretest and post-test improvement marks.

13.3. Pre and post test results:

During pre test, it seemed that large number of participants found providing correct answer below 10 marks and only one participant have secured great mark as 11 and 1 of the participants have secured only 2 marks out of 15 questions.
Late on after completion of the training, only 1 of the participants secured below 10 marks and high number of participants increased their marks compared to pretest and crossed 10 marks out of 15 objective question and 1 participant have correct tick mark on all the 15 questions.

13.4. Conclusion:

Majority of participants expressed their views on essentially need of such training to provide health services to PWID community. The training has encouraged all the participants to gain knowledge on abscess management and overdose management and reflect in their day to day routine work. Basically, the related topics were new but the participants made remarks to be updated on such training topics and useful for their professional career and committed to provide health services to PWID community with systematic and standard service in the days to come.

14. Annual planning and review:

Recovering Nepal organized review and planning meeting on 1 November, 2011 in Chitwan with the 42 key participants from representing chitwan based different organizations. The program was inaugurated and chaired by Executive Director of Recovering Nepal. The civil society

representative and district based RN have expressed their views on importance of review and planning amongst different key stakeholders. They are of the opinion that such event will establish further ties with national federation of drug users network, Recovering Nepal and will make fight against jointly in the issues of supply control, demand reduction and drug decriminalization. In the opening session, RN, Executive Director made remarks on to address the legal, policy and health system barriers that impedes access to services including strengthening community systems and increasing the evidence for advocacy.

14.1. Objectives of the program:

The program was organized with the following objectives as;

- Sharing of various projects implemented by Recovering Nepal focusing to PWID with current progress
- Need of further planning to address the legal, policy and health system barriers that impedes access to services
- Establishing strong ties amongst key stakeholders in jointly moving ahead in order to campaign against drug decriminalization

14.2. Major activities:

By highlighting National HIV Strategic Plan 2016-21, Executive Director of Recovering Nepal stated that Nepal HIV vision 2020 articulates a vision to ending the AIDS epidemic as a public health threat in Nepal by 2030. He presented on the Targets and indicators for Fast-Tracking the response by 2020 are as follows;

- Identify, recommend and test 90% of key populations.
- Treat 90% of people diagnosed with HIV.
- Retain 90% of people diagnosed with HIV on antiretroviral therapy.
- Eliminate vertical transmission of HIV and keep mothers alive and well.
- Eliminate congenital syphilis.
- Reduce 75% of new HIV infections.

With further remarks, Executive Director of RN presented on different projects implemented by Recovering Nepal funded by different donors. He shared major goal with major activities and it's objectives. He informed that RN is implementing FIDU related projects to fulfill the gaps existed in present context. He viewed that legal, policy and health service barriers are the major impediments to address the comprehensive issues of PWID. He emphasized on multistakeholder joint efforts to address the present problems faced by PWID and urged to all of the participants to joining hand together.

The speakers of the program shared on licit and illicit drug use is part of our world, understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors

and focuses on quality of life and well-being–not necessarily cessation of drug use. RN district based partners shared on calls for the non-judgmental, non-coercive, non-moralizing view of services ensures that those with a history of drug use have a voice in the creation of programs and policies designed to serve them. In addition to this it needs to have views drugs users as agents of reducing the harms of their drug use, and empower users to share information and strategies to address actual conditions of use. Similarly, stakeholders attending in the program recognized the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities and needs to address the problems in comprehensive form with strong networking, coordination and collaboration.

14.3. Major conclusions and recommendations:

It is concluded that there is great gaps in the areas of public private partnership along with to address the issues of legislative, policy and health service barriers. The meeting highlighted to invest more funding to address the comprehensive issues related with PWID. It has been summarized that the targeted planning should be initiated from bottom level to achieve satisfactory and effective results. In the mean time, the conclusion has been reached to the issue of drug decriminalization and needed short, mid and longer term planning and review meeting and based on the review findings; it is urgent need to implement accordingly with the greater participation of major key stakeholders.

15. Multistakeholder Consultation meeting:

Recovering Nepal is a community of amazing group of individuals, organizations and thematic networks as the National Federation of Drug Service Organizations led by People who use Drugs (PUD) in Nepal. It was originally founded in 2001 by drug user activists and people who use drugs including PLHA to address HIV and Drug Use. It has 144 organizational members and excluding key individual members.

Legally registered in 2003, Recovering Nepal has reached out to drug users through various support groups helping in addressing stigma discrimination, raising voice to promote basic human and health rights, advocating for policy change and increasing quality access to affordable and comprehensive treatment and care for the PUDs who are living with HIV.

Recovering Nepal aims to influence the policies that improve the quality of lives of PUDs, reinstate their rights and create a supportive environment. The organization promotes provision of HIV and Harm Reduction services while advocating for the rights of PUDs, at the same time focusing on strengthening the capacity of PUDs and their organizations to respond to the HIV epidemic, especially at the grassroots level. It is an organization By PUDs and for

PUDs seeking to increase Participation of PUDs in designing effective policies and programs and their implementation.

15.1. The Multi-Stakeholder Consultation Meeting:

As the In-Country Partner for the HR Asia project for Nepal supported by, India HIV/AIDs Alliance India through the Global Fund, a Multi-Stakeholder Consultation Meeting was organized by Recovering Nepal on the 18th of November, 2018 at the venue of Summit Hotel, Kupondole, Lalitpur Nepal from 10:00am – 05:00pm under the HR Asia Project, with the participation of key stakeholders (NGOs, international NGOs, community organizations/networks, various Ministries/Government departments, international organizations, i.e. UN, bilateral partners) to map a course of engagement to maximize the chances of success in achieving the objectives of RN's HR-Asia Project.

The aims of this meeting were to ignite discussion on policy and practices on the current situation of the Drugs, HIV, Hepatitis, and other related com-morbidities, including, harm reduction, health rights and human rights of PWUD, under the context of the constitution of Nepal, as well as was to help understand the advocacy efforts required at the legal, policy or services level over the longer term for the sustainability of efforts of the national partners' within the national Funding landscape. In this respect, the Objectives of the meeting focused on gaining commitment from stakeholders for:

- Creating an enabling legal and policy environment that supports the implementation of human rights based HIV/AIDs treatment, Harm Reduction and Drug Treatment Interventions
- Capacity Building, Strengthening and empowerment of PWUD networks to enable meaningful engagement with national governments and regional mechanisms for a sustained response to HIV/AIDS and Drug Use related co-morbidities.
- Increasing use of strategic information in generating evidence for health and human rights based HIV/AIDS and Harm Reduction policies and activities through both the previous objectives

- Supporting the necessary review of the Drug Control act, policy, legislation, nation action plan and operational guidelines, in line with the national strategy through health, human rights and harm reduction based approaches to reduce drug led harm among PWUD in the country.

15.2. Participants of the Meeting:

The Multi Stakeholder meeting convened with the with the formal participation of key stakeholders such as NGOs, international NGOs, community organizations/networks, various Ministries/ Government departments such as Ministry of Home and Ministry of Health (NCASC), international organizations, as well as UN, bilateral partners. The key participants from the following organizations were present as follows:

i Ministry of Home
ii Ministry of Health (NCASC),
iii Save The Children
iv UNODC,
v WHO,
vi ANPUD
vii Narcotics Control bureau
viii FHI-360
ix India HIV/AIDS Alliance
x AHF
xi Dristi Nepal
xii Union-C,
xiii CDUN
xiv FDDR
xv SPARSHA Nepal,
xvi SAATHI SAMUHA
xvii Mogul Media
xviii Recovering Nepal

15.3. Agenda and proceedings of the meeting:

Mr. Bishnu Sharma -Chairman of recovering Nepal, started the welcome session by thanking the chief guests for their interest to participation and engage with the issues of people who use Drugs. He also welcomed all the thematic networks and concerned stakeholders for being present and encouraged them all to bear an open mind and engage actively in the discussions and presentations ahead. He gave a quick overview of the agenda9 of the forthcoming programme. He said that Drug use is a multifaceted complex problem very difficult to address. Mr. Sharma articulated how RN had been working since 2006 on policy development, hosted a National Conference on Harm Reduction and had a clear working relationship with all donors stakeholders and government bodies including community based organizations. He said that the high prevalence of 2002 of 68 % and around 94% of Hep C prevalence was an eye opening moment when most of our community got infected and a large majority also died. Back then it was necessary to first stop the immediate deaths and health hazards and then start the prevention activities. "Recovering Nepal has been instrumental in starting the Harm reduction program" he said.. "we have been instrumental in helping the country to limit the HIV prevalence, also, we have been lining the Government strategies into our work plans, with all the 4 pillars of Supply Reduction, Demand Reduction Governance, Harm Reduction and Coordination & Collaboration.

He said that there was a need to focus on what the gaps and challenges were that prevent people from accessing services. He said that our main challenges were, 'How to help people to preserve their health and avoid health hazards'. He said that, although there were different views of looking at Harm reduction we have been have been pushing for a comprehensive response. For an immediate response in Harm reduction, we have to work in close coordination in cooperation and complement the government plans with the Ministry of Home since it is the only body that oversees this issue.

In the end, he thanked everyone for coming and handed the floor the Mr. Bir Rawal – PWID Focal person NCASC, MoHP, GoN.

Mr. Bir Rawal – PWID Focal person NCASC, MoHP, GoN.
Mr. Bir Rawal said that to address the problem of Drug use the government has implemented Needles and Syringe programs, HIV Treatment, Diagnotics, TB, and is implementing Hep C from this year onwards for people who use drugs . He said that although the overall prevalence was a little over 1% for Hep C, it was over 5% in the DU community. He said that we needed to reduce the prevalence, thanked Mr. Bishnu Sharma, and proceeded hand over the floor to the Honorable Secretary of Home Affairs Mr. Narayan Prasad Dawadi.

Mr. Narayan Dawadi -Honorable Secretary of Home Affairs.
Mr. Dawadi said “Thank you to all present. First of all to those from NCASC, RN, NCB and other partners”.

He thanked everyone for being present for such an important issue from the side of Home Ministry. He said that this was a very important meeting and that he had made a slight oversight on the date and thought that it was for tomorrow, viz., the following day and apologized for his genuine mistake. Mr. Dawadi said that the implementation of the Nepal Governments overall National Action Plan10had already started from Asar 24-25, and said that he wanted to put forth his views on the issue at hand. Mr. Dawadi said, “I may not be an expert, and there are more experts present here today but still, from the side of the MoHA I would like to put forth some of my views on the matter. Regarding the Drug problem in Nepal, we have tried systematic programs and policies but the day has come to make a hard assessment of the progress and achievement. The level of understanding on drug use has changed. The situation has changed. Where we have arrived at today and the areas we have done well in, despite a sometimes scary picture, sometimes makes me feel hopeful. In modern times it is the potential and quality of life that we need to protect for the younger generation”. “There is the view that Drug lord drug traffickers destroyed our young generation, which has not really happened. I do not think it is that big of a problem that it just cannot be resolved, although, there are some scary scenarios worth considering, such as the only available Government Research shows an 11.3% growth rate. Young people trapped in the cycle of drug use are human resources with lost productivity, and is a major cause for concern to the MoHA”.

“Also,” he said, “New practices in crime and the use of technology and advanced methods in trafficking is increasing and shows a discouraging picture to us. So, there is a clear need to for us to work from ground zero to ensure we are creating a healthy, civil, educated and progressive society”.

He said “During the discussions that will take place here today, let us be positive about our gaps and see where we can complement each other and inter-cooperate. We should not merely look at the interest of any one organization. Also we need to make sure that home grown evidence is generated without the forced to establishment of its results. We need to maintain an open mind and objective view. In my experience, we are weak at prioritizing. We will also discuss the role of Ministry of Home Affairs and Law Enforcement.” He said, “we are all co-actors and no one is on the sidelines, since it affects everyone”. MR Dawadi pointed out that, “ Even in the scenario of drug demand reduction, rehabilitation and treatment, our recent research suggest

that a number of basic rights violations are happening in the name of Drug Treatment, which we also have to address."

"Regarding the Governments Plan" the Honorable Secretary said, " I would like to share a few points with you about its' seven priority areas". The Honorable Secretary of Home Affairs then proceeded to share the following points.

- Demand Reduction –this area is a first priority although there is no consistent consensus on its effectiveness. We have a 60% literacy rate with lack of education and poverty, so let us discuss our role , it is our responsibility to save the lives and prevent the young generation from drugs, we need ministry wings on the ground to establish partnerships.
- Awareness Oriented Campaign – There is need to inform the young generation so running an instruction program in schools is essential. They (the schools) also need to have counselling which addresses personal problems, social and financial loss, identifying symptoms of addiction, it's negative effects and techniques to prevent consumption leading to addiction.
- Source Destruction–Although there is not much area for partnership, it is one of the activities to identify and destroy crops such as marijuana, poppy or cocoa plants, although we welcome peoples participation in identification and destroying crops.
- Monitoring Inspection, supervision, check and control and legal action – Monitoring of our work, and deploying intelligence to control transportation of Narcotic drugs in transit areas such as border check points and customs, inquiry into doubtful areas such as medical use without prescription.
- Framing modification and amendment of policy, act, law, directives, procedures regulation – There is a need for wider consultation to review the drug laws need to discuss decriminalization. Directives – Although the rehabs and non-state actors are providing some drug treatment, there is a need to solve the human rights crisisin these centers with newly developed Guidelines that stipulate basic living conditions.
- Study Research and Survey – This is an important process since it also entails learning by doing, we require your support and cooperationin order to assess the impact and explore areas such as the reduction of drug related harm and what the most effective methodsfor prevention would be. There is a need for your (the participants) expertise and involvement here.
- Mutual cooperation coordination cooperation – The efforts of no any one single organization is complete without multi-stakeholder participation for the sake of complementing and supplementing, each other, to reach a common goal and common target. By bringing in a comprehensive pool of expertise together, especially in areas of UN Global Mandates, such as who best in prevention, who in harm reduction ad doing a

stakeholder mapping we can be more effective in our coordination with task and information sharing.

The Honorable Secretary of Home Affairs, Mr. Narayan Prasad Dawadi said, " In the areas of planning and policy development, we have a great opportunity right now. The opportunity is that currently, drugs alcohol and social reform is a top priority of the Ministry. However, we have not been able to establish an evidence based policy culture, but from a resource perspective and program perspective, drug related harm and drugs issues including drug related crimes and health the health aspects need to be balanced right from the policy level . We can also establish a homegrown Regional Prevention Model for Nepal. We have several options as well Ayurveda and such options in Nepal such as natural and herbal medicines deserve looking into as well."

"Above all, and most importantly", he stressed, "We do not have any significantly disaggregated data." He said that he was aware that most entities did have different types of partial data but he emphasized that we did not have a proper research based information on the comprehensive picture. He said that there was a need to explore the roles of each of us and the outcomes of the activities we undertake. He pointed out that the Central Bureau of Statistics was available to the Ministry of Home to design and devise a data system as well different types of research. He said that we also needed to explore where each one of the participants could have a role can have a role, (such as UNODC, WHO, NCB etc.) in such activities. He said that this was a sensitive process and that if the data didnot match the response, we could get derailed. In closing the Honorable Home Secretary said "I am hereby asking for your cooperation, I hope that your discussion is fruitful. Please share the findings and outcomes of this discussion in the coming days and we shall look forward to have closer working relationship". He said, "Now the Home Ministry also views this as a health issue as well. We need your assistance for Prevention as it is also the a mandate area of many of us here. Also, HIV, Hep C and drug related treatment are also necessary part, so let us do a large comprehensive survey, so we can justify to the policy makers the course of action that we are taking. Having said that, I would like to once again say, thank you to all present and would like to end my presentation, right here."

After the Home Secretaries Presentation, Mr. Bishnu Fueal Sharma – Chairperson of Recovering Nepal, then made an announcement that he had just received a phone call from the Global Fund, conveying their support for the proposed plan for evidence generation and proceeded hand over the floor to Mr. Bir Rawal – PWID Focal person NCASC, MoHP, GoN.

Mr. Bir Rawal – PWID Focal person NCASC, MoHP, GoN. Mr. Rawal said that although the overall HIV prevalence was around 1.5%, the in the DU community, the prevalence was much higher. He said that we needed to reduce the prevalence, thanked Mr. Bishnu Sharma, and

requested the journalist from “RaatoPaati”11 to take up a panelist seat on stage. Since many of the key participants had to be leaving early before the end of the program, he proceeded to hand over the floor to a group Photo/Picture Session12, to capture the participation of all the major stakeholders present.

Mr. Bishnu Sharma -Chairman of recovering Nepal, re-convened the Multi Stakeholder meeting after the group Photo/Picture Session, he thanked everyone for their cooperation and handed the floor the Mr. Bir Rawal – PWID Focal person NCASC, MoHP, GoN.

Mr. Bir Rawal thanked Mr. Bishnu Sharma and said that to address the problem of Drug use and HIV the government of Nepal, the Ministry of Health, National Centre for AIDS and STD control is engaged in implementing the Comprehensive package of services for PWID as recommended by UNODC, INPUD, UNAIDS, UNDP, UNFPA, WHO with Needles and Syringe programs, HIV Treatment, Diagnotics, TB,and is implementing Hep C from this year onwards for people who use drugs. He then proceeded to hand over the floor to the Dr Purshottam Sedai who is the Deputy Director of National Centre for AIDs and STD Control (NCASC) and HIV/AIDS focal person for the Health Ministry.

Dr Purshottam Sedai- Deputy Director of National Centre for AIDs and STD Control (NCASC)– Dr Sedai welcomed the Home Ministry, Partners, India Alliance, RN and all other organizations, donors and stakeholders. He noted that the renowned Nepali HIV/DU activist Mr. Rajiv Kafle from ANPUD was also present and humorously asked for permission to proceed. He reminisced, briefly on the early days of the HIV epidemic in Nepal, the AD, 2002-2003 era, when Mr. Rajiv Kafle was leading the activist movement for access to ARVT treatment, at a time when no AIDs care or ARVT treatment was available in Nepal.

Dr. Sedai said “ Before this, our Honorable Secretary of Home affairs has made a comprehensive and clear presentation on how the country perceives this problem, where we are and where we need to go, and the Honorable Secretary of Home has pointed us in a direction.” He said, “From the side of NCASC and the Health Ministry we are working with full commitment, both in Drug prevention and harm reduction. The of the most glorious fact is that we have the ‘Constitution of Nepal’, which articulates and addresses human rights for all. He said, “Since now, we have all partnerships in place, so, let us all move forward together, working at all three levels of the Federal, Provincial and Local Governance Hierarchy.” He said, “ this is a crucial point that we all must emphasize to make the decentralization model possible.

Dr Sedai went back to a time in history, and said “Way back In 1988 the first case of HIV was identified at a time when there were no diagnostics, treatment or programs and today we have

arrived at meeting the MDGs which is a proud moment for now. But, we still have many problems with us. Let us go to the subject at hand." He said, "Our actions are guided by policy documents and there is no confusion that we are going on a fast track as recommended by the HIV vision 2020- HIV strategic plan." He stressed that," Focus on case management and enrollment to treatment will remain top priorities and there will be self-testing to focus on the integration of Community Led Testing (CLT) to consolidate our achievements." Dr Sedai Illustrated some important aspects of the program, saying, "Our program has been based on the IRRTTR strategy to Identify, reach, test & treat and retention in adherence. We also have our 10 Key indicators that we are familiar with, however there are still some major challenges for us such as the treatment cascade"13, which he illustrated through his presentation14of the treatment cascade saying that 30,000 -41,000 need to be on treatment right now. Dr Sedai said that the expansion of self-testing. basic service package in PWID as well as NSEP uptake needs improvement, He was of the view that the OST client uptake was ok, but we could do better and in closing thanked the audience.

15.4. Mr. Anjay Kumar KC- Technical Advisor – RN:

After the Tea Break Mr. Bishnu Sharma, Chairman of Recovering Nepal, started the session and handed the floor over to Mr. Anjay Kumar KC- Technical Advisor - RN to present on behalf of the National DU Network. Mr. Anjay Kumar KC Introduced the HR Asia project to the audience where India HIV/AIDS Alliance is the Principle Recipient (PR) for the Global Fund regional Harm Reduction Advocacy in Asia project (2017-2019), involving 7 countries in Asia (namely, India, Vietnam, Indonesia, Cambodia, Thailand, Nepal and the Philippines) which aims to maximize impact of investments that help break the cycle of transmission of HIV among PWID in concentrated epidemics by addressing legal, policy and health system barriers that hinder necessary outreach, coverage and access to core services.

After that, Mr. KC presented "An Overview of Recovering Nepal's – Harm Reduction in Asia Project: Addressing health and rights of people who use/inject drugs"15. The purpose of this presentation was to map a course of engagement among key stakeholders such as NGOs, international NGOs, community organizations / networks, various Ministries / Government departments, international organizations, i.e. UN, bilateral partners, in order to that will maximize the chances of success in achieving the objectives of the project.

The presentation consisted of mainly 3 areas:

- A brief Situational analysis at the country level
- Direct activities to be implemented to address barriers
- Strategic Activities for results to be achieved and overall envisioned impact.

15.5. Dr. Mukta Sharma, Regional Advisor WHO SEARO:

Dr Mukta Sharma started out her presentation online jesting that "You know about it more in your own countries than me. " They gave an overview of a multistage systematic review Louisa Degenhardt et al. on the Global prevalence of injecting drug use and socio demographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs. The Results illustrated that, 179 of 206 countries or territories report IDU (31 new countries compared to 2008). She Illustrated data that showed globally:

- 15.6 million PWID
- 17.8% HIV+ prevalence
- 52.3% HCV+ prevalence
- 9% HBSag+ prevalence
- 83% mainly using opioids
- 33% mainly using stimulants
- 58% history of incarceration
- 22% subject to homelessness

Dr Sharma Shared the Principles of harm reduction with the WHO recommended package of interventions which Provided together at high coverage reduce up to 50% of new infections in PWID. Dr Sharma Also Shared WHO's recommendations on Public Health, Human Rights and Universal Access.

As a final Recommendation she said that:

- Ending epidemics of HIV and hepatitis can only be achieved with a renewed focus on key populations, including people who inject and use drugs- treatment of addiction in the community, may be more cost-effective at reducing health, social, and economic harms of illegal drug use…
- There is a Need for focus on health and structural interventions and Governments may … wish to review their penal admission policies, particularly where drug abusers are concerned, in the light of the AIDS epidemic and its impact on prisons. (WHO, 1987)= Alternatives to incarceration may be more cost-effective at reducing health, social, and economic harms of illegal drug use…
- Need for continued global advocacy and concerted efforts - prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community. (WHO, 1993)
- Top-down and bottom-up approaches- Alternatives to incarceration, such as treatment of addiction in the community, may be more cost-effective at reducing health, social, and economic harms of illegal drug use… Ultimately, reducing the number of people who are in prison because of problems related to their drug use must be a priority.(WHO, 2007)

The following are some WHO recommendations from 2014 and 2016, as presented by Dr. Mukta Sharma, Regional Advisor WHO SEARO.

- Countries should work toward developing policies and laws that decriminalize injection and other use of drugs and, thereby, reduce incarceration.
- Countries should work toward developing policies and laws that decriminalize the use of clean needles and syringes (and that permit NSPs) and that legalize OST for people who are opioid-dependent.
- Countries should ban compulsory forced treatment for people who use and/or inject drugs.
- As countries work toward developing non-custodial strategies, targets can be set for reducing prison overcrowding generally.

15.6. Presentation by Mr. Kunal Kishore:

Note: [The Associate Director for Drug Use & Harm Reductions from India HIV/AIDS Alliance- Mr. Kunal Kishore's Presentation was on 'Global Fund Regional Harm Reduction Advocacy in Asia' covering global issues of financing interventions, socio demographic and structural challenges of HIV, HBV, and HCV in people who inject drugs .Although it was not thoroughly presented adherent to the agenda, due to turn of events, and deemed an integral part of the documentation, a copy of this presentation can be found in Annex 8 of this document.]

15.7. Presentation by Mr. Rajiv Kafle- Regional Coordinator from ANPUD:

Mr. Kafle talked about the era of Crystal methamphetamine, and It's culture as a recreational drug. He said that in the southeast Asia region, migrant workers who workedat least 16 hours a day used it as an energizer.
In past, Mr. Kafle, said, 'there used to be small pockets of opiate users branded as the bonafide drug using population, but all of a sudden, now even the sporadic users have to be accounted for as well as the migrant worker population including the growing and trending MSM chem-sex scenario', he deliberated.

As a food for thought Mr Kafle, asked some rhetorical questions such as. "How can we learn from lessons of the past ?". He said that the ANPUD strategy at present is facing vast amounts of networking challenges. He said that a Networking strategy is now required for both Demand Reduction as well as a Harm Reduction Strategy, since now that the opiate scenario seems small. Mr. Kafle made his verbal presentation in a new way on decriminalization by discussing different country models and programs to support DUs. He said that in Nepal, the focus is on a push to remove 'drug usage' in itself, as a crime. This however has proven very hard to do due to lack of understanding of policy makers. Networking and working with governments has proven very difficult in Asia as some governments will not even admit to their being a serious drug issue within their country, for instance, Cambodia continues to maintain that they have no

drug problem at all with most recent estimates counting up to at least 13000/- people who use drugs so far.

Mr. Kafle also gave examples of war torn Myanmar where the drug producing sector mainly resides in segregated areas belonging to political paramilitary rebels. So far UNODC has been unable to close them down. The drugs produced here can Increase in price up to 10 fold from the start of the purchase chain. Further, every day around 400-500 kg.s of ice, (crystal meth-amphetamine), cops say are smuggled out of these areas for distribution far and wide and cops are able to actually capture or confiscate only upto10% or so and the other 90% ends up in the hands of dealers, distributors and end users. The "Philippine Drug War", or "War on Drugs", refers to the drug policy of the Philippine government under President Rodrigo Duterte, who assumed office on June 30, 2016. In Philippines – The Filipino president's brutal war on drugs has led to the killing of thousands of his poorest citizens – including many teenagers and children.

India has just banned the marketing and production of Phensedyl, a Codeine based medicine used for the treatment of a dry cough that is often taken recreationally and abused. The ban has generated some controversy in India due to its sweeping scope. However, it has been well-received in Bangladesh, where Phensedyl addiction has taken its toll on society. Codeine is a strong opiate. It has medical uses as a pain reliever and a cough suppressant. It is particularly useful for relieving pain in cases where paracetamol and ibuprofen are not effective. However, it is also highly addictive and commonly misused and are still available in Border pharmacies.

Mr Kafle also spoke of the different "Regulation Models" of drug policy. He said " These past years, voices haves been raised to demand a new approach concerning drug laws. Different drug regulation models exist that can be applied. Some of them are defined by their reduction in the severity of penalties for drug related offences such as 'Depenalization'". He also talked about 'de facto Decriminalization' where use or possession of drugs for personal use still remained unlawful but in practice, the person using or in possession of drugs is not arrested or prosecuted criminally. In the Decriminalization model, he said that Drug use and/or possession of drugs, production and cultivation for personal use were no longer dealt with penal actions, although drug trafficking remains a criminal offence and sanctions can be administrative in nature or completely abolished. Lastly he talked about "Legal Regulation" where all drug-related infractions are no longer dealt within the criminal law sphere, but production, supply and use are strictly regulated by administrative laws, as it is for tobacco and alcohol.

Mr. Kafle then talked about Cannabis in Nepal which had been made illegal since 1973, due to pressure from USA. Now USA itself has legalized it in almost 30 states, but in Nepal the region has a long history of use of cannabis as a traditional medicine and social lubricant and marijuana is endemic to the geography where it continues to grow wild pretty much

everywhere, and all over Nepal and even in side bushes of commonly used roads and paths. Historically, Due to it's good quality, Nepal has served as a transit point for both Marijuana and Hashish(Marijuana resin) which has a reputation for having high medicinal quality. He reminded the audience of how those in power were involved in the drug scene by the example to Mr. Shared Chandra Shah, the head of the National Sports Council, who was caught in the attempted smuggling of heroin hidden in a football during the ASIAD games and Retd. Lt. Colonel Bharat Gurung who had served as the Royal A.D.C. to Late Prince Dhirendra Shah of Nepal in the 1980s until his imprisonment in 1987 for his involvement in the drug trafficking and smuggling of Heroin became the fall guy.

Mr. Kafle talked about another criminalized area related to drug use, namely female sex work. He talk3ed about Baadi women who were a traditionally untouchable Hindu caste in Western Nepal. Badi women work as prostitutes, beginning in puberty and continuing until they are too old to attract customers, or get married. Because of lack of education and access to the outer world, Badi girls grow up learning that prostitution is actually a way of life for them. They learn all about sex and how to dress and act to attract customers from other members of their community, usually from their mother or an older sister. Within a few months of reaching teen hood, Badi girls begin prostituting themselves. The Government's apathy towards the Baadi girls has led to a great public uproar, but going back into history it is hard to blame them at all. He gave examples of how the Thai Government was tackling the health Issue among Sex workers in Thailand through formal registration.

Mr Rajiv Kafle also talked about the injustices and corruption within the Drug Control JudicialSystems of Nepal and gave specific examples of when small poor farmers who have no other option for livelihood are sent to jail for a small amounts of marijuana, whereas large smugglers of Precursors such as with 49216 kg of pseudoephedrine (a precursor chemical for the manufacture ice had been exonerated and released by the criminal justice system.

Mr. Kafle then talked about Crime decrease due to regulation. He gave the example of how Portugal decriminalized the use of all drugs in 2001. Weed, cocaine, heroin, everything and Portugal decided to treat possession and use of small quantities of these drugs as a public health issue, not a criminal one. The drugs were still illegal, of course. But now getting caught with them meant a small fine and maybe a referral to a treatment program not jail time and a criminal record. He said that the reality is that Portugal's drug situation has improved significantly in several key areas. Most notably, HIV infections and drug-related deaths have decreased, and even crime has decreased - while the dramatic rise in drug use feared by some has failed to materialize. Mr. Kafle said that while there are variations in how 'decriminalization' is defined and implemented, around 25 countries have removed criminal penalties for the

personal possession of some or all drugs, contributing to the growing global shift away from punitive drug policies. He then thanked the audience and proceeded to hand over the floor to Mr. Bishnu Sharma President of RN. Mr. Bishnu Sharma President of RN- took the floor to the ending session of the event. He said that there is a growing evidence that has clearly demonstrated the importance of paying attention to gender orientation as a factor in the course of substance use initiation, development of addiction, participation in treatment and outcomes following treatment. He said that it was necessary to build on the foundation of previous research to examine how gender influences access to services and the course of treatment taken, including subsequent relapse, and abstinence. In particular, the gender roles demonstrates various ways in which social context influences substance use and treatment participation differentially for men and women and among LGBTIQ. Therefore, we assume that the longitudinal course of recovery for men and women will be influenced differentially by social context, including family and work relationships; interactions with social institutions, such as criminal justice, social welfare, and health services; and treatment and self-help participation.

16. SAARC Meeting:

South Asian Association for Regional Cooperation (SAARC) consists of Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka. SAARC was established during the first Summit of the Heads of Government or State in 1985 and Afghanistan being the latest member to join in 2007. The role of SAARC is to promote facilitate collaboration on regional issues and to promote public-private & civil society partnerships for the effective implementation of global and regional commitments of social and economic development[17].

initially, a SAARC Tuberculosis Center (STC) was established in 1992 to support Member States in the prevention and control of tuberculosis in the region by coordinating efforts of national programmes. The center was renamed as SAARC Tuberculosis and HIV/AIDS Centre (STAC) in 2005. The responsibility of coordinating and

implementing regional activities related to TB and HIV/AIDS has been assigned to STAC.

16.1. The SAARC Convention on Narcotic Drugs and Psychotropic Substances:

On the other hand, to fight drugs and drug related crimes within the region, the SAARC Coordination Group of Drug Law Enforcement Agencies was established. The SAARC Drug Offences Monitoring Desk (SDOMD) was established in Colombo in 1992 with a view to collating, analyzing and disseminating information on drug related offences in the region. Moreover, SAARC has adopted a convention on narcotic drugs and psychotropic substances. The SAARC Convention on Narcotic Drugs and Psychotropic Substances, which was signed on 23rd November 1990 in Malé at the Fifth SAARC Summit and came into force on 15th November 1993 following its ratification by all Member States[18] .

At the Thirteenth SAARC Summit (Dhaka, 12-13 November 2005) the Heads of State or Government directed that concrete measures be taken to enforce the provisions of the Regional Convention on Narcotic Drugs and Psychotropic Substances through an appropriate regional mechanism. The SAARC level meeting of Drug Demand Reduction and Rehabilitation of Victims of Drug Abuse was held on 22 February 2007 in New Delhi, at the invitation of the Government of India. The Meeting discussed matters relating to awareness generation and counseling interventions, identification, treatment and rehabilitation of drug abuse victims and training and capacity building for service providers. The First Meeting of SAARC Ministers of Interior/Home (Dhaka, 11 May 2006) and the Second Meeting of the SAARC Ministers of Interior/Home (New Delhi, 25 October 2007) reviewed the progress in the implementation of the Convention. At the Fourteenth SAARC Summit (New Delhi, 03-04 April 2007), the Heads of State or Government agreed to work on the modalities to implement the provisions of the existing SAARC Conventions to combat terrorism, narcotics and psychotropic substances, trafficking in women and children and other crimes considered transnational. At the Fourteenth SAARC Summit (Colombo, 02-03 August 2008), The Heads of State or Government further emphasized the importance of completing all legislative and other relevant measures to implement within Member States, the provisions of the Regional Convention on Narcotic Drugs and Psychotropic Substances. The leaders noted the considerable work done to promote cooperation in Police matters. The leaders appreciated the offer of Pakistan to host the Third Meeting of SAARC Ministers of Interior/Home in Islamabad during 2008.The Third Meeting of SAARC Interior/Home Ministers preceded by the Secretaries of Interior/Home Ministries, Eighth Conference on Cooperation in Police Matters and the Third Meetings of Focal Points of STOMD & SDOMD were held in Islamabad from 23 – 26 June 2010.

At these Meetings, the progress in the implementation the SAARC Convention on Narcotic Drugs and Psychotropic Substances, was taken up for discussion and the Member States

informed the Meeting on measures/actions taken/being taken by them to implement the Convention including enactment of enabling legislations at the national level to give effect to the provisions of this instrument.

16.2. Advancing health through rights based approaches and harm reduction services for people who use drugs in SAARC Countries[9th-11th, Dec. 2018:

The SAARC Charter envisages acceleration of social progress through active collaboration and mutual assistance amongst Member States. Focus on social issues under the broad heading of Health and Population Activities were one of the five original areas of cooperation identified by Member States during the inception of SAARC[19]**.** The SAARC Secretariat and UN partners have developed SAARC Regional Strategies on HIV/AIDS, which guides SAARCS work in coordinating regional efforts to prevent HIV/AIDS**.** With the additional mandate to support SAARC Member States for prevention of HIV/AIDS. The SAARC vision of the strategy is to halt and reverse the spread and impact of HIV and AIDS, to commit leaders to lead the fight against HIV and AIDS and to provide People Living with HIV and AIDS access to affordable treatment and care and enjoy a dignified life. In this context, a SAARC level regional meeting on '*Advancing health through rights based approaches and harm reduction services for people who use drugs in SAARC Countries*', was held from the 9th-11th December, 2018 at the SAARC TB/HIV center in Nepal, in the district of Bhaktapur, in Kathmandu Valley.

16.3. Objectives of the meeting

Main objectives for this workshop will include the following:

- Discuss and initiatives, experiences and challenges, opportunity and commitments for sustainable drug prevention program in the SARRC regions.
- Discuss initiatives, experiences, challenges and opportunities in ensuring effective HIV prevention among People Who Inject Drugs (PWID) in SAARC Member States (SMS) with harm reduction programmes and health focused drug intervention polices.
- Exchange views in aligning identified priorities and polices for materializing SDG - Goal #3 that is related to the Health Development Agenda (vision 2020), National work plan on drug control program and response to communicable diseases among SAARC particularly on HIV/ Hepatitis C, TB and advocacy on HIV prevention among PWIDs.
- explore critical regional strategies and partnerships in moving forward, relevant to advocacy on preventing HIV among PWIDs in the context of the SAARC on Responding to All Hazards and Emerging Threats
- Identify capacity building needs and technical assistance for SAARC Member States for and by potential partners involved with PUD/PWID.

16.4. Scope of Work:

informed by the results of the discussion on Objectives '1.' and '2.', agree on:

(a) Develop a set of key evidence based advocacy messages and recommendations,

(b) draft an outline and content of an advocacy brief for policy makers and programme planners and implementers incorporating those advocacy messages and recommendations

(c) Seek commitments and a call to action from national programsthrough their endorsement to the advocacy brief

16.5. Deliverables:

The expected outputs of this activity are as below:

a) Set of key messages and recommendations relevant to the *Advocacy on Preventing HIV among People Who Inject Drugs*

b) Areas of gaps and priority cooperation and collaboration identified(See Proceedings-21)

c) Advocacy brief for policy makers drafted

d) Advocacy workshop conducted (Conducted)

e) Workshop report (This Report)

16.6. Outcome Indicators:

a) Number of advocacy briefs developed for stakeholders addressing key barriers

b) Number of SAARC member States participating in workshop

16.7. Participants at the meeting:

There were over 103 relevant personnel present at one time or another, over the three day meeting period owed to availability and opportunity to attend the event. The meeting was organized under the leadership of the Government of Nepal under key bodies related to HIV/TB and Drug Use, such as the Ministry of Home Affairs (MoHA), National Centre for AIDS and STD Control (NCASC), Ministry of Health and Population (MoHP), and SAARC TB/HIV Centre. The participants to the workshop included the following:

16.7. SAARC Member States and SAARC Secretariat:

At least 2-3 Government Officials and Dignitaries from all the eight SAARC Member States were invited for this event initially, from:

Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.








However due to the lack of time or preceding commitments some of the Government Officials and Dignitaries from SAARC Member States were unable to attend such as Afghanistan, For other SAARC Member States at least one Authority, Body, or Civil Society NGO was present. The

Officials and Dignitaries and Dignitaries present were in one or more roles in their own countries or offices.

a) HIV Focal Points focal points Senior Officials on Drugs from SAARC Member States
b) Officers from the Health (HIV/AIDS) Divisions and the Security (Law Enforcement) Divisions from SAARC Member States
c) Representative of communication/advocacy team from SAARC Member States.
d) Representative of the Law Enforcement bodies from SAARC Member States
e) Civil Society Allies, Key Civil Society Organizations Harm Reduction , Other Drug User and KAP Networks and Key Civil Society Harm Reduction Activists from SAARC Member States.

The Meeting was facilitated by Recovering Nepal in partnership with India HIV/AIDS Alliance and organized involving representatives from relevant ministries belonging to SAARC Member States (SMS) and particularly from the sectors of Health and Security based on the ASEAN architecture with key civil society organizations, UN organizations and selected representatives of countries from South Asia Association for Regional Collaboration (SAARC).A signed list of participants can be found in **Annex 1** of this report

16.8. Overview and Agenda of the 3 Day Event:

The agenda for the 3day event from the 9th-10thof December, 2018 had to be flexible in order to accommodate for the timeliness of the dignitaries and officials as well as the need to work around other commitments.

On the December 9, 2018 at the ***'Gala Dinner'*** the welcome Address was delivered by the Government of Nepal, STAC, Recovering Nepal and Alliance India. The Key Note Address was delivered by the Guest of Honor - Minister of Home Affairs, Govt. of Nepal the Inaugural Address was conveyed by the Chief Guest - Deputy Prime Minister of the Govt. of Nepal. A Global HIV response in relation to drug use was Presented by UNAIDS and Financing Harm Reduction and HIV prevention amongst PUDs was presented by the Global Fund Harm Reduction Advocacy in Asia was presented by Alliance India then the group broke for a Group photo with the Chief Guest/s & Dinner Ensued Topics discussed on Day 1 and Day2 : December 9th and 10th, 2018 consisted of Drug Use, Health and Human Rights in SAARC – Regional Overview, problems and challenges by Dr. Ravindra Rao, National Drug Dependence Treatment Centre, AIIMS, India and a talk on Drug Policy Reform in South-Asia and Member State's follow-up to the UNGASS 2016 on "The World Drug Problem" by Ms. Tripti Tandon, Legal Policy Expert. The event presented Engaging law enforcement to expand health and rights based approaches for People Who Use Drugs by Dr. Nicholas P.F. Thomson, Co-Director, Security and Health Executive Leadership, Institute, University of Melbourne and then had a Group photo and Tea Break , After the break, with a plenary of 1 Govt. and 1 CSO representative per country, country updates were presented on Drug use, communities and HIV prevention amongst

people who use drugs fist by Bangladesh and Bhutan; then by India and Maldives; which was followed by Nepal, Pakistan and Sri Lanka.

Ensuing topics discussed were Health and rights based response to HIV and drug use, Experiences from South Asia- Minimum Standards of care and Community System Strengthening and Policy Advocacy with speakers such as Dr. Ravindra Rao from National Drug Dependence Treatment Centre, AIIMS, India, Mr. Rajiv Kafle, Asian Network of People Who Use Drugs (ANPUD). After Lunch Emerging issues, challenges and good practices in tackling HIV among PWIDs were discussed such as Challenges in scaling-up OST, NSP and ART among PWID ATS use and HIV, Good practices in community led responses: PLI, NSP, OST and Drug overdose management by Dr. Wenvuan Yin, Regional Program Advisor, UNAIDS. Dr. Nicholas P.F. Thomson, Co-Director, Security and Health Executive Leadership, Institute, University of Melbourne shred upcoming challenges and opportunities for programming and Mr. Charanjit Sharma, Community Representative and Technical Advisor – Drug Use and Harm Reduction, IHAATalked about realities on the ground. RN women presented- Drug Use, HIV and Women and Dr. Sandeep Bhola, Psychiatrist, Kapurthala, Punjab, India presented Women Friendly Harm Reduction Service Delivery Model.

Kathmandu Declaration on "Advancing health through rights based approaches and harm reduction services for people who use drugs in SAARC countries" was initiated by Mr. Kunal Kishore. There was a Site visit of Integrated Harm Reduction Programme – One Stop Shop for Harm Reduction Services SPARSHA Nepal and a presentation by Mr. Narayan Dawadi from MoHA. Summary, wrap up was given by Recovering Nepal and next steps by India HIV/AIDS Alliance and the event ended with lunch.

16.9. Proceedings of the 3 Day Event:

On the evening of the 9th December, 2018, a 'Gala Dinner' was held at the Hotel Malla Heritage, in Sano Thimi, Bhaktapur, to honor all the arriving dignitaries. The event was organized by Recovering Nepal in partnership with India HIV/AIDS alliance. One of the side aims of this "Gala Dinner Event" was to orient the dignitaries and officials present for the 3-day meeting as well as to promote an environment for open policy dialogue, over the proposed 3-day Workshop period involving representatives from relevant ministries of SAARC Member States (SMS) particularly from the sectors of Health and Security based on the ASEAN architecture; civil society organizations, the UN organizations, and selected countries from South Asia Association for Regional Collaboration (SAARC). Mr. Bishnu Fuel Sharma-President of RN and Mr Kunal Kishore From IA jointly facilitated the meeting and welcomed everyone to join in the festivities for the evening. Snacks and Soft Drinks were served with tea and coffee and the Dinner was Presided Chief Guest at the was the honorable deputy Prime Minister by Mr. Upendra Yadav. Dr

Purshottam Sedai Deputy Director of from NCASC performed the role of the 'Master of Ceremony' and welcomed the honorable deputy Prime Minister by Mr. Upendra Yadav, as well as all the dignitaries and everyone else to the meeting. He outlined that the importance of this event was in its contribution to the sustainability and going to the next level of HIV/AIDS interventions in Asia. During the Meeting, different officials and dignitaries spoke informally.

Welcome Address was delivered by Dr Rajendra Pant on Behalf of Government of Nepal, STAC and the Key Note Address was delivered by Mr. Mahendra Shrestha as the Chief of Family Health Coordination Division, Ministry of Health and Population, Govt. of Nepal. He said that this was a great achievement to be able to convene together like this, and said that he hoped for a fruitful next few days.

Inaugural Address was delivered by the Chief Guest - Deputy Prime Minister, and Minister for Health and Population Govt. of Nepal, Mr. Upendra Yadav. Afterwards, a Presentation on the '*Global HIV response in relation to drug use*' was presented by Dr. Salil Panakadan from the UNAIDS Regional Office for Asia and the Pacific . He presented the HIV AIDS scenario globally. He depicted a progressive timeline and covered the scenario in ASIA especially among the SAARC countries. In his presentation he outlined the situation of HIV and AIDS problem in Asia with a regional overview of HIV epidemic and response. Dr. Salil described how the prevalence trend is increasing in some Asian countries. Specifically, in the SAARC region he said that out of 9 countries 7 had had decreasing HIV/AIDS epidemics, whilst 2 of the countries had actually increasing epidemics, which was a cause for concern in the SAARC Region, since due to mostly Inter-border mobility in the SAARC region it is very easy to get to go back to a highly focused or even generalized epidemic from a concentrated one.

An online presentation on 'Financing Harm Reduction and HIV prevention amongst PUDs' was presented by Dr. Palani Narayanan - Senior Technical Advisor from the Global Fund. During the dinner Dr. Palani Narayanan - Senior Technical Advisor – of the Global Fund to address the audience through an online skype presentation. He encouraged the guests to have an open discussion while also pointing out that some of these discussions could be difficult in nature but it has become but necessary to have this open policy dialogue globally. He said that changes were happening all over the world. Dr. Palani Narayanan said that, the reality is that that over 250 million people around the world currently consume one or another type of prohibited drugs. Prohibition greatly increases the risks when people use these drugs, which also has been increasing the global burden of disease, certainly HIV and now Hep C, and fuels a criminal economy. Dr. Palani talked about, accepting this reality and putting in place an effective regulatory strategy to manage it was a part of the role of a responsible government. He said that we need to have some evidence-based approaches that deal with the worlds realities, as they are, in contrast to the ideologically driven moral views and ultimately counterproductive

attempts to create a “drug free world”. Dr. Palani conveyed commitment from the Global Fund to the Honorable Deputy Prime Minister to discuss ways to support the government of Nepal to explore how the different models of decriminalization could apply to the context of Nepal. In closing said that he hoped that the government would consider this offer whether it be research, or capacity building to reach our goal of ending the epidemic by 2030.

A presentation on ‘Harm Reduction Advocacy in Asia’ was presented by Dr Umesh Chawla Executive Director of IndiaHIV/AIDS Alliance.Dr. Chawla, conveyed the need for a change in the way we do things when it comes to HIV and Drug Use interventions in Asia. He said that it was the appropriate time to have these discussions in Asia around drug use and HIV/AIDS for some reform. Further He said that he was looking forwards to having an uninteresting discussions.

Dr Purshottam Sedai Deputy Director of from NCASC, gave the closing remarks of the evening and thanked everyone for their presence. The evening was wrapped up in dinner and some pictures after which everyone left, in preparation for the next day’s event. After wards a Group photos with the Chief Guest/s and all Participants were taken& Dinner was served.

16.10. Day -2: [10thof December 2018]:

Mr. SM Zakir Hossain, Director (Treatment & Rehabilitation) Department of Narcotics Control opened the Opened the welcome session on behalf of organizers of the event. Mr. Kunal Kishore from HIV/AIDS Alliance India requested the delegates to join up in the stage close to the podium. In response to his request the dignitaries that were present from the different countries took their places on stage for the opening ceremony.

- Mr Phuntchok Wangdi the Director General Bhutan Narcotics Control Authority-Bhutan
- Mr. NgawangChoida, National HIV, AIDS and STIs Control Program-Bhutan
- Hassan Shaheel, CEO, National Drug Agency-Maldives
- Abdul Hameed, Program manager TB-HIV, Health Protection Agency-Maldives
- Mr. SM Zakir Hossain, Director (Treatment & Rehabilitation) Department of Narcotics Control Bangladesh
- Mr. Devendra Singh Ministry of Social Justice- New Delhi, India
- Dr Ravindra Rao, National Drug Dependence Treatment Centre, AIIMS, New DelhiIndia
- Dr. Sandeep Bhola,Consultant Psychiatrist, (ICAP-II), Kapurthala, India
- Mrs. BhadraniSenanayake- Director - Research- National Dangerous Drugs Control Board, Ministry of Defense-Sri Lanka
- Dr.Chitran Hathurusinghe MD- Consultant HIV & SH Physician- NSACP - Colombo Sri Lanka
- Dr. Maimoona Malik form NaiZindagi, Pakistan.
- Dr Salil Panakadan of the UNAIDS Regional Office for Asia and the Pacific
- Dr Rajendra Pant, SAARC HIV/TB Center

- Chief Guest- the Honourable Deputy Prime Minister and Minister for Health and. Population , Mr. Upendra Yadav,

The opening ceremony was chaired by Dr Rajendra Pant, Director of the SAARC HIV/TB Center. Dr Pant greeted the guests and said, "Namaste and good morning Honorable guests and Honorable representatives and participant, it is my privilege to welcome you all to this meeting being organized in Kathmandu" Dr Pant gave a brief overview on the SAARC Tuberculosis and HIV/AIDS Centre (STAC) which is one of the Regional Centres of SAARC working for prevention and control of TB and HIV/AIDS.

Dr Pant said that, different countries would be sharing their experiences as well as their expertise, prepared to make serious commitment. He said that SAARC Tuberculosis Centre (STC) was established in 1992 and the Centre started its functioning as SAARC TB Centre since 1994. Since then, Dr Pant said, that he Centre had been supporting the National TB Control Programmes of the SAARC Member States providing , capacity development and technical expertise. 'So' He sid, ' I Hope we all can get to know a little bit about STAC, today ". He said that his discussions with UNAIDS on how HIV/TB could be addressed in SAARC region, he felt, would be further informed by this two day workshop, and said that it would help guide us to carry out our activities effectively . In closing he requested Deputy Director of National center for AISDS and STD Control Dr Purshottam Sedai, to deliver the inaugural speech. Since Dr Sedai had not already arrived yet, at the time, a request was made out to Mr. Bishnu Sharma to Deliver a few words in pace of the inaugural speech. As Mr. Bishnu Sharma was unavailable at the time, the floor was requested to be taken by Dr. Umesh Chawlha- Executive Director of India HIV/AIDS Alliance. Dr Umesh Chawlha- Executive Director of India HIV/AIDS Alliance, went up to the podium and addressed the honorable deputy prime minister and other high dignitaries. He said, 'Welcome to you all to the work shop ! ". He said that he represented India HIV/AIDS Alliance, and wanted to thank the STAC, and the Govt. of Nepal, under whose guidance the coordination and organization of this meeting took place. He said that this meeting would be very important particularly in relation to HIV and other diseases Such as Hep C. Despite the years of Interventions, Drug use has increased in diversity and complexity and overall size has not decreased. So it is timely, he said, for us to be looking at HIV driven by Drug Use as an opportunity with an important role to play in bringing countries together to ease the harsh laws and social environment that impeding services. In closing, he announced that there were hopes that a year from now another country would take the initiative and lead role to host this important meeting next year.

As the potential lead country to host the event for next year, Bhutan was proposed. Although there was a positive response from Bhutan the Officials they said that they would need to formally confirm the matter through the government process once back in their own home

country. This temporary closure was considered to be on a a positive note, thus creating an entry point to follow-up for organizing next year's meeting. In closing Dr Chawlha thanked everyone for being present and committed , and said "Thank you, hoping for a strong End ". The facilitator of the meeting then requested Mr. Bishnu Sharma- President of Recovering Nepal to deliver a few word as the inaugural speech.

Mr. Bishnu Sharma started by saying, " First of all respected chair, chief guest honorable deputy Prime minister and respected guest from all the member states and the Government of Nepal, UNAIDS, Alliance India and colleagues from RN, thank you for your presence and your seriousness for this important meeting". He said that in his experience, less people seemed interested in talking about this problem. He said that even overcoming the perception was very difficult, but regardless, he said, 'this is bad but, it is part of our problem as a society.'. We must take ownership for this problem. We have had new laws passed in other areas, but we who are working in this field are still stuck within the same draconian policies and obsolete laws from over 40 years ago, from BS 2033 [=AD 1976]. He said that we have made some progress since 2002 when HIV was 68 %, and although it is now less, there is a very critical situation now with high rates of Hep C. He said that it has been very difficult to provide services . But now we have finally started talking about decriminalizing . In closing he said that , experience has shown us that when we criminalize we lose massive lives in the DU community. At the same time we must also understand and realize that we are not advocating for 'legalization' of drug use but 'decriminalization'. He then proceeded to hand the floor to Mr. Kunal Kishore from Alliance India. Then, Mr. Kunal Kishore from Alliance India asked Dr Rajendra Pant from STAC to felicitate the honorable guests with '*Khukri*' souvenirs, as small memento on behalf of their participation to the event. On behalf of Civil Society, Mr. Rishi Raj Ojha, one of the Pioneering and Longstanding Harm Reduction Activists from Civil Society was asked to convey a few word on-stage. Mr. Rishi Raj Ojha gave his salutations to all the dignitaries present, he said that he was very happy to say something there in such a high level forum for the first time. He said that for the first time in Nepal we were having a SAARC level meeting on Harm Reduction although we have a Harm Reduction programme of sorts, since 1991.

He said that, Drug Users, brothers and sisters were desperate, being jailed, beaten and tortured. He said, " We need some modification in the laws". He said that we needed some change for the sake of youth, young children and adolescents who are also involved in drug use. ' I am very happy as a pioneer of harm reduction in Nepal, today, which is also '*World Human Rights Day*' , that we are talking about this issue. I hope that the Ministry of Health and population can take the lead . The Honorable Chief , Deputy Prime Minister and Minister for Health and population then delivered his opening remarks. He started out by greeting all the participants present with a "very good morning" to all the distinguished guests. He said, 'I am pleased to welcome you all on behalf of Government of Nepal , and we wish you all a pleasant stay in Kathmandu'. He continued his speech saying that every year Human rights day was organized on the 10th Dec. He said that however this year's event organized was a first of its in Nepal. He said that the meeting would also highlights Nepal's progress in the High level UN General assembly . He

said that the meeting would be a instrumental in taking stalk of the regional commitments on progress to the UN General assembly special session, on the world Drug Problem.

He said that in addressing world drug Problem, inclusion must be at the core of the agenda for the SDG's. He said that although the New Constitution of Nepal, the law of the land, clearly states that health is a human right, he said that, often, new rights linked to human rights that seem new are often ignored. In Closing, the said 'It is clear that HIV AIDS and Human rights are clearly linked by the right to access services for the sake of one's health, I look forward to constructive and productive discussion and conclude my opening remarks', and handed the floor to Dr. Ravindra Rao - Associate Professor National Drug Dependence Treatment Centre, All India Institute of Medical Sciences(AIIMS), New Delhi. Dr. Ravindra Rao - Associate Professor National Drug Dependence Treatment Centre, All India Institute of Medical Sciences(AIIMS), New Delhi. The title of Dr. Rao's his presentation was "Drug Use, Health and Human Rights, SAARC Regional Overview". Dr. Ravindra Rao talked about the operational difficulties with naloxone with policy because often Drug Users are often first responders but are not allowed to administer it at an OD site in such a case. He said that also it was not that effective for prophylaxis treatment. Also he said that social perception was very disillusioned since most families, he said, believe that only detox or abstinence is the best option, or the only way. He said that, once a person is into drugs to manage them pharmacotherapy is required depending upon the treatment goals, whether it is maintenance or it is abstinence . Even the policy makers also believe the same non-evidence based views, he said.

Regarding concomitant drug use, he said that, in the OST programme we have to accept that some external drugs will be used simultaneously by some,. He said that in his experience, most common was cannabis and benzodiazepine use in conjunction with OST. Dr Rao confidently said that Cannabis was forgiven and made no real makes no difference for the OST patient and he said that the evidence said the same. However he said that the concomitant use Benzodiazepines there is a chance of overdosing. He said that there were some medicines that could be used to treat for Benzo addiction. 'But', he said, 'such cases are very difficult to resolve'.

Dr Rao then talked about mortality data in India, regarding concise, true desegregated studies of OD and Naloxone. He said that 2 studies from cohorts in Chennai shoed that the Mortality rates were found to be much higher than in the general population. However he said we do not have good prevalence data in India. At least, ¼ had experience of non-fatal overdose, at one time or another. This he said was a precursor indicative of highly probable dosing problems. The main problem in India he said was, naloxone is available in Pharmacies and Hospitals, but not on the community street level. In closing he handed the floor over to the facilitator who called upon Ms. Tripti Tandon, who is a legal and policy expert from Lawyers Collective

Ms. Tripti Tandon legal policy expert Lawyers Collective said that she had had the opportunity to review policy for PWID, 2005-2006 h13 project of UNDP. It's Findings, - published on the UNODC site, she said, said that although the legal environment was not conducive yet, at the time, Harm Reduction projects took off and established firm roots. She said that she also found out that it was a good environment for dialogue between law enforcement and health bodies and both formally and informally with services.

For those apprehended by police., at harm reduction sites – Informal talks with police to back off from the health interventions also happened and were complied with. She said that, In this region, despite a lot of hardline policies, a lot of flexibility was demonstrated in practice in this region. She said that, in their report, they we had suggested some legal ways forward for each country and their people to decide. She gave a number of following points. Firstly, Most Drugs laws allow controlled substances to be used for medical purposes. OST be seen as part of this medical use.Secondly, Provide Safe Havens for interventions, where the law will stay off course. Thirdly, Health service providers doing Harm Reduction should be immune from prosecution. She said that treatment needs to be defined from a holistic point of view. Also, she said the it was recommended that Laws make a clear distinction between Users and traffickers. She said that in the present situation, Harm Reduction was now part of most national policies and programs, and that Harm Reduction had been institutionalized. On the one hand it's great that we now have the formal endorsement. But on the flip side, harm reduction was supposed to be about meeting the community on their terms, which now have become part of government programs where commodities have to be accounted for while we have a program which is largely not humanely responsive. Point in case is that, Harm Reduction is taking care of HIV but has not been not able to take care of Hep C .

Ms. Tandon said that the legal environment and the laws have changed in some way or another, for good or for worse, for India progressive strides with narcotics laws to match the Harm Reduction, and the management of drug addiction is the focus. Also, the HIV/AIDS act to gives community services to key populations, she said.

Ms. Tripti Tandon also pointed out that in other countries, changes were taking place as well. She said that Bhutan had replaced its 2005 drug law penal provision with a substance abuse act , Maldives also had replaced it's 1977 law on narcotics, although it seemed that the old act has not been repealed formally yet.

She talked about Indonesia, which is about to step up its efforts in the drug war has proposed revisions to the it's criminal code to promote harsh penalties for the use and possession of narcotics - including society's ultimate sanction, the death penalty - instead of a health-oriented approach. She said that Pakistan had also introduced some liberal changes to its laws regarding drug treatment. These reforms are centered on the distinction between users and traffickers, based on amount confiscated. Now, also introduced as dependence defined a needing help, treatment, care etc , Also there are changes to the use of terms such as avoiding the term 'Addict' , I hope that Bhutan and India, as well as others can take note of this. She said that there was also the need for the Regulation of Drug Treatment centers. She candidly pointed out that, it would be a very progressive move If dependence related crimes were mixed with health interventions. Ms. Tandon talked about sentencing practices for offenses related to drug use. She said that one of the reasons court ordered treatment had not been effective was that the period spent in treatment was usually not counted as part of the sentence, so that the offending people who used drugs, would rather stay in jail. She said that, such types of treatment has now become the main stay of the region.

She said that certain bad things had also come in. In this region, we now have compulsory drug treatment. If police only even suspect you they can take you for a compulsory examination, etc. and refusal to go into treatment often means additional punishment, use of force etc. Also, mostly treatment has been defined to focus on detoxification and abstinence only, with only inpatient based institutions and the most dangerous part is that it is entrenched in the Criminal Justice System, which defies common sense. Coming in to UNGASS 2016, she said that most countries had signed the outcome document that stated that a response to drug use must be guided by the health and welfare of mankind. We also have Gender and Youth, equally cross cutting issues. She said that substitution treatment is given a lot of emphasis In all the different section in human rights concepts, as well. Regarding prison based interventions, Punjab was finally forced to have OST in prison whenthey realized that mostly there were all drug users in Prison. She said that , for a very long time SAARC countries have looked to Southeast Asia on how to handle drug cases and they have been repressive measures such as long jail sentences and the Death Penalty. However, Thailand is amending it's laws. She talked about the story of a young woman who was found with 5 methamphetamine tablets, who was initially charged with 2 years jail. However, later during case review, they realized that since she was found near the border, the law indicated a crime of ' intent to export and trafficking ', this caused the sentence to be 25 years . This caused a lot of controversy regarding the unfairness of a 25 year sentence for such a small amount and caused realization, all the way to the top of the Monarchy. As a result is amending it's Drug laws.

Singapore has done away with the death penalty, and Malaysia is considering stopping the death penalty and legalizing cannabis. Here too there was a similar case of a man whose wife had cancer , he was desperate and so he ordered some cannabis from the internet and sentenced to 20 - 25 years in prison for it. This incidence also raised controversy and caused a shift in paradigm where things have begun to be looked at differently.

Government s re beginning to recognize the importance of addressing this problem. The Question is that ' is offering treatment enough ? or do we need to go further ?. However there is still confusion in the view of government's, as to whether to regard a drug user as a patient in need, or a criminal. She said that evidence based policy statements from policy decision makers can help. Substitution Therapy needs to have a better place in the broader sense, such as using the term medication. The world has changed, Ms. Tandon said, now Cannabis has been decriminalized and legalized by the lead proponents of the drug war and others are following suit and generating revenue with it. In closing , she said that we hope to see these positive changes happen in our region too. This was followed by a number of questions from the participants, and their answers, which are as follows.

Q1 - Could you please clarify on who when and where Immunity to law enforcement applies ?.

Ans. Immunity to service providers does not extend to users and only to within the premises of the health and harm reduction services, it stops when they leave the premises since changes in Narcotic law have made treatment legitimate.

Q 2 Is there any provision in the Indian HIV/AIDS Bill that criminalizes, sero-discordant couples or one partner as Intentional Transmission?

Ans. If Criminal or Malicious Intent is proven it would go under the Criminal Penal. India's HIV Bill or code, if you will, does not criminalize intentional transmission in that way if couples are consenting.

Q3 Can you tell us how we can deal with the self-stigma for better service uptake ?

Ans. – The self-stigma makes people more volatile, involving PWID in just outreach is frustrating communities. Communities feel that they are left out when services become rigid. Adherence and retention is more important, policing is not necessary. Law enforcement activities have not been adequately articulated in the National HIV strategic plans, with Partnership roles in Harm Reduction and HIV control. We have seen that lower level awareness does not work in the chain of command and needs to be part of a larger police mandate.

When you see people in uniform they are an an extension of the state. Police officers upholding the human right charter. Human rights orientated training should be part of the professional development. Looking at trials , trials help build data, so we should not be afraid of trials. Legal Literacy, such as knowing ones rights and resources from Law enforcement data that speaks to police are important elements.

The next session was led by Dr. Nicholas Thomson from the Law Enforcement and Public Health Program, University of Melbourne and Johns Hopkins School of Public Health.
Dr Nicholas Thomson said that in order for us to bring about change, the way we do advocacy with the UN has to be different. He said that the presence of heavy security police environment was not good for these types of discussions . Normally police are only interested in Data which could help them reduce crime and increase, Increase safety. Dr Thomson pointed out that, Generally Police face arrest quotas or quotas for diversions. In a changing world, he said that it was necessary to change the metrics of policing and find a new way of looking at law enforcement indicators. There is a need to develop new data sets that can generate the evidence for change.

In his presentation Dr. Thomson gave the background and context of his presentation which outlined three existing conditions at present. Firstly, he said that partnerships between Law Enforcement and Community Service Organization in the context of HIV service provision for people who use drugs are extremely rare, the exception rather than the norm. Secondly, he said, the ongoing documentation of rights violations and negative impacts on access to essential services warrants the need for such a partnership. Thirdly, Dr Thomson emphasized that the main challenge would be to consider a transitional strategy for 'How do we move through persistent conflict into a partnership?'.

He gave the Rationale for Engaging Public Security in the HIV Response. He said that In combination: police forces, military services, internal security forces are somewhere between 10 and 10000 times larger than the public health sector. Also he said, In a world of shrinking resources for HIV we need to mobilise this human capital as partners in the HIV response and pointed out that there is also a broader application to multisector partnerships in pursuit of global health and Universal Health Coverage.

Dr Thomson made reference to a number of Relevant Political Frameworks such as UNESCAP Resolution 66/10 and 67/9. He said that both these resolutions called for the scaling up of partnerships between

law enforcement, criminal justice, public health and civil society in the context of the provision of Universal access for all key affected populations, also he talked about International Health Regulations (WHO, GHSA, JEE) which have core requirement to have partnerships between public security and public health in the context of pandemics.

Dr Thomson gave examples of cases where in 2014 - 2015 Medicines Sans Frontiers requested the US military to intervene with the full force of their logistical capacity to bring Ebola under control. Similiarly, in 2015 Dec-2016 Jan the Brazilian military's was deployed to deal with the Zika virus on the ground.

A sharp increase in Pakistan's polio cases in 2014 prompted the mobilization of over 5,000 police from the provinces participate in the vaccination campaigns each month.

Dr Thomson then put forth the question of 'What do we know about the intersection of policing and people who use drugs in SAARC Countries?'. He said that the available data sets and reports predominantly described that people who use drugs are at significant risk of arrest, incarceration and human rights violations at the hands of state actors including police – all of which negatively impact the national HIV response. (the references to the related literature and research in in the presentation).

We know that there have been a range of efforts aimed at understanding how harm reductions programs interact and engage with police Speaking on Police and Harm Reduction across the region, Dr Thomson acknowledged the need to work on police reform as well as work with judges and prosecutors on drug policy sensitization and police corruption. He recalled that, between 2012-2015, a large number of UNODC supported regional and national level dialogues between police and CSO to discuss collaboration had taken place. Also it has been heard from Police in some countries that have reported that communication from the NGO service delivery agencies to the police has been lacking. Dr Thomson emphasized that, we need to know and find out what don't we know as just as much there was a need to educate law enforcement. He shared some outstanding case studies where the impact on policing metrics of harm reduction programs (in Vietnam police reported a 40% drop in crime when community methadone program was established), Also the time and resource implications of diversion quotas versus arrest quotas makes it easier to avoid hassle for police. There is a need to figure out how to support structural reform of Police policy and standard operating practices so that we create a win-win partnership between health and public security.

Dr Nicholas Thomson argued that we have very active and strategic CSOs but the key is to create a partnership. He Presented various resources and Training manuals for Law Enforcement Officials on HIV service provision for people who inject drugs. Dr Thomson also articulated the need for the Development of critical tools at the reimplementation phase right from the policy levels such as:

- National HIV Policy for Law Enforcement Officials,
- Standard Operating Protocol for Law Enforcement Officials interacting with Key Affected Populations (KAPs),
- Occupational health and safety for Law Enforcement Officials (Universal Precautions),
- Articulation of the role of Law Enforcement Officials in the National HIV/AIDS Program response

- ❖ Integrated operational framework for how Law Enforcement Officials collaborate with multi-sector stake holders including Public Health, Non-Government Organizations (NGOs)

Dr Thomson talked about a three stage implementation process, where the following can take place.

(a) Adapting & Preparing the Training Guidelines for specific country context
(b) Training of trainers from Law Enforcement Training Institutes and Field Offices
(c) Implement training at Law Enforcement Training Academy and selected strategic sites/ field offices ahead of national scale up

Dr Thomson also presented an evaluation for implementation process, where the following can take place.

(a) Pre Implementation Preparedness Checklist
(b) Pre Implementation Baseline Survey on Knowledge/ Attitudes/ Behaviors and Practices of Law Enforcement Officials around HIV/ AIDS

16.10. IMPLEMENTATION PROCESS:

(a) External Evaluation; Key Information interviews with other stakeholders from Health Service Sector, Communities and NGOs working with KAPs to assess impact of Law Enforcement Officials in enhancing services provision for people WID, PWIDS and other KAPs
(b) Post Implementation Baseline Survey on Knowledge/ Attitudes/ Behaviors and Practices of Law Enforcement Officials around HIV/ AIDS

POST 12 MONTHS:

Evaluation of Law Enforcement specific variables of interest including:
a) perceptions of community safety
b) crime rates
c) use of police time and resources
He stressed that it was critical to recognize that the most critical time point for interventions is at the point of arrest and proposed a roadmap for building enhanced partnerships between law enforcement, public health and civil society. He then proceeded to explore some Future Opportunities in his next slide such as.

- ❖ The articulation the National Strategic Plan of the role of police as partners in the National AIDS Program
- ❖ Making a resourcing case for bilateral and multilateral donors to support police engagement (policies and protocols for working with key populations – do no harm)
- ❖ National level discussions on cost-effective policing and implications for drug policy
- ❖ Professional development of policing in the region
- ❖ Trials of diversion to community based services versus arrest quotas
- ❖ Scaling partnerships between police, service provider

- The role of legal aid and pro bono legal services to reduce engagement of drug users in criminal justice systems and reduce pressure on system

In his final slide Dr Thomson raised the question what the end Game was about ". He then proceeded to articulate the main objectives being :

- To help support investment strategy options that mobilize security sector reform resources;
- To build the science of the enabling environment and align it with the politics in terms of our interventions and advocacy;
- To work towards a health in all policies approach to pre arrest, incarceration and post incarceration,
- To promote persistent cross-sectoral dialogue

He then shared a bit of a humorous anecdote where some of his colleagues jested him by saying, 'Dr Nicholas are you trying to create public health armies ?" to which he replied, in good humor but on a more sober note, " Not public health armies but public security actors that promote and support public health endeavors !". Dr Nicholas Thomson thanked the audiences and ended his presentation and took on some questions from the audience.

Q-1 , Dr Sandeep Bhola – We have been talking about reforms, which we see in the west, has it been ever tried in the SAARC countries , since Australia is seen as a partner to Bangladesh in this area.

Ans.- Bangladesh Increased the no of Female officers and that has shown to improve access to HIV services. The establishment of methadone program was shown to reduce crime in Vietnam by 40 %. Also there is the example of legal literacy and Legal AIDS to sex workers in India which led to reductions inb prosecutions. Also, Chinas methadone program was shown to reduce crime. WHO calls for these type of partnerships but so far no one wants to fund this partnership of Public Health and Justice Actors. Where we have strong partnerships, such as Thailand, we see reduced HIV incidence, conversely, in countries like Russia and Uzbekistan we see expanding epidemics.

At the same time we need to realize that although we need partnerships, at some level, we do not want to institutionalize it, but build enough of a working relation just enough to give the mandate to work, and more importantly capitalize on the opportunity to generate the evidence for success.

Ms. Tripti Tandon: In the instance of India, a Directive from the Courts or the Government must be issued to the police before any such partnerships initiative can be taken by the police.

The Floor was ten given to Dr. Purusotam Raj Shedain, Deputy Health Administrator, National center for AIDS and STD control (NCASC), of Nepal.

Dr Purshottam Raj Shedai Deputy Health Administrator of the National center for AIDS and STD control (NCASC) of Nepal gave his presentation on " the HIV/Harm reduction response in Nepal. Dr Shedais Presentation came in 2 parts. The First Part Consisted of and overview of the HIV Scenario in Nepal, whereas the second part consisted of a snapshot of the Harm Reduction Scenario. In the first part he presented Nepal's estimates of HIV Infections from 2017, with ttotal PLHIV being 31, 020 with HIV prevalence in the 15-49 age group at 0.15% and the HIV Prevalence in the 15-24 age group at 0.02%.

The data he presented indicated that 835 New HIV infections were diagnosed last year. There were 304 mothers Mother in need of elimination of vertical transmission (eVT) services and 1,306 Deaths attributed to AIDS related complication in Nepal. He presented percentage distributions of key populations being FSWs at 1%, clients of FSWs at 7%, PWIDs at 4% MSW's at 6%, MSM/TG at 7% with Low Risk Males (including Migrants)at 38% and Low Risk Females at 37%. He also presented a summary of the latest size of Estimates of key populations in Nepal in 2016. There were 30,868 People who inject drugs (PWID), 60,333 Men who have sex with men (MSM), 21,460 Transgender (TG), 18,287 Male sex workers (MSW) and 49,018 Female sex worker (FSW) Estimated in 2016. He gave a picture of the estimated HIV Treatment Cascade in 2017 where out of the 31,020 estimated PLHIV Only 19,702 Knew their status (estimated) with only 15,260 Receiving ART (estimated). Further, only 7,998 were actually HIV Viral Load tested last year while an estimated 7,184 were Virally Suppressed. Out of the average of 0.15% HIV prevalence among adult aged 15-49 years, 0.18% were male and 0.12% were female. He also presented a graphical figure of new infections versus the deaths in Nepal from starting from 1985. The following is an excerpt for New Infections and Deaths for the past 10 years in Nepal.

Year	New Infections	Deaths
2008	2809	1,766
2009	2305	1,687
2010	2116	1,687
2011	1934	1,694
2012	1665	1,635
2013	1423	1,599
2014	1266	1,549
2015	1101	1,450
2016	931	1,369
2017	835	1,306
2018	745	837

He also shared an excerpt of the National HIV Strategic Plan 2016-21, Nepal HIVision 2020, whose Vision: is about Ending the AIDS epidemic as a public health threat in Nepal by 2030 and it's Targets and indicators for Fast-Tracking the response by 2020, such as:

- Identifying, recommending and testing 90% of key populations.
- Treating 90% of people diagnosed with HIV.
- Retaining 90% of people diagnosed with HIV on antiretroviral therapy.
- Eliminating vertical transmission of HIV.
- Eliminating congenital syphilis.
- and Reducing 75% of new HIV infections.

The Second Part of Dr Shedais Presentation consisted of an overview of the Basic Service Package along with an overview of OST GUIDELINE [2070 BS :2013 AD]. He said that the Comprehensive prevention package of Harm Reduction services in Nepal consists of:

- Harm reduction Program (NSE, OST)
- IEC, BCC, Condoms
- HIV testing and counseling
- STI diagnosis and treatment

In 2015 the Percentage of PWID who were living with HIV were 6.4%, the target for 2021 is to reach 4%. The percentage of PWID in 2015 reporting the use of a condom with their most recent partner was 52.5% and the target for 2021 is to reach 90%. Further, the percentage of PWID who received an HIV test in the past 12 months and knew their results in 2015 was 27.9% for 2021 the target is ti reach 90%. Crucially, in 2015, the percentage of PWID reporting the use of sterile injecting equipment the last time they injected was 96% and we hope to maintain that at 96% till 2021. He showed a Map of Nepal where Harm Reduction was targeted in 26 districts and OST Program had been scaled up to 11 districts out 75 districts. Dr Shedai Shared and excerpt of the IBBS survey (N=340) on PWID in the Kathmandu valley in 2017 that showed out HIV at 8.5%, Active Syphilis at 1.7%, those with a history of Syphilis were 2.0%, Hepatitis B prevalence was indicated at 1.3% and Hepatitis C at 18.8%. Further, Co-infection of HIV and HBV was found to be 0.29% while Co-infection of HIV and HCV was found to be 7.14%. His next slide presented figures of 15 OST sites in 10 Districts, with 739 currently on methadone and 277 currently on Buprenorphine which represented only 3.3% of overall coverage needed against the total number of estimated PWID {(Male: 27567:Female: 3301):[Male: 3.6%:Female: 0.6%]}. He said that the Targeted Intervention Program in 2017 Targeted Intervention Program in 2017 was 6,71,631 (22/per person) and the number of needle syringe distributed per PWID per year (1,871,765/30868) translating to an allocation of 61 per year, per PWID. In his next slide Dr Shedai talked about Innovations/ new Initiatives such as the IRRTTR strategy, namely, Identify, Reach, Recommendation, Test, Treat & Retain till we reach 90-90-90. He said the National health Sector Plan (NHSP) 2016–2021 has endorsed, community-led HIV testing (CLT) as part of the CBT strategy, following the 'test for triage strategy' for screening and referral. Another new initiative was the national survey on drug use and the assessment of the harm reduction program with a currently working draft treatment guideline for Hepatitis B and C in Nepal. In closing, he outlined the 2 main key achievements on Nepal to be the Reduction of HIV prevalence in general population form 0.55 % in 2005 to 0.15 % in 2017 , HIV prevalence among PWID reduced dramatically for 68% in 2002 to 8.5% in 2017. He then entertained some questions before handing the floor over to the facilitators.

Q-from Bhutan-As community based testing is established what are the acceptance and challenges faced in Nepal and the results of this study published in Nepal. .

Ans: Dr Shedai- There is a difference between Community Based vs Community led. We have been implementing the community based strategy for some time now which is to provide services at the at community level where they can get tested by a healthcare provider. However, in the case of Community led Testing, the HIV Test itself is test done by community people from KAPS populations. The Idea is that though they are not trained yet they have the experience as outreach workers so we train these lay people and we give them the authority to test for HIV. If this screening test is positive then they are linked to a confirmatory test and if the positive test is confirmed, they are linked to treatment and if Negative they are linked to OST and other services. In Nepal we have newly introduced,

Saliva Oral kits the other is determine kits. Both are equally acceptable, we are going to publish the study and then provide it Formally .

16.11: Plenary Session from the countries of Bangladesh, Bhutan(1 Gov 1 CSO representative per country):

After lunch our main dignitary from Bangladesh, - SM Zakir Hossain, Director (Treatment & Rehabilitation) Department of Narcotics Control of Bangladesh presented his presentation. He said that the laws that had been enacted in 1990 had been now recently changed in Nov 2010, with 3 elements, i.e. Demand reduction, Supply Reduction and Harm Reduction. He said that the Bangladesh Govt. currently four of owned its own Rehabilitation Treatment centers , and they were planning for 800 more beds. He said that the government was also encouraging the CSO's to run drug treatment and rehabilitation centers. He said that there was a strong partnership with Govt. and non- Governmental organizations with EDPs playing a vital technical role, such as ICDDR,B . The presentation was jointly presented by the honorable SM Zakir Hossain, Director (Treatment & Rehabilitation) Department of Narcotics Control & Mr. Ezazul Islam Chowdhury Senior Programme Manager, Programme for HIV and AIDS, ICDDR,B. They talked about the HIV situation in Bangladesh- at a glance. In Bangladesh the first HIV case was detected in 1989. So far HIV prevalence remains <0.01% among the general population but in in KPs it is now 3.9% (which was 0.7% earlier). HIV prevalence has crossed 5% in male and female PWID in Dhaka, with 22% HIV prevalence in Dhaka city (IBBS 2016). Estimated number of People Living with HIV is about 13,000 (UNAIDS 2017) but reported cumulative cases are 6,455 which is around half of estimated cases (ASP 2018). Bangladesh is one in seven countries in the Asia-Pacific region experiencing an increase in HIV prevalence (UNAIDS 2017).

Their presentation illustrated the Prevalenceof HIV in all KPs over the years in Bangladesh with a current figure of 3.9% prevalence. Next was theCumulative annual number of reported HIV cases in Bangladesh form (1989-2018) was 6,455 case with total reported deaths due to AIDS: 1,072. They had 869 newly diagnosed case of HIV in 2018. The next slide was about the History of Needle Syringe Programme (NSP) and land mark events. The Harm reduction programme was supported by policy/strategy of Bangladesh Government and started direct implementation from 2004 under operational plan of AIDS/STD Programme (DG-Health) . Mr. EzazulIslaamChowdhary shared the PWID situation in Bangladesh, at a glance .There were and estimated 33,066 PWIDs (including 6,157 in Dhaka) . Current coverage is 9,000 (5000 approx. in Dhaka) but suggested coverage by National Strategic Plan (2018-22) is 75% of estimated number which is around 24,000. Coverage of Needle/ Syringe Programme (NSP) in Dhaka is >80% (~5000). Harm reduction follows comprehensive approach, although other than NSP, coverage of other components are low. Funding is shrinking (since 2016, Global Fund is only source). Out of 850 detected PWID with HIV, there are approximately 550(65%) on ART . He then showed data that showed the prevalence of HIV in PWID increasing over the years. There were 330 new PWID case identified in 2017. Regarding the Harm Reduction services for PWID: (Nine intervention of WHO, UNAIDS and UNODC), He said that Almost all the components of comprehensive approach (WHO, UNAIDS, UNODC 2009) were available but coverage was not adequate.

Mr. Chowdhury then spoke about Oral Substitution Therapy (OST): An evidence based harm reduction option for PWID in Bangladesh. He said that OST started in Bangladesh as a form of pilot study in 2010 implemented by icddr,b under a project of UNODC/ROSA . Currently, five clinics are operational (including one in DNC run treatment clinic) and reaching out 950 PWID (3%) but there is allocation of funding in current global fund project to include more 750 PWID by 2019. icddr,b, Save the Children and Care Bangladesh are implementing OST under technical assistance of icddr,b. There is an allocation of OST in 4th Health Sector programme for 1500 PWID but when the government is going to release it, is a question of patience he said. Department of Narcotics Control (DNC) and Assistant Superintendent of Police (ASP) are in monitoring role of OST project.

He talked about the role of AIDS/STD Programme in national response of HIV. Which acts as a nodal agency in the HIV response, providing policy support, strategic direction to HIV intervention of KPs and other HIV and AIDS issues, on behalf government of Bangladesh. He said that there were various technical working groups monitoring the implementation of the intervention through Mainstreaming HIV intervention in Govt. health systems to ensure future sustainability. They were also Implementing care and support component (through 6 Govt. hospitals)under operational plan of 4th Health sector programme and recently established 23 HIV Testing Service Centers in a Government setup. Total Patients in OST Treatment since August 2018 was 3,265 and Out of 869 detected HIV+ in 2018, of them 665 have already been enrolled in ART (76.52%).

A total of 5-7 million Drug users are in Bangladesh (estimated). Recently on 27th October Narcotics Control Act 2018 was approved in the parliament . Main features of the new act are: Shifted methamphetamine from 'B class' to 'A class' drugs and if found Yaba up to 200 gms, 1-10 years imprisonment but for more than 200 gm, life time imprisonment or death sentence Punishment is same for Pethidine, morphine, buprenorphine etc. if recover more than 25 grams, life time imprisonment or death sentence but for less 1-10 years imprisonment.

There is now a major shift in the understanding of role of DNC as it has showed OST and NSP as harm reduction approach as effective (Drug report 2017). 147 NGO, 262 private treatment centers along with 4 DNC run centers have been licensed for treating drug users. The DNC has been engaging the corporate sector for setting up of treatment centers in a collaborative way.

He posed some Serious questions such as L:

- Why UNAIDS best practice site of NSP (UNAIDS 2006) experienced sharp HIV increase?
- Why an intervention which may have substantially reduced PWID HIV transmission once (Foss A et. Al, 2007), failed to control HIV among PWID?
- And Why a country fails particularly that one which was one of the 12 countries where more than 200 needle/syringes /PWID/year are distributed as suggested by WHO to have impact?

He shared the Review of harm reduction programme in Bangladesh by Dr. Tasnim Azim and Gary Reid in March 2018. The findings indicate that the ratio of PWID to Outreach Worker had doubled in the last few years, motivation of field workers was less due to less engagement of management level staff. Limited availability of OST. Despite adopting the Test and Treat policy, not all HIV positive PWID were

receiving antiretroviral treatment (ART). Neglect in giving special attention to HIV positive PWID to prevent them sharing their used needles/syringes, Inadequate monitoring and evaluation (M&E) with Limited efforts at advocacy so that harassment by law enforcement and general community members continued. Unabated needs and declining funds have led to cost cutting measures that have affected programme delivery negatively leading to a compromised programme[20].

He said that the measures taken after sudden increase of prevalence were to revised the ratio of PWID to outreach workers. Introduced community based HIV testing by the trained lay-providers, following WHO Guideline, 2016 with comprehensive DICs to provide HTS, ART, OST, TB-HIV management as one stop service point at hotspots while Introducing ARV DOTs by case workers from positive PWID peer workers to strengthen ART adherence.

He went on to share some Challenges of harm reduction interventions and talked about Homelessness: with 34.3% PWID living on the street (IBBS, 2016), *Homeless PWID are five times vulnerable than home based PWID to get HIV infection (Azim T , Khan et al. 2009). NSP solely focuses on individual behaviours, which can reduce the transmission risk of HIV to 48%, at most (Platt et al., 2017).*

The next was Legal barriers: Narcotics legislation criminalizes consumption of drugs. Supplying equipment like needles/syringes to PWID that facilitate illicit drug use constitutes 'abetment'. Using space for DIC also is an offense as per narcotics law.

Forced Mobility: Anti-drug drive/clean up drives of law enforcement agencies and sometimes also community members forcing drug users to move other places from their usual drug using spots, which create difficulties for the service providers to contact PWID (Azim, Chowdhury et al. 2008). Once HIV was concentrated in Dhaka city, it is spreading sharply in other districts (Programme data, Quarter 4, PWID Intervention).

Reduced Commitment for Funding: Funding is being squeezed day by day, which will eventually lead to compromised programme interventions designed. The National Health sector programme is also yet to come on board. He also talked about current advocacy efforts for responding to the emerging challenge. Inter-ministerial committee (supported by UNAIDS)-currently working with all punitive laws affecting HIV intervention. Also, National Task force (NTF) of HIV, chaired by Chairman, National Human Rights Commission (proposed)- ASP and NHRC already endorsed the committee. Meeting of the committee is yet to be held. He said that the current limitations of the advocacy have been-working separately to achieve the target, not collectively , therefore the response is not as strong as demanded. 'Right audience for advocacy at right time'- most of the times is an under achieved goal and hence more coordination is needed. Also, HIV implementers/development partners currently seem les vigilant to mobilize community responses, voices etc. he talked about Other programmatic challenges such as HIV

testing services (HTS) (18.2% to 29%) for KPs and very inadequate for general populations, ART coverage significantly increased but inadequate viral load of PLHIV comparing to "90-90-90" targets. Also, low coverage of OST service (only 5%) and HIV has increased to a critical level among PWID and is increasing among other KPs. The public health system has yet to be more responsive, friendly inclusive and accessible to KPs who need HIV prevention care and treatment services.

Inclosing he recommended some ways forward.

- Advocacy effort should be strengthened with involving all relevant. Although there are some sections in narcotics control act, DNC is supportive to continue the OST and harm reduction programme.
- Harm reduction intervention in prison is essential. PWID those who are on OST and ART facing difficulties to continue the medication
- OST should be extended up to standard level 40% at least in Dhaka city
- Concomitant drug use among OST client is common. Needs solution
- Harm reduction do not address methamphetamine users, but it should be. Need to explore opportunity
- HIV should be multi sectoral approach in real sense. Social welfare ministry, corporate sector can be linked with harm reduction programme
- Point-of-Care testing for HIV, STIs to be explored and implemented for scale-up
- Viral load testing through GeneXpert machines

Upon ending his presentation, Mr. Ezazul Islam Chowdhury passed the floor over to the facilitator.

16.12. Plenary Session from the countries of India, Maldives (1 Gov 1 CSO representative per country):

Honorable Mr. Phuntsho Wangdi, Director General, Narcotics Control Bureau From Bhutan, Shared his presentation with the audience. The honorable Director General Mr. Phuntsho Wangdi, gave a brief background on the Narcotics Control Act of Bhutan, the Bhutan Narcotics Control Agency Secretariat is made up of two offices, the Narcotics Control Office and the Tobacco Control Office which operate under the Narcotics and Tobacco Control Board. He said that Bhutan had a Supply Reduction Department and Demand Reduction Department under the Bhutan Narcotics Control Agency Secretariat which functioned under the Narcotics Control Board Members. They consist of :

1) Honorable Minister, Ministry of Health, Chairperson
2) Honorable Secretary, Ministry of Ministry of Home and Cultural Affairs , Vice Chairperson
3) Honorable Secretary, Ministry of Ministry of Education, Member
4) Honorable Chief of Police, Royal Bhutan Police, Member
5) Director, Department of Revenue and Custom, Ministry of Finance, Member
6) Director, Department of Trade, Ministry of Economic Affairs, Member
7) Drug Controller, Drug Regulatory Authority, Member
8) Executive Director, Bhutan Transparency Initiative (CSO), Member
9) Executive Director, NazhoenLamtoen (CSO), Member

10) Director General, BNCA, Member/Secretary

The Last Board meeting was held on 12/03/2018 and the next upcoming Board meeting was scheduled to be held on the 1st of December or within the last quarter of 2019. He talked about the different partnerships Networking and Collaborations with entities such as UNODC, INCB, CPDAP, with In-Country
partners with both no-government and government bodies. His illustration demonstrated that Bhutan also has active Regional/Bilateral partnerships with Government of India, ONCB of Thailand
SDOMD and BIMSTEC.

Mr. Wangdi illustrated the patterns of drug use in Bhutan. He showed that most commonly used substances were Cannabis, then Pharmaceuticals then Solvent Sniffing and then Brown Sugar Heroin. The Number of offences, Substance-wise was also highest for Cannabis, then Pharmaceuticals then Solvent Sniffing and then Brown Sugar Heroin. He showed the highest number of Drug Users were either students of Jobless Adults. Drug Related Arrest from 2001 till 2014 have increased from 1.1% to 14.1%. He said that current treatment Services consist of Drop-in-CentresLocated in 7 major towns across the country and the key challenge has been to Identify and encourages substance users to seek treatment. The Psychiatric Ward of Jigme DorjiWangchuck National Referral Hospital (JDWNRH) and other hospitals, are also offering Drug Detoxification for a maximum of 10 days. Generally Rehabilitation is of 3 months duration. He said that Bhutan has had Harm Reduction Services since 2015 which has proven more effective for Opioid and alcohol users, he said. Mr. Wangdi talks about changes to the Legal Framework such as the NDPSSA (Amendment) Act 2018 and the re-Classification of controlled drugs and substances. Also he talked about the norms of differentiation between Drug Abuser and Drug trafficker in the law based on Quantification and the Offences and penalties articulated for use, transportation as well as precursor chemicals. Now there is also classification of controlled drugs & substances with and without medicinal value. He described the way Offence of Substance Abuse and compulsory treatment works in Bhutan. When someone gets arrested by police they are sent to a Treatment Assessment Panel (TAP) which makes a recommendation for mandatory Drug Treatment. Non-compliance of treatment is then considered an offence otherwise generally, he said, clients undergo treatment & submit letter of successful completion.

For first timer offenders one month counseling if he or she does not require treatment or rehabilitation, and not less than three months if addicted. For a second time offender , counseling not less than 6 months, Third offence carries no less than 1 year counselling and community service and fourth time offenders , no less than 1 year counselling with is 1 to 3 years imprisonment and mandatory community service. For Repeat juvenile offenders and minors Compulsory treatment is assigned as a period of one year or less at a juvenile correctional center.

The Honorable Director general shared some of the Key Issues and Challenges faced by the government of Bhutan . He shared that the growing Issues of Drugs and Alcohol in the country was mainly due to the Porous border, accessibility and affordability as well as the time immemorial wide and abundant growth of Marijuana in the country. He said that there were still some confusions in the quantification of drugs in the law regarding drug peddlers and users. Also he said that challenges in the treatment of

compulsory clients consisted of the scale of the problem, motivation and high relapses. He said that there were Inadequate drug rehabilitation centers in the country and people often had to get on a waiting list, with high relapses, and high cost etc.). Also there is the problem of Social Stigma, developing skills for employment, post-treatment etc.). There is basically lack of resources, manpower and finance as well as lack of Coordination amongst the stakeholders since agency goals and priority focus the budget allocation, skills somewhere else. Also there is Lack of community support due to lack of awareness, good organization and empowerment.

He then gave the Highlights of Key initiatives taken on drug control programs in the Country so far such as the development of legislation which recognizes addiction as a disease as a fundamentals problems of addiction. There has been the Inclusion of essential services and facilities in the legislation to empower agencies with legal teeth. Also, there has been the establishment of Treatment Assessment Panel Services to assess and provide adequate treatment options. The Empowerment of Narcotics Board by the Parliament to amend the lists and the quantity of drugs in the schedules has been another landmark point. There has also been Capacity Development of Law Enforcement agencies and other stakeholders in essential Supply and Demand reduction programs with the Institutionalization of drug prevention programs which carry out Advocacy, Sensitization, drug testing etc. programs within the dominion of local governments, school administrations, service agencies etc. Also there has been a realization of need for after care services and support Such as keeping them safe, imparting skills, and giving employment priorities etc.

In Closing , the Honorable Director General, Phuntsho Wangdi, recommended some Ways Forward for the SAARC region to mull upon.

There is need for the timely review of the provisions of drug laws which should not be not static but dynamic. Dynamic laws are evidence based laws). There is a need to Increase awareness, coordination and Information sharing mechanism in both Supply and Demand reduction measures by bombarding information through the media and interactions. Also we need to promote institutionalization, resource sharing, capacity development etc. in Drug and Alcohol control programs by building political and Institutional bases. Crucially, we need side by side to encourage and empower community participation in drug control measures through awareness, capacity development, networking etc. Further we must lobby for resource support from our national bodies and international donors, corroborated through evidence based findings. We need to promote and institutionalize harm reduction measures, it's reach, type and information for easy and sustained access to those in need. We need to promote better international cooperation and timely sharing of best practices and resources through periodic meetings, exchange programs and MoUs along with periodic survey, monitoring and evaluation to facilitate the appropriate socio-economic and political responses. He ended with a thank you the kind attention massenger and handed the floor over to the facilitator.

The Next Presentation Titled"*25 years of HIV in Bhutan*" was given by Mr. NgawangChoida,. Sr. HIV/AIDS Counselor /laboratory officer, National HIV/AIDS and STIs Control Program, Communicable Disease Division, Department of Public Health, Ministry of Health Mr. NgawangChoida shared the trend of HIV/AIDS in last 25 years in Bhutan, and till date only 623 HIV cases had ever been detected. The 30-

39 age group was found to be the most prevalent and the major mode of transmission was through the sexual route (93%), with very low injecting (1%) and from mother to child (6%). Regarding the occupational background of reported HIV/AIDS cases, the highest number was found to be housewives. People living with HIV in Bhutan come from diverse occupational backgrounds and districts. They include farmers, housewives (half identified through contact tracing), armed forces, and female sex workers. Mode of transmission is primarily sexual identified through Contact Tracing, Medical screening, Voluntary Testing, ANC, Blood Donor Screening and Mobile Testing. There are about an equal number of men and women identified as HIV positive. Two-thirds are between 20 and 49 years of age. Bhutans Goal is to Eradicate HIV and achieve 90-100-90 national targets for HIV response by 2023, and continue through the planning period, towards ending of the HIV epidemic by 2030.

Some of the Key strategic directions-National Strategic Plan 2017-2023 of Bhutan are the prevention of HIV transmission through outreach and in reach to reach key and vulnerable populations, providing Universal access to HIV Testing and screening for all the populations with Comprehensive continuum of care, support and treatment for people living with HIV and people with STIs and TB/HIV co-infection. Another area of focus is generating strategic information for evidence based program planning.

The current, existing Harm Reduction Strategies involve, programs, advocacy and community involvement in interventions along with the establishment of HISCs, Drop in Centers and Rehabilitation and treatment centers. Also, he said, detoxification services are instituted at the hospitals and currently Bhutan is pilot testing Oral Substitution Therapy (OST) in two major hospitals with training of health care workers and community members on HIV, AIDS including substance abuse (IDUS/DUs).

Mr. NgawangChoida said that the main Key issues and challenges were a Case detection gap of about 50%, as per the UNAIDS spectrum estimation of 1265 PLHIV in early 2018. The other challenge he said was defaulter and non-compliant cases leading to further transmission of HIV and AIDS. Mr. Choida pointed out that there was a bit of a diffused pattern of HIV epidemic in Bhutan leading to unfocused prevention interventions. Also, High sexual activity both in males and females (40% male & 36% female) was reported as having multiple sexual partners: *Sexual Network study, 2010*). He also stressed that social and self-stigma continuously deters timely diagnosis and treatment and so far there has been no real size estimation of IDUs and DUs in Bhutan. Inclosing he handed the floor over to the facilitator and there was brief Question Answer and Discussion Session

16.13. Q&A Discussion:

Q-1for Bangladesh- from Ministry Social Justice India,- Can you please tell us how the reduction has happened ? Was if first reduction in funding ? or reduction in program ? or vice-versa reduction.

Actually in principle there has been no reduction but actual implementation and quality is going down. Also there is appositive decision from the Government side which has a new allocation for 1500 for harm reduction program, but it has not been released yet. I think the problem has been low coverage logistics as the main reason.

Dr Maimoona Malik from NaiZindagiPakistaan to Bhutan – Asked the question of how Legislative Acts can adopt the disease model as a justification? Dr. Malik made a compelling, argument that

conceptualizing drug addiction as a chronic disease is both misleading and erroneous. In developing his argument, she pointed out that the best survey data available indicated that drug addiction was inconsistent with a chronic-disease model. She contended how basic choices and social influences can lead to addiction, arguing that people do not choose to be addicts, but that normal choice dynamics can lead them to that condition.

Ms. KavitaKhadka from the NGO Lakhsham from Bhutan responded to Dr Maimoona Malik's concern by saying, ' Yes it is true, we have many draconian laws that need changes such as also for LGBTIQ people since sodomy is criminalized in the law'. 'But', she said, ' We can still advocate for changes and be hopeful that we can bring some change'. She said that in practice 'Traffickers' were punished severely. For drug users tested and found positive for drugs, mostly the practice was to deliver them to treatment. Both compulsory treatment and voluntary treatment had differences outcomes, she said, with relapses mostly among hardcore drug users who were early initiators.

Q -2 Rajiv Kafle-Program Coordinator- Asian Network of People Who Use Drugs. Mr. Kafle raised the issue why Alcohol, Sugar Coffee Tobacco are not criminalized ? Alcohol, nicotine, and caffeine are the most widely consumed psychotropic drugs worldwide. They are largely consumed by normal individuals, thus, normal individuals tend to abuse all three substances. Scientifically and socially, alcohol is the worst drug of all. These drugs can all create dependence, Sugar Is Addictive In The Same Way As Nicotine, Caffeine and Alcohol, so, he ended with the rhetoric question to all " Why has your country not criminalized these state approved drugs? ".

Ms. Tripti Lawyers from Lawyesr Collective, raised the point that just dumping people in rehab or treatment mandatorily was becoming a trend with some Asian countries in which is actually an unethical practice since treatment is supposed to be voluntary. She said that some countries were also moving toward thinking of mandatory Hep C treatment.

Honorable Mr. Phuntsho Wangdi, Director General, Narcotics Control Bureau From Bhutan responded to the issue saying that in Bhutan although the laws were strict in practice most of the treatment was counseling oriented and not detention.

The next presentation was from the island nation of Maldives- by Mr. Hassan Shaheel, CEO, National Drug Agency and Mr. Abdul Hameed, Program manager TB-HIV, Health Protection Agency. After a brief stretching and group revival activity the gentlemen dived into their presentation.

Maldives has a population of 436,330 with 30% living in the capital of Malé and 70% in the outlying atolls. There are 4,342 drug Users in in Malé and 3,154 in the outlying atolls. They showed that a large diversty of drugs were used in Maldives, such as cannabis, alcohol, opiates, methamphetamine, cocaine, benzodiazepines and methadone, and many of the drug users were multiple users using 2-3 or more drugs concurrently. They said that this was a challenge for the harm reduction services.

Regarding Existing Harm Reduction Strategies, programs, advocacy and community involvement in interventions the MMT program was Initiated on 16th October 2008 by the Government of Maldives, with the support from UNODC , A total of 12 patients were initiated on the MMT program at the start

with Various stake holders involved in this program such as the NDA as the mentor agency and other NGOs namely Journey, SWAD, & SHE.

In 2017 the Government decided to discontinue MMT and look for alternative options, with a decision to introduce Naltrexone. WHO assisted in training officials, preparing SOP's for Naltrexone program at NDA and the last MMT client was weaned off on 25th February 2018.

Prevention efforts consist of awareness programs in 30 Schools in the Capital City (Male') and in 2 of the Southern 2 Atolls –8 Schools have been reached, as well as among , Youth. There is a Parent's program with the NGO Journey and also a program for Media officials but there is a lack of support.

Regarding HIV/AIDS – Problems and Responses, they said that as of 2017, 25 HIV positive cases (cumulative) had been reported among Maldivians, among which 12 have died. Close to 400 HIV positive cases were found among expatriates during pre-employment screening. Since HIV was first detected, the annual rate of new infections detected has ranged from 0-2 cases per 100,000 population and all PHLIV are on treatment since Maldives has a test and treat policy since 2015. They said that the majority of the cases were identified through case reporting.

Most infections were reportedly acquired through heterosexual transmission with one case of transmission via blood transfusion in 2013. HIV infection was found among men who have sex with men (MSM) in 2011, and among injecting drug users in 2012. Risk behavior mapping has estimated 1139 FSWs, 1199 MSMs and 793 PWIDs nationally, highly concentrated (FSW 37%, MSM 48% and PWIDs 53%) in Malé (MOHF 2011). The BBS of 2008 and the National Drug Use Survey of 2011/2012 showed considerable risk behavior among all three KPs and with networks stretching across KPs and into the general population. More than one third FSWs also injected drugs. The Cumulative Reported HIV cases in the Maldives 1991-2017 are illustrated in the following table:

Reported HIV cases	Male	Female	Total
Cumulative number of people living with HIV diagnosed	21	4	26
Cumulative number of AIDS-related deaths	9	3	12
Number of people who are alive and know their status	10	1	11

Regarding problems and responses to the Harm reduction package of services, they said that Drop-in centers range and status of services needed to be confirmed since the opioid substitution therapy (OST) focused mainly on people who use opioid drugs, Peer led outreach services (mainly focused of HIV prevention and safe injecting while HIV testing and access to free condoms was available there were assessment of gaps in policy and program implementation with implications for the National Strategic Plan, Service delivery, Community mobilization and Existing HIV and Harm Reduction advocacy and strategic partners and The existing polices do not explicitly cover migrant workers with frequent changes in government policies on service delivery mandates.

There is Stigma attached with substance abuse clients and a widening funding gap. Maldives is eligible for the GF but no allocations from GF have been proposed, Earlier grants covered a majority of targeted interventions.

There is only Knowledge without Behavior Change in the young people with Limited number of CSO/Community groups working in the field there is also a lack of capacity to test for New Psychoactive Substances the young people come across.

There are limited number of CSO/Community groups working in the field, hence, there is limited civil society and community engagement in service provision, compounded by lack of mechanism for providing grants/financial support to CSOs for targeted interventions. There is a lack of employment opportunities for recovering drug users from the private sector.

They said that a proper assessment of progress needs to be carried out with some examples of some activities going on such as the establishment of rehab services for minors, Improved data collection of rehab services and capacity building of professional staff with support from Colombo Plan, UNICEF and WHO.

They recommended to the SAARC level meeting that the government of Maldives should review the decision on discontinuing MMT and explore broader alternatives. Consultations with communities should take place to review and further contextualize harm reduction package of services. Also the scale up of the standard interventions complemented with anthropological studies and operational research is necessary

Advocacy to strengthen support for targeted interventions and reduce stigma towards PWUDs needs more active support from policy makers while at the service provision level, decentralized treatment facilities are required along with total decriminalization of substance abuse. In closing he thanked everyone for listening and handed the floor over to Mr. Ahmed Nazim, Chief Operations Officer, Journey-NGO, Republic of Maldives.

The following presentation was given by Mr. Ahmed Nazim, Chief Operations Officer, Journey-NGO, Republic of Maldives. Mr. Ahmed Nazim shared his presentation on the Journey-NGO, He shared its vision and mission and said that it was established to Support & Help drug users maintain recovery, Empower and Educate Youth & Public on DRUGS & HIV and Use Science, Data & Evidence in all the work of NGO. He said that the current government of Maldives does not support harm reduction for PWID. Mechanisms and modalities through which harm reduction interventions are implemented at the NGO level are Daily Outreach, Drop-In-Centre, VCTC, RISE Program, Leaflets. the Barriers faced by Community in delivering and accessing services are, limited NGOs working for Drugs and HIV, Lack of Funds, Limited Space, Political Polarization, Religious extremism, Lack of Political will. Unrelated personal – representation at boards Decision makers, policy makers doesn't consider harm reduction approaches, Lack of technical skills at decision making level, Not acknowledging the signed agreements.

Mr. Nazim's Recommendations to the government of Maldives at the SAARC level meeting were to Motivate more NGOs to work in the field, Provide adequate space to NGOs to conduct programs,

Educate and sensitize policy makers and religious scholars, Acknowledge the importance of evidence-based approaches, to consider facts, evidence and scientific studies at decision making levels and to establish a mechanism to support NGOs that work in the field.

There is a need revise or reelect the board with representatives who are educated in the field and who understand the technical knowhow, he recommended. Last but not least he said the government must first Implement, restart methadone programs and OSTs and then revise the drug law to include harm reduction approaches and decriminalization.

Mr. Devendra Singh - Ministry of Social Justice India was the next presenter.

Mr. Singh Share His Presentation on " *INDIAN PERSPECTIVE DRUG DEMAND REDUCTION*" and said that India is a signatory to all three UN Conventions, namely the Single Convention on Narcotic Drugs of 1961, the Convention on Psychotropic Substances of 1971, and the Convention on Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988.

He talked about the existing legal and policy framework Narcotics Drugs and Psychotropic Substances (NDPS) Act, 1985 – which empowers the Government to establish, recognize or approve as many centres as it thinks fit for identification, treatment, management, education, after-care, rehabilitation etc. of addicts. Also the National Consultative Committee On De addiction And Rehabilitation (NCCDR) advises the Central/State Governments on issues related to Prevention, De-addiction, Rehabilitation and Harm Reduction.

Coining the term 'Harmonizing Of The Work' he presented the work area classifications of the different bodies working in Drugs. He pointed out that, Supply Reduction was overseen by Ministry of Home Affairs & Department of Revenue, Ministry of Finance. Demand Reduction was overseen by Ministry of Social Justice & Empowerment and Harm Reduction was overseen by Ministry of Health & Family Welfare.

He stated that the role of the Narcotics Control Bureau was to Co-ordinate actions by various offices, State Governments and other authorities under the N.D.P.S. Act in connection with the enforcement provisions of the NDPS Act, 1985 and the Implementation of the obligations with respect to counter measures against illicit trafficking under the various international conventions. He talked about the extent, trend and pattern of drug abuse in India. He said that there were high levels of alcohol abuse in the North-East and Northern Regions with high Cannabis use and in the North-East and Eastern Regions whereas there was High Opiate use in North and Western Regions.

The Ministry and UNODC conducted a joint survey in 2001 among the age group – 12-60 years in a sample size of 40,697 Males. The estimated size of drug users: was Alcohol users – 62.5 million, Cannabis users – 8.7 million and Opium users – 0.2 million with 17-26% were dependent users.

With users of alcohol- 68.88%, Cannabis- 9.93%, Heroine -7.88%, Propoxyphene -2.14%, Sedatives -1.19%, Inhalents -1.08%, Opium -2.11%, Cough Syrup -0.72%- and Others6.07%.

The Governments approach to Drug Demand Reduction is adopting a three pronged strategy towards addressing the issue by 1) Awareness building and educating people about the ill effects of drug abuse,

2) Community based intervention for motivational counselling, identification, treatment and rehabilitation of drug addicts, and

3) Training of volunteers/service providers and other stakeholders with a view to build up a committed and skilled cadre towards achieving Whole person Recovery.

He said that the assistance for prevention of alcoholism & substance (drugs) abuse to NGOS/civil societies was being provided by the government, Implemented since 1985-86. The Financial assistance was mainly provided up to 95% of the project cost for setting up/running mainly for Integrated Rehabilitation Centre for Addicts (IRCAs), Awareness generation programme etc. Presently about 400 IRCAs are running with approximately 100 thousand addicts treated per year. He then presented a Map of India with all the sites with the number of (IRCAs).

National Instituted of Social Defence (NISD), is an autonomous body under the administrative Control of MSJE, anodal training and research institute for interventions in the area of Social Defence. A National Centre for Drug Abuse Prevention (NCDAP) within the NISD ahs been established for capacity building and training. The Implementation of the NAPDDR 2018-23 is contingent on NISD for carrying out drug demand reduction activities in a mission mode.

Regarding new initiatives, he said that the national survey was assigned to all India Institute of Medical Sciences (AIIMS). With the objectives to provide national and state-level estimates to map the presence of services and interventions and Identify the gaps in service delivery. The survey covers 0.15 million households and cover high risk groups such as prisoners, female sex workers, transgender, transport workers etc.

Also a national toll free help line no. 1800-11-0031 has been established with a Drug Abuse Monitoring System (DAMS) along with Media campaign through electronic, print and social media. The system also confers national awards biennially and gives accreditation to de-addiction centres as per the National Action Plan On Drug Demand Reduction (NAPDDR) 2018-2023.

He recommended ways forward through conducting education & awareness building at all levels, capacity building & training of service providers, running de-addiction centres in each district, de-addiction centres in prisons, juvenile homes, and industrial establishments etc. Data collection and management and accreditation of de-addiction Centres.

Also, Setting uniform quality standards, Focused intervention in vulnerable areas, Innovations in the field of Drug Demand Reduction and Technical and Financial Support to State Govt. run institutions in the field of drug demand reduction through National Institute of Social Defense (NISD) were recommended as ways forward.

Dr Ravindra Rao, Associate Professor National Drug Dependence Treatment Centre, AIIMS, New Delhi presented the Dr Rao talked about Drug use disorders being a complex health problem with

psychosocial, environmental, and biological determinants, which need a multidisciplinary and comprehensive response from different institutions working together.

He then illustrated a multi-dimensional concept of standards of health care where to be *Effective* it must be evidence-based, and to be *Efficient* it must be maximizing resource utilization and minimizing waste. By *Accessible* we mean timely, geographically reasonable and *Acceptable* meaning patient-centered with *Equitable* being irrespective of personal determinants. Further, *Safe* means it must minimize risks / harms

He talked about management of supply and demands side players, such asMinistry of Home and , Ministry of Finance being on the Supply Reduction Side. While Ministry of Health and Family Welfare (MoH&FW) with Ministry of Social Justice and Empowerment (MoSJE) and Private Sector on the demand reduction side. Dr Rao talked about Provision of treatment through Government hospitals and the

Establishment of Drug 'De-addiction' Centres (DACs) in medical colleges/district hospitals with 122 DACs established in the country so far which follow a 'medical' model of treatment, primarily pharmacotherapy with secondary psychosocial support and focuses on both inpatient and outpatient treatment.

He talked about Integrated Rehabilitation Centre for Addicts (IRCA) with MoSJE's Central scheme to establish drug treatment services Operated by NGOs targeted for 350 – 400 IRCAs established with Inpatient services – 15/30 beds, focused on psychosocial aspects of substance use disorder and minor focus on medical treatment, led by paramedical/non-medical staff. The private sector is run by run by individual psychiatrists, psychiatric hospitals, NGOs, others.

He said that the Harm Reduction Aim was prevention of harms due to drug use, specifically Injecting Drug Use. In India the National AIDS Control Organisation is the nodal agency but Focus is on HIV prevention and establishing Opioid Substitution Therapy (OST) by NGOs and Government hospitals.

Status: Currently more that >300 TIs for IDUs and more than >200 OST centres.

De-addiction Centres: Standards of care Developed by NDDTC, AIIMS in 2009 for DDAP, MoH&FW, provides standards for services, infrastructure, staff, training service providers, and monitoring and evaluation.He said the different Standards of care provide different treatment goals such as maintenance and abstinence .

He talked about the private sector with high variations in services such as psychiatric hospitals to centres run by recovering users , there are no numbers on how many there are and modality such as medical, 12-step facilitation, Therapeutic Community etc. He talked about reports uncovering torture and

also deaths in some of these beyond the government radar, so called rehabs. Assessment of existing status of treatment and client experience Most centres run by "recovering drug users" Most had part-time doctor, including psychiatrist Most had counselling provided by "recovering users"/ "senior clients of the centre".Need to develop documentation, evaluation, recommended standards.

In conclusion Dr. Rao said that the understanding of drug use problem has undergone a sea of change – from moral/social to biological and now evidence exists on which type of treatment is effective and not effective. Also, Standards of care documents exists for the Govt. and the Govt. supported centres. Whether they are followed or not, gross violation of human rights and dignity in unregulated, private centres is the government responsibility. He continued his conclusion saying that there is a need to expand centres, expand menu of service options currently available, bring out uniform standards of care, ensure the standards are implemented, conduct periodic assessments, establish grievance redressal mechanisms at district and state level and educate the public about addiction as a disease and treatment options.

16.14. Discussion - Q&A:

There was a bit of discomfort with the idea of 'Mandatory Rehab' and some of the participants raised their concerns on the potential for Human Rights Violations. A question was raised about the '*minimum duration*'[21] someone in treatment should stay to be cured of their addiction ? Another question was, 'Were the treatment durations for all kinds of substances the same ?'.

Ans- Mr. Devendra Singh said that there is an assessment to determine if the client should go through a certain duration program determined by the authorities in the matter. He said that the Duration was dependent upon an 'assessment' of 'Readiness Indicators'.

Dr. Rao said that he was saddened by the unfortunate news that Maldives had decided to stop methadone. The las 60 clients were weaned in February, 2018. The good news, he said was that they were working with the new government to bring back the methadone program including other options. Another point made by Mr. Kunal Kishore from India HIV/AIDS Alliance was that Maldives often gets left out of ANPUD forums and discussions so there need to be a more tangible mechanism to network with the DU community in Maldives..

Anjay Kumar KC – Technical Advisor- Recovering Nepal/ President - Coalition of Drug Users in Nepal (CDUN) raised some objections regarding the terminology used such as the term "de-addiction". The term "de-addiction" implies an entirely "abstinence only" focused mindset, as well as patronizing and oppressive connotations.

He said that, such a mindset, purposively, closes its eyes to the reality that some people are unable or unwilling to quit. He said that the act of 'Drug Use' by Itself, in itself , does not have any victims like a classical crime does. It does not hurt, maim, kill, injure cheat, steal from anyone and is not a violent act towards anyone. The user, after using went goes onto a euphoria /trip and so there is no real crime for 'Drug Use' by Itself, in itself, here. He said that the term "Recovery" is not all black and white and while it a ubiquitous concept, it remains poorly understood and ill-defined, hindering the necessary effectiveness of treatment. He said that from a practical stand point, drug use has always been associated with human history and so for Harm Reduction Patients/Clients , whether they are using or not using is not really the issue at all. We as service providers should be more concerned about their health and wellbeing-manageability, functionality and sociability, whether they are able to carry out

their duties and responsibilities effectively or not and not causing harm to others or to themselves. He said that it is more important to promote stability client through maintenance therapy.

He said that he often encountered this 'total abstinence' mindset even in OST service provision, which puts an unspoken pressure on the client to quit or remain on a low sub-optimal and inadequate dosing, often leading to mixed street drug supplementation. Governments are generating so much revenue from alcohol and tobacco the hypocrisy is rife. Nepal never had a major Issue with Marijuana which grows endemically everywhere in Nepal, is part of its social customs, tradition and culture and religion and accepted everywhere and In many cases in remote areas where life is primitive, it is still the only natural panacea and remedy also for both livestock and humans. Until in 1976, USAID decided to pressure Nepal to join it's 'War on Drugs' policy and pressured Nepal to criminalize Marijuana in exchange for USAID development money. Ganja has always been part of our culture and heritage and religion and was really doing no harm back then. Today marijuana has been legalized in over 30 states in US, but in Nepal, it remains criminalized, thus for the Nepali people for whom Ganja was a part of life, they have become victims to US interference, as have the people of many other countries globally .

Dr. Ravindra Rao Responded to Mr. KC's Concerns regarding the term "de-addiction" and the total Abstinence mindset . He said that it was used mostly in policy documents and admitted that the authority bodies need to have a better grip on the terminology, such as for example, he humored, in diabetes, one cannot "de-diabetize" a patient, which was followed by laughter. He said in practice It is mostly about managing your condition and living your life around it.

Rajiv Kafle – Global Fund Coordinator – ANPUD said that when we are talking about polices and laws we are also talking in comparison to size. India is in the extremes, Rajiv said, Alcohol is absolutely Prohibited in some states, with extremely punitive laws and policies as well as practices. At the same time you also have a society which is a very lenient and supportive society to Drug users but at the same time, are on the high alert lookout for Traffickers.

For example, he illustrated, In the railroad stations and the auto rickshaw circles, the police leave the Drug users alone, they even do not do anything even when they see them using right in front of them, but they but target the traffickers and dealers. So how can you say there is one policy In India as a country ?

Dr Rao Responded to Rajiv's point by saying that States have their own laws and policies, but for Narcotics drugs there is one single policy, Practices may be slightly different because it is such a diverse and vast country but the main law is the same . There are some provisions to amend the law, otherwise, he said the law is the same.

Dr. Maimoona Malik from NaiZindagi Pakistan proposed that the group not use the term "De-addiction" anymore, from this point forward and in practice. She said that it is understandable that some us need to be updated , but we are all public health professionals, so let us have some courtesy for the communities which we work with, and all the participants agreed to not use the term "De-addiction".

16.15. Plenary Session from the countries of Sri Lanka and Pakistan and Nepal:

Sri Lanka led the first presentation among this group, which was a joint presentation by Dr. Chitran Hathurusinghe MD, Consultant HIV & SH Physician, NSACP – Colombo, and Mrs. BhadraniSenanayake, Director – Research, National Dangerous Drugs Control Board, Sri Lanka, Ministry of Defense

Sri, Lanka. The presentation was led by Sri Lanka- Mrs. BhadraniSenanayake. Mrs. Senanayake commenced her presentation with a picturesque introduction of Sri Lanka and its rich cultural history and heritage.

The population using Heroin (non-injecting ?) was estimated to be between the range of 45,000-50,000 and the estimates number of Cannabis users was around 200,000 or so. According to a study by NDDCB in 2017, (where N=721 and indirect sources) the Injecting drug users in Sri Lanka were estimated between a range (705-1209) with 957 on average. Sixty 9 percent were found to be 69% daily users with 31% alleging to be occasional users whilst in past 44% had shared injecting equipment .

The highest number of Drug Related arrests were seen among cannabis and heroin users. In a Rapid assessment of drug use patterns in Sri Lanka (RADUP) done in 2017 by NDDCB and NSACP among (PWUD – 283, PWID – 174), over 90% of males were in their late 30s and over 90% were educated and employed. Also, over 90% said they used heroin for injecting, while Heroin smoking and Chasing started around 19-20 years of age injecting started around 28 years of age. “Peer pressure” and “curiosity” were the most common reasons cited behind drug initiation. About 83% said they injected daily and of them about 64% said they were injecting 2-3 times in a day. Most (85%) said that they had shared their injecting equipment at some time or another, while 64% said that they had shared in the past. Further, 52% of PWID reported unprotected sex and 41-42% reported that they were receiving medical treatment of some sort , shared Mrs. Senanayake. Regarding Legislations related to the Drug treatment services and Harm Reduction Mrs. Senanayake shared that the Drug Dependent Persons (Treatment and Rehabilitation) Act No.54 of 2007, Facilitated for Two types of treatment admissions. Voluntary admissions and Compulsory admissions decided on a case by-case basis, Assessment by an assessment panel. The Compulsory admissions were usually Referred by court, Referred by office in-charge of a police station with a report issued by government medical officer.

The Sri Lanka National policy for the prevention and control of drug abuse, she said, articulated that:

a.) Drug dependent persons are required to seek treatment services. Central government, local government and provincial councils must ensure sufficient counselling and treatment services are available.
b.) No single type of therapy is appropriate for all Drug dependent persons therefore different types of therapy are employed.
c.) To be more effective, medical interventions are combined with counseling and other behavioral therapies.

d.) Treatment programmes are integrated with assessments for HIV/AIDS, other sexually transmitted diseases (STD), hepatitis B and C and to see if tuberculosis is present among the DU's enrolled in intervention in Sri Lanka at present.

Mrs Bhadrani said that the NDDCB ensures the right of every citizen to receive rehabilitation from addiction either voluntarily or through the intervention of guardians through a systematic, methodical and scientific treatment program free of charge. The Treatment model is Mainly Psychological counseling . There are 4 treatment and rehabilitation centres in *Colombo*, *Galle*, *Kandy* and *Nittambuwa* and 2 counseling centers under the NDDCB. In addition, Services are provided by the designated Prisons. The treatment centers are controlled by the Bureau of Commissioner General of Rehabilitation and 25 private treatment centers. HIV Prevention for people who use drugs consists of Clinical services - Counseling services, Health education, Referred to Testing, Referred to Clinical services and Follow-up. While, preventive services consist of training of prevention officers and outreach officers, HIV prevention parallel with drug prevention, Developing linkage with NSACP. She then talked about Interventions for IDUs such as Community based treatment camps provided by NDDCB and Referred to general public health care and to STD clinics with Drop-in centres in high prevalence areas. She also said that Awareness, Preventive , education and training activities on drug abuse and HIV with Health education as part of the treatment plan with Home visit follow-up mechanism is existent. She said there is a need to Strengthen the capacity for Outreach coverage , of the provincial and local government institutions and the communities for drug prevention and control while Providing services for drug dependents and their families, high risk groups in community and the general public & follow up.

drugs and sex education and STI/HIV testing for high risk groups – IDUs, youths who use drugs, female drug users, commercial sex workers is also present she said. Progress on commitments towards UN General Assembly Special Session on the World Drug Problem-2016, were mainly Demand reduction related measures. She said that Sri Lanka Had instituted evidence based prevention measures for different target groups in multiple settings - Parents (Early childhood development),Education sector, schools, the universities, other institutes, Plantation Sector, Govt. and private work places, Law enforcement, health sector and local communities. Also Public awareness raising campaign using social media platform – launching "New life" Facebook page. There were TOT programmes with Teachers and other relevant professionals with cooperation between public health, law enforcement, education and other government authorities. Currently the collaboration between Ministry of education, NDDCB and The Presidential Task Force on Drug Prevention. eg. "sathipasala", "thirasarapasal" hs resulted in "drug prevention committees in schools and at the community level while providing quality education and to empower Sri Lankans towards a drug free life & healthy life. She said that the Government encouraged voluntary participation of individuals in drug treatment programmes while there was strong government and private sector partnership in treatment and care. Currently she said, 25 private treatment centers were registered under the NDDCB and running drug treatment programmes. She talked about the need for appropriately mainstreaming gender perspective in drug related policies as well as promoting human right and the dignity of all individuals in treatment and rehabilitation services. Regarding voluntary admission for treatment, she said, different types of treatment services were offered such as

psychological counseling, faith based, inpatient, drop-in centers, community base treatment camps, with a Balanced treatment plan, detoxification, therapies, vocational trainings, spiritual aspects, family meeting and gathering etc. with Community involvement in treatment and care and outreach.

Dr. Chitran Hathurusinghe MD, Consultant HIV & SH Physician, NSACP – Colombo form National STD/AIDS Control Programme continued the presentation as he talked about peope living with HIV.AIDS in Sri Lanka.

He said that there were around 3500 adult cases of HIV in Sri Lanka and Lass than 100 Children's cases of HIV, He said that the new infections in 2017 wer4e less than 200 and the deaths from AIDS related complications was less than 500. The adult HIV Prevalence among those above the age of 15 is at 0.1%

IBBS Conducted in 2017-2018 in Colombo revealed zero prevalence of HIV among PWID.

However, HCV is on the increase among PWID, but reliable data is not available on this

There is a need for urgent and strong advocacy measures for initiating evidence-based treatment for drug dependence (Opioid Substitution Treatment) and harm-reduction interventions (including access to clean injecting equipment) for PWID. PWUD remain at risk of switching to injecting route, Under the influence of PWID, he said. Although nio prevalence of HIV was found 2 cases who tested positive for syphilis by VDRL (0.3%) and 17 cases tested positive for Hep C (6.2%) as well as 1 case was found positive for Hep B (0.1%).

Dr Manisheks presentaion pointed out that the Profile of PWUD / PWID was demographically strikingly similar. Most were In their late 30s , Educated, Employed and Living with their families

They Key vulnerabilities and challenges in Sri Lanka, he said, were that young, productive men were engaged in drug use and the majority were suffering from heroin dependence and it's serious adverse consequences. A Majority of PWUD are at risk of transitioning to injecting behaviour due to the high prevalence of risky injecting practices among PWID. The existence of risky sexual behaviors with risk of HIV transmission to other groups, a heavy criminal justice system response which appears to be ineffective with high levels of stigma and discrimination exacerbating vulnerability including lack of access to effective, evidence-based treatment for opioid dependence are some of the major Key Issues and challenges.

Further, misconceptions among policy deicion makers specific to harm reduction interventions must be cleared and they must be educated. There is limited access to specific harm reduction approaches in current domestic laws and regulations and the type of program and policy reforms will need to tackle the misconceptions. If more DUs transition to injecting, the potential for more harm would increase. (Addressing harm reduction issues and reassessing DU intervention model are considered to be essential steps. He spoke of pesrons who chose to discontinue their treatment for HIV as 'treatment defaulters'. This may be attributed to comparatively poor knowledge on HIV. About one-third of PWID in Colombo have never heard of HIV/AIDS -30.0%. Also, a majority of PWID in cannot gauge their personal

HIV risk (46.9%) and Knowledge about HIV prevention is low with low condom usage. Poverty is another factor where earnings are around 20,000 Sri Lankan Rupees (127 USD) per month (86.7%).

Among Risky Injecting behaviors reported , two-third of PWID shared injections in last one month due to the main reasons being non availability of injecting equipment, poor knowledge about safe injecting practices , indiscriminate disposal of used injection equipment. indiscriminate disposal of used injection equipment also puts the larger community at risk .

Ther is also risky sexual behaviours and sex with casual and commercial sex partners, Almost half of those who reported sex with commercial partners, reported un-protected sex which carries the risk of spread of infection to general population !

Regarding Legal complications and access to services, most PWUD / PWID tend to have financial problems since they spend their families' income on drugs and are forced to borrow and even indulge in criminal activities. A Majority had been subjected to criminal justice interventions; More than 90% had been apprehended by the police and about 80% had been to jail. Hoever, Jail terms have had no effect on drug use and there has been relapse after relepse. So now it is time, he said, to work based on the evidence with comprehensive package of interventions and presented the list of WHO reccomended comprehensive package of interbventions.

His recommendations were, structural and policy reforms. There is a need to facilitate the policy discussion to revise national policy of prevention and control of drugs abuse in Sri Lanka with the participation of all relevant stakeholders. Also, Clinical services maintained by the government hospitals with the involvement of psychiatrists should be linked with other treatment setups.

His second recommendations were on Implementation and scale-up of intervention programmes – Targeting the the sub groups of persons who are not sensitive to prevention programmes, drug dependent, individuals who are not motivated to attend treatment facilities, non-responders to treatment and who continue to abuse illicit drugs, and patients who easily relapse into substance abuse.

His third recommendations was on Capacity Building- Current outreach services are effective in high prevalence areas and should be expanded covering island wide districts. And lastly he reccomended generating data and utilizing the evidence.

In closing Dr. Kudu Manishek who is a GF SR, said that the GF was directly covering 12000 DUs through the GF. There was a peer intervention system that was being discussed with Govt. control bodies. Injecting is very low and HIV is very HIV very Low so we need special systems to go through communities, Focal systems to do counselling and reinterring as well with confidentiality maintained since they trust in CSO's. A total population approach working as a team to tackle this can be a success story.

Dr Maimoona Malik from NaiZindagi-Pakistan was the next to present her piece. She started out by articulating HIV infection rates continue to rise among people who inject drugs (PWID) in many lower- and middle-income countries (LMICs) from the low prevalence countries among PWIDs in Pakistan.

Although progress is being made in prevention and care for PWID in some settings, coverage of essential services remains low. However the government is also making and effort to provide interventions. She said that Pakistan has had a Chaotic Landscape of Harm reduction . with Hetero-sex workers. NaiZindagi has been the GF PR in Pakistan since 2009. Currently there are 100,000-120,000 drug users mixed in with the general population. There are MSMs here. Even Wife's are registered. There are 13 ART centers art in Pakistan. In the name of quality, one is lucky to be safely rehabilitated and get a job. She said that 248 outreach workers on bikes, and 2 each provide services in the night. We have 1500 Human Resources Trained but still strained.

There is no university that teaches Harm Reduction she said. Over the years NaiZindagi has developed methods to capture real time Data to analyze and immediately drafting an action plan within next 30 days regarding any generalized sub-epidemics. She said that the essence of NaiZindagi was involving Key Populations in the 'Nothing for us, without us' principle. Many DUs are homeless in Pakistan. Approximately 6%(6.7 million) of the population had used any drug in the last year Poly drug use is common, and approximately 0.8% of the population are regular heroin users. 1.06 million people are using opiates. PWID estimated to be 430,000 or 0.4% of the population. Now trace levels methamphetamine users are emerging. New mixed pharmaceutical preparations are emerging. The majority of opiate users(76%) reported that they wanted help. Punjab has the highest number of drug users- UNODC Report(2014).

An estimated 100,000 to 120,000 injecting drug users co-exist with the general populationin urban and rural settings. The increasing HIV prevalence among them is fuelling the HIV and AIDS epidemic in Pakistan. It is due to sharing of contaminated syringes/needles among themselves and also as a result 89-99% are Hep C positive. HIV prevalence increased almost 4 folds from 10.8% to 38.4% between 2005-2017, among people who inject drugs and is the highest in any vulnerable population in Pakistan. Those infected are mostly men between 18-35 years of age; 81% inject heroin; mostly poor and 40% uneducated; 47% started using drugs below 18 years of age; 50% have been married; only 10% have regular jobs and over 40% have been to jail Punjab has the highest (60%) burden of injecting drug use followed by Sindh (25%), KPK (10%) and Baluchistan (5%).

Absence of comprehensive coverage/Services for Drug Users/Bridging Population/Subgroups, Lacking Infrastructure/trained human resource Absence of political commitment, Lacking knowledge and reluctant realism, Absence of OST, Treatment, care and support, Rehabilitation and path to Recovery, Policy and governance ,

What NaiZindagi Does:
Services are provided in extremely difficult circumstances: hostility from community, law enforcement drug pushers; extreme weather conditions; outreach services at graveyard, garbage dumps, abandoned sewerage pipes etc.; long and varied working hours that have to be adjusted to availability and timings of clients. Human resource trained and skilled in harm reduction services which include: needle syringe exchange programs, counselling and awareness, HIV testing, AIDS treatment related services, living support packages and programs for spouses Innovative bio-metrics based Management Information System to monitor and evaluate service delivery and impact in real time and cost effectively Operational

research and assessments to monitor changing trends and adapt service delivery ART Adherence Unit/ Support to Detoxification Rehabilitation.
Also NaiZindagi focuses on establishing rights based (voluntary, confidential & non punitive) HIV and

AIDS prevention and treatment services based on science and evidence for people who inject drugs and their spouses in 30 districts across Pakistan Since 2012, we have tested 41,726 people who inject drugs of which 17,817 (42%) were HIV positive and 6,706 have been linked with AIDS treatment services in the Public sector We have also tested 3,740 wives of HIV positive people who inject drugs of which 327 (8.7%) were HIV positive and 255 are linked with AIDS treatment services in the Public sector. This program was initiated in 2012 with Global Fund grant through EAD and Ministry of National Health Services, Regulations & Coordination. The current grant of 17.5 million US dollars is for 2018-2020. Regarding the Impacts of their efforts, NaiZindagi's Prevention efforts have resulted in reduced incidence of new infections among people who inject drugs, their spouses and children due to awareness and needs based services in most of the 30 districts where prevalence was lower and less mobility among this population. Further, Identification of 18,144 new cases of HIV through community based HIV testing and linkage to AIDS treatment services was carried out. Quality services are at the door step in outreach settings consistently and regularly. Rights based drug treatment and rehabilitation services resulting in reduced incidence of injecting and drug use. There is Innovative and cost effective follow up services to ensure adherence to AIDS treatment medication (ARVs) and The numbers of people who inject drugs on treatment jumped 132% in the 12 months from the end of 2013 to the end of 2014 (PAS 2015). The availability of trained Outreach Staff at grass root level, Retention rates to treatment in absence of OST Regarding gaps in HR response Dr Maimoona said that the Global Fund supported program is currently the only preventive and treatment related efforts in the HIV and AIDS sector in Pakistan for people who inject drugs. Post 2020 the fate of this grant is not yet known, a nonexistent program for non-injecting drug users. There is absence of outpatient based oral substitution to shift injecting drug users to non-injecting and prevent transmission of HIV. Approved Provincial PC1s have not been engaged since July 2016, particularly in major cities of Punjab which remain without services and have high incidence and prevalence (above 50%) of HIV infection among people who inject drugs, resulting in low coverage with services. Double stigma and discrimination towards people who inject drugs and/or living with HIV and AIDS and their families often results in human rights violations and difficulties in accessing health care services.

There is a spillover of HIV from people who inject drugs to the general population e.g. wives, non-injecting drug users and this will expand to other communities of the general population e.g. JalapurJattan and KotImrana outbursts on which the Honorable Chief Justice has rightfully taken suo moto notice.

Her Recommendations to the meeting were that Currently approximately only 30% of those in need have access to services in order to prevent, halt and reverse the HIV epidemic among people who inject drugs and their families. However at least 80% need to be reached, hence services need to be expanded on a fast track basis. She said that services need to be scientific, evidence based, at scale, un interrupted and contextually appropriate. Also PC1s need to be revised in light of appropriate quality services and

engaged on a fast track basis to expand services and reduce new infections. Funding should be recurrent and not project based.

Health and law enforcement professionals need to be educated in order to reduce stigma and further marginalization and promote access to rights based services. Punitive policies and interventions will only fuel the epidemic. Majority of people who use drugs want drug treatment which they cannot afford and is often non-voluntary resulting in human rights violation. Drug treatment should be free and

voluntary for those who cannot afford Her Final Slide depicted slogana and principals to help people who use heroin to switch from injecting to smoking behavior. After her presentation Dr Maimoona Malik Took Some questions from the Audience:

Q- One of the participants asked why NaiZindagi has not been able to cover all districts.

Ans. NaiZindagi is the PR for the GF. The Government wanted to do the rest of the districts so we did 30. It was more about partnership and government ownership.

Q- from Bangladesh- Since 2004 you have been without OST and the jails will also not allow service provision. But the General incidence is going down.

Ans. There is a strong Monitoring Mechanism in place and we have encourage Law enforcement to improve on discrimination. Also, outreach workers have bio metric machines with built in forms. Which preserves the confidentiality but at the same time is able to help us track every one very closely.

Binod – From ANPUD: Why is it that people who are actively using drugs cannot work in your organsiasion?

Ans. Drug use is still criminalized in Pakistan so the law in Pakistan does not allow for any actively using drugs to be employed, plus we do not think it sets a good example in the context of Pakistan.

Q-Mrs. BhadraniSenanayake form Sri Lanka : How do you coordinate the services and follow;

Ans. the outreach workers have bio metric machines with built in forms which resides on a central server so we are able to track our providers as well.

Chair-SM Zakir Hussain: We have Seven Countries Similar problems so we will discuss and find a solution.

The Nest Session was presented by Mr, Rajiv Kafle, GF coordinator for ANPUD. Mr. Rajiv Kafle, GF coordinator for ANPUD started his presentation by saying that same evidence that has not worked 5 years ago has not worked today. He said, ‘today, want to talk to you as parents as dad and moms and as grandparents’. He said, ‘You must have been frustrated too…, we evaluate then sign treaties and we fail. What is the target ?’ He continued, ‘In 50 years we have failed to deliver a drug free world. Apologies for not being politically correct. We all live one life. I have met no one who has lived two lives

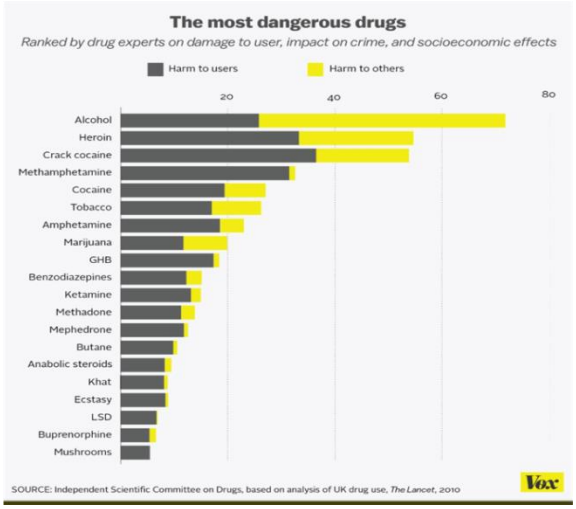
so, in this sense, that makes us all equal. If we are all equal, why does someone need to decide what I put in my body ?

If anyone who had lived three previous lives then one could see that they would have had more experience to tell me that I am living my life the wrong way. To start with, it is my right what I wear what I take or what I put into my body. I have been taking drugs for the past 30 years living with HIV for the past 20 years. I used to think it was my fault. Then I realized that a simple piece of equipment could have saved me. My government decided to ban syringes because they thought it would encourage drug use. So it was my governments fault that many of us got infected and soon they realized there was an infection and epidemic. We tend to follow our predecessors and forget that this is about real lives. I have 20 years probably even a lot more years to go. I have over 20 kids. I have people who worship me with incense because there was as a time in life when I rescued them, helped them access treatment, so they do that out of gratitude. After this, I was called an addict- needing '*de-addiction*' treatment. But I don't need treatment. People like myself are being killed in the name of war on drugs. I don't want to name names. We are being tortured in the name of treatment. The only form of medical treatment where a doctor is not needed and it is still acceptable, where a majority of them are run by non-doctors and it is acceptable because people who use drugs are expendable. Here locking people up is also part of an acceptable part of treatment.

Why would someone want to run away …? It's simple, it's the quality of services ! And instead of improving, it is made acceptable to pursue and capture someone and torture them in the name of treatment? Would it be acceptable to you if it happened to your own kids ?

When you hear people making clients lick urine, they need to be shut down and arrested. The monitoring of the Ministry of home figured out that they only had no TV and a very small premises.

Mr. Kafle, gave a brief introduction of ANPUD as the Asian network of people who use Drugs. He said tha the role of ANPUD was to astablish and support networks and groups of people who use drugs in the partner countries, Build their capacity in Organizational Development, Strengthen and build their linkages with other national, regional and global networks, Create an opportunity to build innovative networks that are sustainable, independent and are built around a business model.



He said that Governments need to Involve us since we are the experts in drugs or try out drugs yourself. First of all alcohol is the most dangerous drug he said and illustrated the most recent research on the most dangerous drugs.

I Know that ANPUD sounds like a criminal organization but its' not, he said.

We support capacity building on strategic advocacy, he said and provide technical and financial support on advocacy efforts. We help to organize and collaborate

advocacy campaigns and share information and resources while also Joining campaigns and organizing actions in collaboration.

Learning from other big movements like the PWID, MSM and FSW movements, right now PWUD face High Criminalization, Low Coverage of services, Conflicting policies for 3 decades. Drug use is not a problem at the grassroots as presented now, it is a top down, prejudice based and politically motivated policies and profiteering and partners in crime. There is a need to get away from the Get away from the disease model he said. He presented the case of Portugal as depicted in the graphic to the left. In closing Mr. Rajiv Kafle Gave his Recommendation to the SAARV Level Meeting as follows:

- ❖ Decriminalize personal use of all drugs
- ❖ Legalize medicinal use of Cannabis
- ❖ Make syringes available in 7 eleven, corner store and 'Pan Dukan'
- ❖ Make substitution therapy available through pharmacy
- ❖ Get away from the 'disease model' for responding to problematic drug use

in closing he said every person has a right to life and presented a quote:

"People do not lose their human rights because they use or sell drugs" –**Office of the High Commission on Human Rights"**

16.16. Day 3: [11th of December 2018]:

Dr Wenyuan Yin Regional program advisor UNIADS China: Presented the government model for taking harm reduction to scale. In her presentation, Dr Yin, began by providing an overview of the latest epidemiology of injecting drug use and HIV, including the changing patterns of mode of transmission of HIV in China. She then described the national policy context, expansion of the national methadone maintenance and needle and syringe programmes, including positive impact of the programmes in having averted a significant number of HIV infections in China.

There are almost 300000 clients attending 700 clinics in 30 provinces. The agencies that were tasked with the program's expansion have been confronted with many challenges, including high drop-out rates, poor cooperation between local governing authorities and poor service quality at the counter. In spite of these difficulties, ongoing evaluation suggested reductions in heroin use, risky injection practices and, importantly, criminal behaviors among clients, which provided the impetus for further expansion. Clinic services were extended to offer clients a range of ancillary services, including HIV, syphilis and hepatitis C testing, information, education and communication, psychosocial support

services and referrals for treatment of HIV, tuberculosis and sexually transmitted diseases. Cooperation between health and public security officials has improved through regular meetings and dialogue. However, institutional capacity building is still needed to deliver sustainable and standardized services that will ultimately improve retention rates. The steps China made in overcoming the many barriers to success of its methadone program and its lessons might be useful for other countries in the region that are scaling-up their methadone programs.

CDC China – A National Working Group for Community-based Maintenance Treatment for Opiate Users was established in August 2002, with Ministries of Health, Public Security, and the State Food and Drug Administration, and three experts on addiction and HIV/AIDS. The National Working Group was given overall responsibility for managing the program, supervising the operation and overseeing its expansion.. For scale up. In February 2003, the Ministry of Health, the Ministry of Public Security and the State Food and Drug Administration jointly issued the *Temporary Scheme for Community-based Drug Maintenance Treatment for Heroin Dependents.* This protocol laid the foundation for administrative and technical support at all levels of government, from national to local. The *Temporary Scheme* prioritized MMT implementation in those areas most severely affected (more than 500 drug users) and outlined eligibility criteria for participation. The eligibility criteria to participate in MMT were: (i) opiate users who had failed more than one attempt to quit; (ii) at least two terms in a detoxification center or once in a re-education-through-Labour detoxification facility; (iii) at least 20 years of age; (iv) a local resident and settled in the local area where the clinic was located; and (v) capable of complete civil liability. Drug users testing HIV-positive needed only to fulfil requirements (iv) and (v) to qualify.

Clients were permitted to miss a maximum of 15 days in 90 days, or risked expulsion. They could also be expelled for not cooperating with clinic doctors or failing to obey program regulations, which included maintaining abstinence from opiate use while in treatment. The temporary scheme also outlined the protocol to guide methadone production, transport and distribution under the supervision of the State Food and Drug Administration. Methadone powder was purchased centrally and distributed to participating provinces, which produce methadone liquid according to the Chinese Pharmacopoeia. Also Dr Wenvuan said that the peer groups paid a vital role in retention and expansion uptake of the of the services. She said that they had installed Electronic IC card central database access all over the country, so mobility within the country was not a problem. Also they were working on supplying 7 days take home dose provision with provision to avoid OD. Currently the program is predominantly supported by Government Funding, even though the GF pulled out. In closing she handed the floor to the facilitator.

Dr. Nicholas Thomson, from the Nossal Institute for Global Health and Johns Hopkins School of Public Health, took the floor. Dr. Thomson, Said that recently there has been particular Focus on Amphetamine Type Stimulants (ATS). He said that in the Asia region the choices of drugs mostly focused on opiates but that, the scenario was rapidly changing. The use of Amphetamines has been increasing since 2000 but now it's now production and trafficking is happening the in SAARC countries too. As a Harm Reduction Challenge, we need to rethink for the next 25 year for ATS users.

Dr. Thomson, presented his Background and Rationale saying that there were significant numbers of amphetamine users in many countries in the region. Large no's of seizures in Asia Region much coming out of Golden triangle. Also, he said, in relatively a short period of time, amphetamine became the predominant illicit drug if use in at least Thailand, Laos, Cambodia and the second most used illicit drug in many other countries. Large numbers of ATS users are being arrested and sent to either prison or compulsory detention while the relapse rates to ATS use, post detention or after their prison term is extremely high. He said that there were limited programmatic harm reduction efforts in the region around ATS use.

He shared some Key Facts such as Yellow Yaba Pills being smuggled inform India and Myanmar as animal supplements. There are some 3500 drug peddlers active across Bangladesh and about 90% of the pills enter Bangladesh from Myanmar through the Naf River. Around 40 million pills were seized last year. Some 287,254 cases have been filed in the last five years. Regarding growing trafficking and local production, he illustrated the New Yaba Route through India and Bangladesh.

He talked about a Large ATS based peer trial, the only large trial for regional relevance. the ATS situation is the same since 10 years such starting using stopping dynamics. High prevalence of depression. There is a high prevalence of depression among ATS users almost 31% in Males[22]. Dr Thomson Illustrated the relation between the duration of amphetamine use in yrs Vs. the frequency alcohol use in last 30 days in Chiang Mai, Thailand, 2005, Dr Thomson indicated that usually ATS users binge use and then go through a depressive burnout stage in cycles which on an average lasted 7 years or so.

His research indicated Increased sexual risk behavior, Particularly were females unaware of having chlamydia. He said, with the Risk sex behavior of FSWs, there is a relation to HIV, high risk sex and people going into prisons. His research also indicated high prevalence rates of STI such as *Chlamydia trachomatis(18.5-29.4%)* and *Neisseria gonorrhoeae* infections (5.5-7.7%), among methamphetamine users in Chiangmai, Thailand in 2005[23]. Only 12% seek treatment from any health services and an anonymous VCT showed 0.1% HIV prevalence. In his Comparison of Chlamydia Rates Among ATS Users to Sentinel STI Data by Country, it was seen that ATS Use was associated with Sexual Risk. [24]

Also the highest Most Recent Arrest by Country in Thailand, Cambodia and Laos was arrests for using drugs more than fighting or, carrying or selling drugs. Almost80% had a history of arrest. People are not being arrested for trafficking but not trafficking and vulnerable young people being arrested for really small amounts, clogging up prisons, he said. He said that the Estimated number of ATS users in northern Thailand in 2011 was 311,600.The WHO-ASSIST Score among ATS ever users, Household Survey, 2011

showed that 1.4 % had more than 26 score while 12% had a score ranging from 4-26 and 86.6% had a score of 0-3%.[25]

Dr Thomson then posed the question "*So what do ATS users need ?".* He offered 3 strategies namely:

- Drug use and sexual risk reduction strategies
- HIV/STI awareness, testing, treatment
- To remain in the community

He talked about the results of the Community-owned Comprehensive Program for Methamphetamine Users in Northern Thailand Including, after-release users and users under probation whose results are illustrated in the table below.

Results of Community-owned Comprehensive Program for Methamphetamine Users in Northern Thailand

Year	No. treated	Successfully Recovered	On-going care
2010	47	44	3
2011	30	24	6
2012	18	16	2
2013	7	2	5
Total	102	86	16

80% or ATS users do not meet the criteria for abuse or addiction, treatment, so how to keep the people in the programs is an important question. In Conclusion, Dr Thomson Illustrated that an example of an intervention in the rural Thai community where the majority of users are not high-risk dependent group, the community can effectively look after their members with proper technical support. He then talked about the challenges of ATS for Harm Reduction. He said that, designing and implementing programs that reach the larger target groups needed to be totally rethought about how to reach the larger target groups. Responding to emerging cohorts Unique needs will not be addressed by conventional Harm reduction programming. Regarding Policing and ATS users, he said that it is critical that we emphasize the need for the police-health-harm reduction partnerships and provide community wide stigma reduction with genuine drug awareness. He said, societies perception needs a definitive effort towards destigmatizing these types of drugs usage. Although changing discrimination is hard, we need to break down the idea of drug use and People who use drugs. He said we should not hesitate to run Pilot Programmes that can generate the evidence for managing low level ATS use. We also need to have Police agreeing to work with us along with outreach by health workers and peer based services. At the same time we also need to Delivering new capacities specifically for Harm Reduction for ATS. He then handed the floor over to the facilitator.

The next session was from Mr. Moses ZofakaPachuau, the General Secretary of Mizoram Drug Users. Mr. Moses ZofakaPachuau gave the audience an overview of Mizoram. He said that it is a Christian

State and people who use drugs are regarded as 'sinners' and not a drug tolerant State'. Despite advocacy there is and discrimination even among service providers with punishments. He said that Mizoram had a very strong community based NGO (Young Mizo Association). Mizoram has their own AIDS control society but no community involvement. A group of users who came together with UNODC support, thanks to Mr. Kunal Kishore who was with UNODC at the time. He said that now Mizoram has a hepatitis C response team and many Neighboring states followed suit along with the advocacy from DNP+ . The Government is going to give free Hep C treatment all over India. Also there is a Module being developed for schools. All the insights from the community have been collected into the group module and the social welfare department is making an accreditation system for 'De-addiction' centers, Every team, will have a community member. Also we are doing a survey on minors on Substance abuse and developing a prevention package for young people all the way to college level. He said, when you make polices for DUs, you should engage DUs in place to help because we can help. If you give someone shoes instead when they need a shirt, it will not work. He talked about the Harm Reduction Landscape and Provisions at the National Level. NACO (National AIDS Control Organisation) works under the Ministry of Health and Family Welfare (MoHFW). Every State has their own SACS (State AIDS Control Society) and NGO/CBO's are contracted by SACS. The DICs' are supposed to cover all the high HIV prevalence areas and low prevalent areas are taken up by Link Worker Schemes. But the coverage is still not enough in terms of service provision as well as man power.

Provisions of the services to the community is not sufficient all areas are equal importance in terms of HR and funds, which means area-specific programming has not been developed yet for service delivery. Services provided by the DICs are NSEP, Condom, OST, referral to ICTC/ART and limited clinical help. As far as community involvement is concerned it is a debatable matter, he said, but the fact of the matter is that, it is very minimal.

On the Status of Miozoram State he said that Mizoram has the highest HIV prevalence in India. There are not enough resources for coverage and services and Communities are not involve at SACS decision making level. There are no State-specific HIV programmes, as it is very different in the North-East, not socially accepted and slow to change communities. Mr. Moses ZofakaPachuau said that Mizoram Drug Users Forum is for drug users (ex/current) to come together and make an effort to help each other out as well as to promote harm reduction principles and ensures it is implemented in areas where it is needed. He said the the primary goal was to ensures services reached people who inject/use drugs (male/female) and said that they had started a women's wing recently. In closing He handed the floor over to Mr. Charanjit Sharma- Technical Advisor for Harm Reduction- India HIV/AIDS Alliance.

Next **Mr. Charanjit Sharma- Technical Advisor for Harm Reduction- India HIV/AIDS Alliance** took the floor. He said, 'Today I will talk to you about what drug use is all about and describe the scenario on the ground. There are many service providers are also here today. We must understand that there are people who come off , some continue, then stop again. Often people want to stop at a certain point, but we do not know where to go, Wherever we go we are stigmatised discriminated . There are also some people who start using and continue using. In this situation Government's and service providers need to make sure that the right kind of commodities are available. Some people do not want to stop and they should be provided Harm Reduction services with Flexibilities for the different types of drugs. As long as

there is no trust with the person receiving services the person does not really benefit that much. We use different names and terms such as 'Hard to reach'. The problem is that services are not designed to reach them. People are not hard to reach, especially nowadays. I know some friends who know how to use their drugs, then go to work effectively. We do not promote laziness.

We need to meet the people in the community. We need to know what people require. We ourselves are engaged in the field level work and talked about 90-90-90. I am speaking as a drug user working in the field as a professional as well. There are 10 Services that the WHO, UNAIDS recommended, for people who use drugs 90% must be covered , 90% provided NSEP/OST and make sure over 92% are using safely without risk to others. The other crucial aspect that I want to mention is the Support System. I have been fortunate to have colleagues who are supportive, bosses also understand Drug Use, My wife , and parents get upset but now they have understand and prtners of Injecting Drug Users need to also understand, Mr. Sharma said.

Mr. Charanjit Sharma said " Good decisions comes from experience but experience comes from bad decisions" . All drug users do not need services and support but we should open the doors for those who do need support".

He said that regarding Hepatitis C in India, the Govt. has announced that Free Hep C treatment will be made available. But we must all realize that this was accomplished through community activism. Still some friends are paying around 900,000/-, Failing treatment 2-3 times and despite paying so much the price has now come down.

After Mr. Charanjit Sharma's Presentation there was a small Discussion and Question Answer session that ensued:

Discussion and Question Answer session

Mr. Kunal Kishore: We don't have many Activists so the focus must also go to bringing new faces as well.

Q. to Dr Wenvuan Yin from Mr. Raju Joshi- Recovering Nepal. Can you please tell us the strategies that are creating your success.

Q-Comment from **Mr. Phuncho Wangdi DG of Bhutan Narcotics Control Bhutan**. – I am a father of three and as a brother, even as an official we have our hearts going out to people. In my country we take drug users into confidence. But even when we made the law DUs were in the panel. Stricter measures in our country have been called for by Drug users themselves. We are requesting the Mayors to give priority to PUD. But also as a government we also have to develop ways so that people can be prevented from getting hooked. HO w can we try to support them as much as possible while ensuring more people are not starting to do drugs ?.

Q Dr Maimoona Malik- How can you have an Incentive reward based system ? For drug users, they will go out and use it to use drugs again. On adherence, cognitive part does not seems to help, so how has it worked for china. Cognitive therapy will not work for drug users adherence.

Ans- Dr Wenvuan Yin- in China amphetamine use is not that complex yet, but in our MMTP setting it very hard in 1 site out of 20 patients, we had only 1 and they created a lot of drama at the site.

Q-Bangladesh – Mobile Health- How does it work for someone who is getting methadone ?.

Rajiv Kafle ANPUD: like Dr Nicholas said Nicholas said that they will be exhausted do not panic. Also HRI demanded more money for Harm Reduction all around the world. Why is there lack of resources if such a good evidence based program ?? Also the CND position is totally different from practice.

Ans.-Dr Wenvuan Yin. There is no easy strategy for retention, Sufficient Dosage and maintenance of high level dosing is key. Retention largely relies on accessibility so If Clinics can also run the extended sites the uptake is high. Our psychological support is more about being contributing members to society. Currently at the clinical site we have 75-80% retention.

Ans. to Bangladesh. - There is a mobile van which does Community Based Testing (CBT) and testing counseling (TC) also there is mobile van which is clinic based but acts as a clinic sub satellite and goes into the community to provide methadone to known users.

Ans. to Dr Maimoona- Yes there is areward system that we have implemented. If retention, their retention is good and if they can bring more peers to the PE.

Ans to Rajiv Kafle . Regarding CND- Narcotic Policy, the CND says Voluntary Detoxification and supports MMT program, but we do not support Compulsory Detoxification, which can be dangerous. Perhaps after 1-2 years in china we hope to have community based Harm reduction programmes.

Comment- Dr Nick Thomson : In Asia 80-85% people do not reach that high level of intoxication, that calls for an immediate clinical intervention. When Amphetamine waves hit a country the media and public create a storm that requires a crackdown by Govt. Villainizing the Drug User. Also, many Clinical Systems in the region do not have the capacity to look after a highly psychotic persons .

Mr. Charanjit Sharma : Regarding overdoses, from 2003, the community felt that we should do something so with our own funding we supported a community based organization to make sure Overdose related deaths were reported. One of Drug Peddlers also wanted to support. Also in India Naloxone is charged around 80 dollars. Alliance India has provided some naloxone Current drug users are satisfied to have Dr give it to them. If they carry it, they feels that they may not know if it's the right kind of Dose that will Dropout. So there is need for Education among Drug Users.

The next presenter was Ms. Sonam C Sherpa, Team leader for RN Women and Vice President of CDUN.

Ms. Sonam C Sherpa started by saying " Nepal is beautiful country. The DU movement is gaining but for women is is left behind. We have nothing here for women and for youth. They say that the youth are the most valuable resources for the future but what have we been doing for them ? … we have been doing nothing. They are largely neglected in the conventional HIV program. During 2008 a female movement was started but was abruptly stopped due to funding discontinuation by UNODC. At that

time we came into so much information and came into contact with so many members of the Female Drug users we found out that DVT is major issue for Women".

She said that, most people who use and inject drugs begin doing so at a young age where the risk of experiencing harm, including contracting HIV, is greatest.Initiation into drugs begins often during teenage years and usually peaks between 18 to 25 years, Peer pressure, curiosity and lack of awareness are often cited as the main reasons for youth getting involved in drug use. (***not moral failing***). Studies have reported that young people form a significant segment of those attending drug programmes, sexually transmitted infection (STI) clinics and those infected by HIV.

Two Surveys were carried out by the CBS with collaboration of the Ministry of Home Affairs on the Current Hard Drug Users (CHDU) in 2007 and 2013. the results showed 46,309 in 2007 and 91,534 in 2013. That is (93.1%) male and (6.9%) female. The annual growth rate was 11.36%. Youth are a valuable resource for the future of a country, and they have the right to be equipped with ample amount of information and services to protect themselves. She talked about the geographical distribution of PUD in Nepal. Among the drug users, a very large majority of which happened to be young users. About 70,390 drug users are below the age of 30. The youth 20-24 years accounted for the highest proportion of the current drug users in Nepal. Followed by 25-29 years age group.

Among the total drug users, 22% are currently attending schools/campus which is higher than in 2063 (14%). he drugs most commonly used are Opiates and are the highest in the age group 20- 24 years around (32.6%). Among the total drug users, 57% (52,174) are IDUs Among them 13% shared needles with someone else.

On reasons for Reasons of drug intake, she said that there for more common reasons for the initiation of drug use because of perceived positive outcomes. Majority of drug users reported reasons like curiosity or experimentation, for fun or peer pressure for initiation of drug use. Only small minorities reported reasons like family problem, study problem and others. Peer pressure is the major cause reported for drug intake (78.7%). Curiosity accounted to 58.5% and Family problem 19.9%.

Ms Sherpa then Talked about Young women who use drugs. Sje said that Young women who use drugs are increasingly affected by HIV. They have unique needs frequently ignored by conventional HIV programs. This is due to age and gender-specific vulnerabilities to both injection and sexual transmission routes, however, these physical and related unique vulnerabilities are not well recognized by policy makers and service providers in implementation of programmes. Age, gender and drug use often make young women more stigmatized than their male counterparts. Young women who use drugs often lack access to anonymous HIV testing and counseling, and young women who use drugs face additional barriers to treatment due to societal and financial barriers. Young women who use drugs sometimes engage in sex work as a survival strategy and/or to support their own and/or their partner's habits. Because of the overlap between drug use and sex work, they also are more vulnerable to experiencing police abuse and harsh law enforcement. Young people who use drugs and sell sex are ignored by most donors and programmers.

Also , Culturally embedded power imbalances between men and women also expose young women who use drugs to violence and abuse, she said. Gender and cultural norms also influence women's power to negotiate condom use which is found to be more difficult for women who use drugs due to their marginalization by society and resulting feelings of disempowerment.

Women who use drugs face immense reproductive rights issues, if they are pregnant they experience harsh treatment from healthcare workers and are often given misleading information about drug use and pregnancy. Also, Young mothers cannot access Harm Reduction services for fear of losing custody of their children to relatives or the state. In some cultures, Young women experience forced sterilization or pressure to have an abortion from family and healthcare workers alike.

She said that the way forward was, as a first step donors and programmers must incorporate an age and gender lens when working on drug use and HIV. Meeting the needs of young women who use drugs requires a comprehensive and holistic approach. There must be greater involvement of young women who use drugs in policy and program development. They must be Be encouraged to speak out on their issues and address the human rights violations they frequently experience.

But for these things to happen, first we must allow young women who use drugs to feel safe and supported to discuss their issues. Donors and service providers must work together across silos to enable more effective programming at the community level. They must create an environment that is friendly for young women; including ensuring young female staff members are employed at service provision level. Programmes must also have links with women's shelters, domestic violence and rape prevention services.

Enable better health outcomes through supporting members to obtain legal documents, access friendly medical care and support HIV treatment adherence.

Ms. Sonam Sherpa said we must start by having honest conversations about reaching under-18 young women who use drugs and sell sex that moves away from a victimization approach and instead focuses on the critical question:

- how do we provide young women with the best possible health care ? (willingly health seeking behavior in still?

Young women who use drugs deserve the recognition and fulfillment of their human right to health – yet this right is consistently violated around the world.

In closing she said that, the National HIV Response must do more to ensure young women who use drugs have access to respectful health services, the protection of their sexual and reproductive rights, living environments free of violence and criminalization, and other essential human rights protections.

She said that retention for women is very low because of different issues such as harassment by men. There is a real need for women friendly services.

Dr. Maimoona Malik : Lots of overlapping issues with NaiZindagi from Pakistan Despite all these years for women, it still feels like we are new to this movement, sincerely there is really nothing.

Ms. Sonam Sherpa. Currently we have established RN women to consolidate the female Drug Using Community. Lack of Sustainability has broken it apart in the end.

Ms. Sherpa then handed the floor over to Dr. Sandeep Bhola, Consultant Psychiatrist, International Certified Addiction Professional (ICAP-II), Master Trainer: UNODC, NACO; Govt. of Punjab Technical Expert: NABH (National Accreditation Board for Hospitals & Service Care Providers), District Hospital, Kapurthala, Punjab, India.

Dr. Bhola, started out his presentation and talked about Kapurthala (Punjab): Demonstrating an Evidence-based Women Sensitive Harm Reduction Model. After 2015 they started believing that they were are doing good enough and that is all what was required to upscale. The ratio of DU's using illicit and any substances male to female was about 28% in males and 0.1-2.1% in females.

Br Bhola shared their strategy to reach out to women who use drugs in Kapurthala. Under the Global Fund supported Harm Reduction Advocacy in Asia (HRAsia) programme, India HIV/AIDS Alliance will be implementing a demonstration project to address the comprehensive needs of the women who use drugs.

The objective of the site will be to present a successful model which is comprehensive, cost effective and successful in terms of addressing the needs of women in a given atmosphere. After successful implementation of the project, advocacy efforts will be done by the programme with central government and other relevant stakeholders for scaling up of the services to address the needs of the larger population in discussion. The following ios a linkage diagram shared by Dr Bhola.

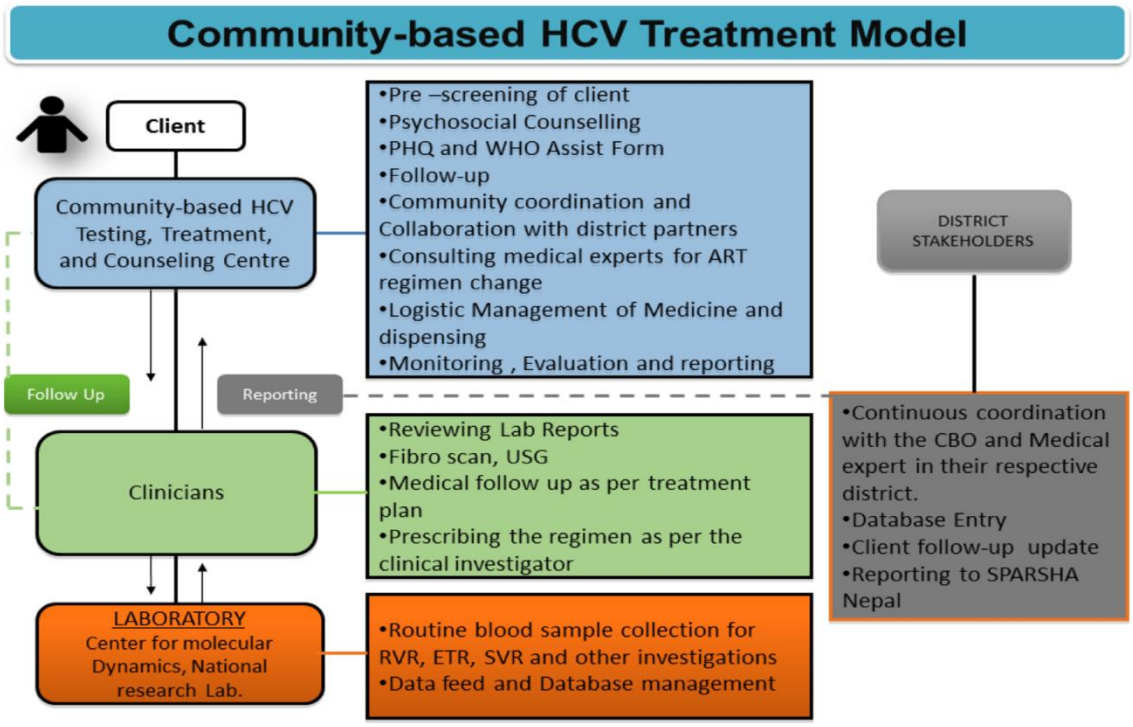
In closing he said that as human beings and as a society we have to grow and develop ourselves, dynamically..!!! with that he said thank you and handed the floor over to the facilitator. During this period Mr. Kunal Kishore from India HIV/AIDS Alliance proposed a commitment declaration document to be signed in consensus by all. Later is was decided to call the document '***A call to Action***' instead with a chance to preview by all before signing.

16.17. SPARSHA TOUR:

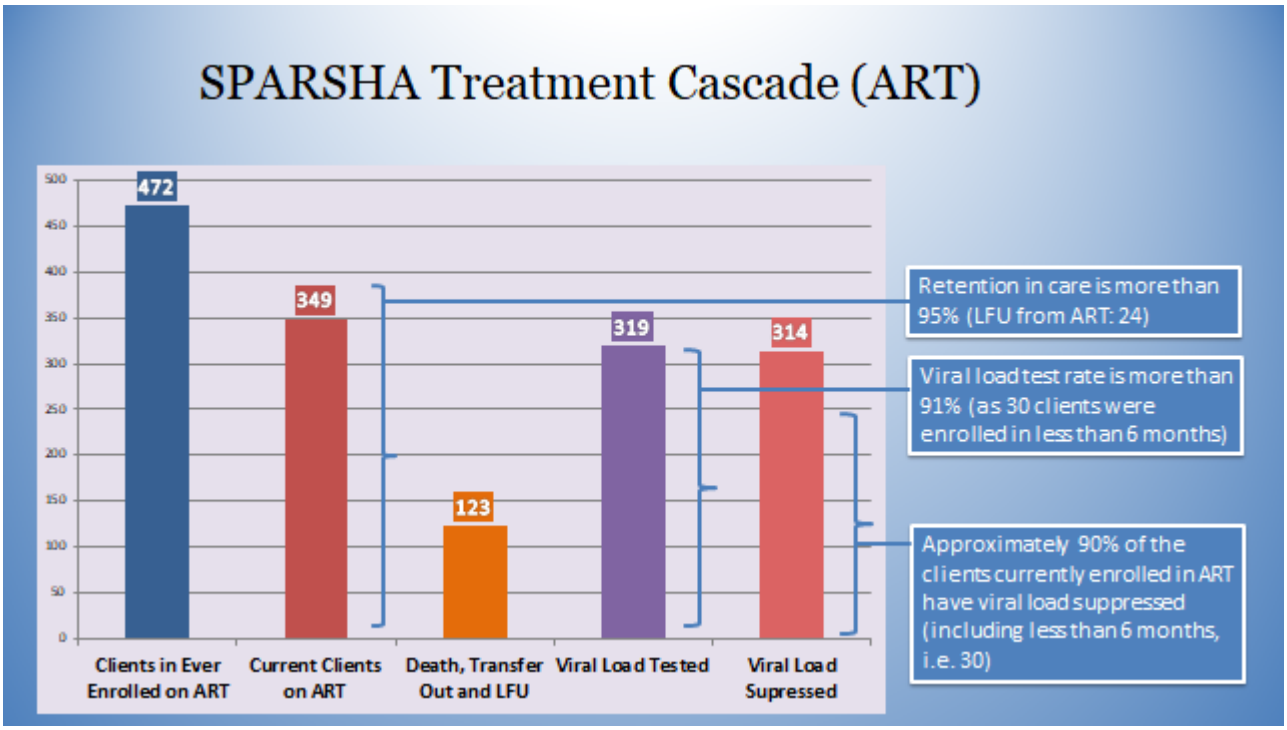
After this the group was taken for a live tour of a model comprehensive service site SPARSHA Nepal where all the WHO recommended interventions were integrated for PWID. At SPARSHA Nepal the dignitaries were welcomed and after a tour of the services site, Mr. Prawchan KC the Program Manager for SPARSHA Nepal gave a brief presentation of the Community Based Comprehensive Service Model of SPARSHA. Mr. Prawchan KC said that SPARSHA started its journey in 2002 as a support group and Registered as a NGO in 2004. It was Initiated the concept of People living with HIV and their friends (PLHAF). SPARSHA works with people living with HIV (PLHIV) and their children and families in particular and key population i.e. People Who Inject Drugs (PWID), Female Injecting Drug Users (FIDU), MSM, FSW and clients of FSW in general. SPARSHA has been able to establish itself as key Community Service Provider organization and one of in-referred site of Nepal in-terms of HIV related service. More than

60% client accessing services are from outside Kathmandu valley. He said that the Service domain starts from HIV Testing and Counselling (HTC) as an entry point to Community Based Anti-retroviral Treatment (CBART), including Community and Home Based Care (CHBC), Community Care Centre (CCC) , Hepatitis Counselling and Referral Centre, Directly Observed Treatment Short Course (DOTS). The Service domain of SPARSHA Nepal is based on the assessment of key populations, communities and with their involvement in planning and designing that caters the services based on true needs of target community.

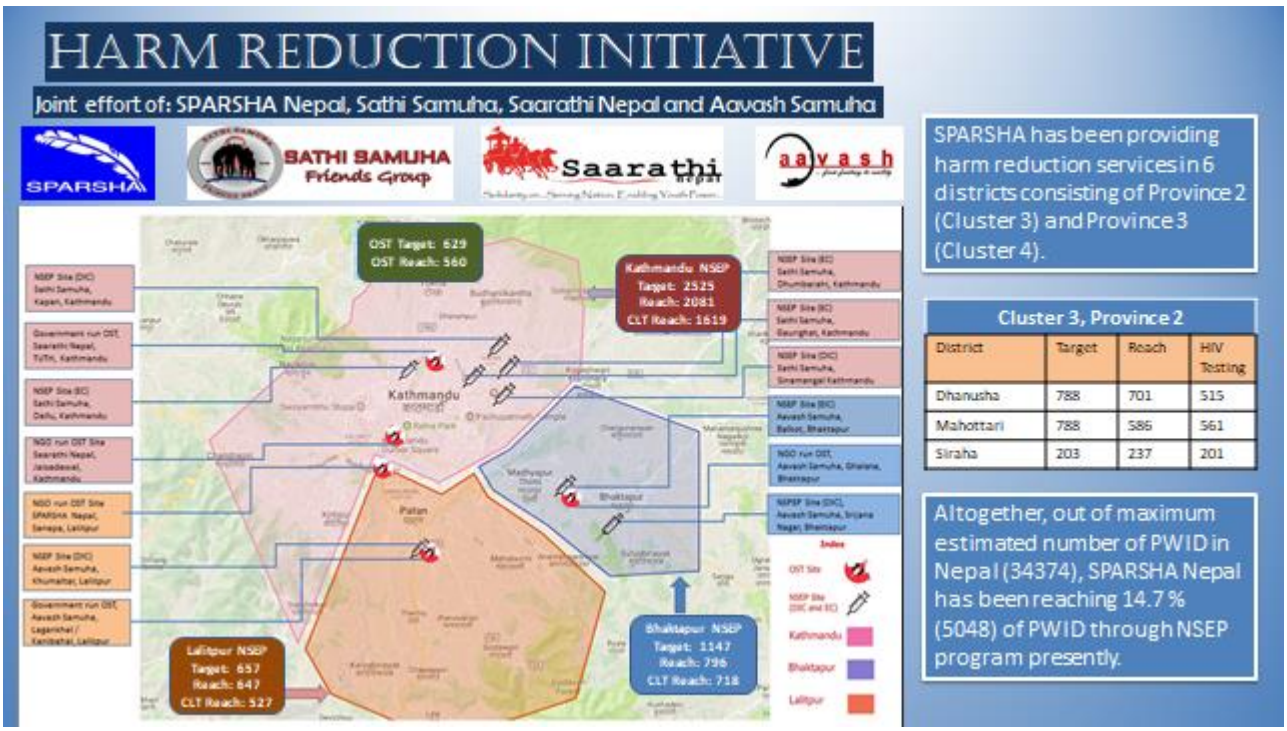
Mr. Prawchan KC then Shared the Hep C Treatment Model as follows.



Mr. Prawchan KC then shared SPARSHAs Achievements till date and the SPARSHA Treatment Cascade for ART where thee retention is 95%.



He also shared SPARSHA Community Rapid HIV Testing and Harm Reduction initiatives, SPARSHA has been providing harm reduction services in 6 districts.



After the Tour at SPARSHA the dignitaries and guests returned back to the SAARC HIV/TB Hall in order to attend the final sessions of the day as well as to have lunch. After returning from the tour the remaining

sessions were initiated by Mr. Bishnu Fueal Sharma President of Recovering Nepal. He welcomed everyone and asked them to take their seats. He welcomed the Honorable State Minister (RajyaMantri) Mr. Dhan Bahadur Budha, and the honorable Deputy Secretary of Home affairs-Mr. Narayan Dawadi and honorable Director general of the Department of Health-Dr Ramesh Kharel. He then requested request the honorable **Deputy Secretary of Home affairs Mr. Narayan Dawadi** to present on behalf of the Ministry of Home Affairs. The honorable Deputy Secretary of Home affairs Mr. Narayan Dawadi started his speech by saying, "it is my honor to share with you." He apologized for the missing part of the event and Congratulated all present for the successful opportunity to learn in the SAARC Region.

Mr. Dawadi Shared the situation of Drug Control Plan in Ministry of Home and said here was a need for Partnerships to address challenges. Mr. Dawadi, presentation covered four areas, namely, the Current situation, the Work plan, Collaboration and Partnerships and Conclusion. First he talked about Structure of the Drug Control Mechanism, Institutional And Legal Framework And Policy and Guidelines. He shared the Organogram of the Governments Institutional Arrangement under the Ministry of Home Affairs (MOHA).

He listed out the High Level Drug Control National Guidance And Coordination Committee under the chairpersonship of Home minister. Which included secretaries from following ministries as members:

- Ministry of Home Affairs,
- Ministry of Finance,
- Ministry of Foreign Affairs,
- Ministry of Information and communication,
- Ministry of Education, Science and Technology
- Ministry of Youth and sports,
- Ministry of Women, children and Senior Citizen,
- Ministry of Health and population.

Two Surveys were carried out by the CBS with collaboration of the Ministry of Home Affairs on the He shared the CBS data on Current Hard Drug Users (CHDU) in 2007 and 2013 that showed 46,309 DUs in 2007 and 91,534 DUs in 2013. That is 85,204, (93.1%) male and 6,330 (6.9%) female. The annual growth rate was 11.36%. Among the total drug users, 57% (52,174) are IDUs. He said that from 2015 to 2017 an average of 7% of registered cases were drugs related crimes as pharmaceutical drugs share a major size among drug related crimes. Mr. Dawadi then shared the Drug Control Work Plan, 2018. He said that the action areas were:

- Special campaign of preparedness on control of crime relating to Narcotic drugs
- Conduct awareness creating campaign
- Campaigning on identification of sources of drugs and disposal
- Monitoring, oversight, surveillance, checking, control and legal actions
- Policy, act, law, guideline, formation of working procedures,update and amendment
- Study, research and survey
- Cooperation and Coordination

He stated the Future Policy Direction of the country would be to:

A) Narcotic Drugs (control) Act : Under Revision, Provisioned With

(a) Criminalization in Diversion of Precursor.
(b) Witness Protection
(c) OST treatment
(d) balanced emphasize on all the Pillars of Drug Control.

B) Directive for Drug Treatment and Rehabilitation center

(a) Action Plan regarding narcotics control is operational.
(b) Sensitization of different tier of Government and partners.
(c) Mainstreaming with all tier of Government

He said that we needed to have a study detailed about OST, what the management issues are and the technical issues since our societies are similar . As a Narcotics Control officer I have requested the concerned agencies to expand or limit the program. In Conclusion to his presentation. Mr. Dawadi Presented his list of Recommendations.

- Mainstreaming of DCP(Drug Control Program) with Sectoral policy, plan and Budget
- Effective collaboration with non-state actors
- Scientific recording and reporting mechanism vis-à-vis monitoring and evaluation (Data base)
- Research and Development
- Capacity enhancement of agencies

After the presentation Mr. Dawadi said “We have a gap in understanding these drug related issues. Let us work together. Our efforts are fragmented and we need more consolidated efforts. – What your area of expertise is ? we must exchange ideas to translate these things into society. Being a narcotics control officer I do not understand how things work in the drug treatment demand reduction areas. We have a gap in knowledge, and how many countries have frequent drug surveys ? We need to get data to quickly evaluate our system and make changes accordingly. Our setup is not consolidated and sensitized yet and so we are trying to meet among Ministries, States and Regions. My understanding is that we have been working a long time but we need a dedicated agency to work on this. I Thank the organizers for this opportunity. Thank all the participants. Let’s have a collaborative clear understanding and common knowledge here. With this opinion I would like to end.”, and thus he ended his presentation. Mr. Kunal Kishore From HIV/AIDS alliance India thanked The Home secretary cordially and said ” thank you Nepal Govt led and Civil Society on the Occasion of Human Rights Day.

Director General of Bhutan NCD MrPhunchoWandi asked the facilitator to represent the participants here. He said that he wanted to put forth a few points. First of all he said “ The Drug Situation is growing.

Growing because of social and cultural development and lot of other reasons. The biggest problem is they (PUD) have the problem and they have the Knowledge. The Governments have resources but no Knowledge . It has always been "us and them'. There has to be compromises from both sides. Or the problem will never be solved. We are all parents , brothers mothers, sisters and fathers. Those of us from the Government we all work for a common solution, If we have citizens who have crime, drugs, poverty it affects the whole society and whole country,. We need to collaborate and work together. Bring in people developing programs laws policies we have from all walks of life. We have weak laws that need changes. It cannot be" My way or the High way" we need a combined solution. Thank you all, and it has been a pleasure. "

Dr Maimoona Malik-NaiZindagi Pakistaan:

" I would like to take this opportunity to represent all the participants to welcome you your presence, it shows your commitment. Thank you Govt. of Nepal for hosting the event and Congratulations to Alliance, RN and the Outreach workers. There is a small tribe in New Guinea. They do not eat, sit, talk, without collaboration -most ethnic tribes. We are all available to each other's experience. The SAARC region is unique. When we go to the west , they ask where does your faith come from. Drug Use does not know borders, HIV does not know borders. Activists should be welcome by governments and stakeholders and be inclusive. From all the presenters was a learning experience. We had a wonderful experience. Thank you"

Dr Ramesh Kharel:
" Chief guest, focal person all the participants from the member states all the people who are here. Bring out your own voice with rights based health approaches for harm reduction. Disease and infection has no boundary. Also its my pleasure to be here today to get my vote of thanks. By the way we had the Deputy Prime minister today the State Minister is here so it shows commitment on their part. Let us try for meaningful coordination. From LALS harm reduction was kicked off. Our progress in HIV and TB have been discussed today after the presentations of Bhutan and we need coordination meaning fully and together we can solve. We have set by 2030 the SDG's and by 2020 the national Strategy for HIV. It seems like a longtime we have worked together not only HIV/Harm Reduction but also in Human rights, new infection are going down, but not at the rate expected but we must still congratulate each other. Colleagues are working in OST NSEP but still fighting for coordination and collaboration. Hetero-sexual transmission we cannot control without coordination. How do we regulate control narcotics ? Now I am convinced we can never fully see success without the decriminalizationof Drug Users. Thanks to HIV/AIDS Alliance India , without your presence, your sharing and discussions, we have to be thankful for the momentum gained and continued with meaningful collaboration. we can achieve the result and SDGs , and thank you once again." **Mr. Bishnu Sharma:** As a civil society we are ready to have a collaboration not only harm reduction prevention but every aspect of drug use .
Minister of State: "It is my honor to put forward the closing remarks . I hope that you all had a productive discussion and good stay . hope all had constructive and productive discussion. The recommendation will be useful. Thanks for organizing this event on Human rights day. New infections are reducing grossly in our region but still we have a long way to go regarding HIV/AIDs SAARC countries should make a common policy regarding Drugs and HIV AIDs. The Govt of Nepal is ready to implement the recommendation given by SAARC member states as you know we have an open border so we can

only eradicate HIV with cooperation. In closing I would like to thank all the organizing team and all the people here and thank you sir".

Mr. Bishnu Sharma:

"RN would like to thank you all one by one by one, Narayan Sir, Distinguished guest from member states. The last two days we constructively worked in this workshop. Thank you for helping us to make it happen thank you for Dr Umesh Chawla, Alliance India, All RN Staff, In future, like Narayan sir said, we will have a joint effort to bring changes not only in Nepal but the whole region. I would like to invite you all for Lunch.