UN General Assembly Special Session on Drugs (UNGASS)in 2016 (Nepal Position / Commitments and Recommendations)

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- Federation of Drug Demand Reduction (FDDR)
- Coalition of Drug Users in Nepal (CDUN)
- National Association of Female Drug Users (NDUPA)
- Hepatitis Treatment C Activists Network(Union-C)
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Background

The 'General Assembly' of the **United Nations** (UN), is the only mechanism in which all 193 UN member states have equal representation. In 1998, a 'General Assembly' (UNGASS) on drugs convened, at which member states agreed on a **Political Declaration on Global Drug Control Issues**. Ten years later, member states met in Vienna to discuss the progress made and to agree on a new **Political Declaration and Plan of Action** on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem.

The next UN General Assembly Special Session on Drugs (UNGASS) was due to be held in 2019 – the target date set out in the **2009 Political Declaration and Action Plan** for the achievement of a significant reduction in or the demand and supply. However in September 2012, the presidents of Colombia, Guatemala and Mexico called on the UN to host an international conference on drug policy reform. Subsequently, a provision was included in an **annual omnibus resolution on drug policy** – sponsored by Mexico, and co-sponsored by 95 other countries – to bring forward this global drug policy summit meeting to 2016 and as a result, the United Nation called a special Session on Drug (UNGASS) to review and address the drug policy problem around the world and make further, recommendations and commitments for immediate future action in 2016. In view of this development, Nepal UNGASS country team has reviewed its national progress and commitments and is has thus put forth this National position paper to the UNGASS 2016.

The state Laws and Policies relating to Drug Problem in Nepal

The constitution of Nepal was promulgated on Sept 20, 2015. It guarantees various fundamental rights, including right to equality and non-discrimination on grounds of religion, race, sex, caste, tribe, origin, language or ideological conviction or any of these.[1]All citizens of Nepal are equal before the law and all persons are entitles equal protection under the law.[2] Further, it sanctions the State to make special provisions for the protection, empowerment of women, indigenous tribes, peasants, laborers and those belonging to economically, socially and culturally marginalised groups as well as children, the aged, disabled and those who are physically or mentally incapacitated.[3]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[4] with certain reasonable restrictions provided at proviso clauses. It further recognizes the right to privacy and information of a person, relating to him or her.[5]Moreover, ***it recognizes the right to free basic care health services sponsored by the State as provided in the law***.[6] According to the Constitution, the State is also responsible for providing free legal aid to indigent persons.[7]Section 4 of the Constitution entails directives, principles and policies requiring the State to establish fundamental rights such as the right to education, health and shelter etc.[8], for all citizens. It also establishes timelines to review amend or formulate both old and new laws in the country.

Infectious Diseases Control Act, 1963 B.S.

To prevent and control the emergence and spread of epidemics among animals, birds or human beings within the country, this Act confers powers to the government of Nepal to take necessary actions, as applicable to the public in

[1] Art. Constitution of Nepal, 2015,
[2] Art. Constitution of Nepal, 2015.
[3] Art. 13(3) - proviso, Ibid.
[4] Art. 12(3), Ibid.
[5] Art. 28, Ibid.
[6] Art. 16 (2), Ibid.
[7] Art. 24(10), Ibid.
[8] Art. 33(h), Ibid.

general or to a group of people,[9] although historically, no such actions have been taken against any group, on the basis of this provision till date. [10]

Local Self Governance Act, 2055 B.S.

The Local Self Governance Act requires all local bodies to prepare and implement programs related to the prevention of outbreaks and epidemics of infectious diseases at the local level.[11] This provision enables the undertaking of programs at the local level.

Drugs Act, 2035 B.S.

The Drugs Act governs all pharmaceutical drugs within the country. The regulation of narcotic drugs also falls in the jurisdiction of this Act. [12] Various drugs are classified in Schedule A, B & C by the Department of Drug Administration (DDA) under this Act.[13] 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 have identified Methadone and Buprenorphine as Psychotropic Narcotics Substances for Import and medicinal use and listed under the essential drug list ".

Narcotic Drugs (Control) Act, 2033 B.S.

The Narcotic Drugs (Control) Act, 2033 B.S. (1976) governs most of the issues related to the use of drugs. Initially, at the time of its enactment, the Act was focused on a punitive approach with the inclusion of relevant definitions of drug related crimes and penalties etc. However, in its 1993 amendment, its scope was expanded beyond criminal justice system, incorporating the principles of major international instruments such as the **SAARC Convention of 1992 on Narcotics Drugs and Psychotropic Substances**; the **Single Convention on Narcotics Drugs 1961 (including the 1972 Protocol amending that Convention)** and the **UN Convention on Illicit Trafficking of Narcotic Drugs and Psychotropic Substances, 1988**. The amendments introduce the concept of legalization of controlled delivery, and corrective measures for drugs user and diversion from criminal justice system. In addition, it also harshly increased the penalties for drug offences. **The Narcotic Drugs (Control) Act prohibits cultivation, production, preparation, purchase, sale, distribution, export or import, trafficking, storing or consumption of cannabis and other narcotic drugs.**[14] However, consumption of narcotic drugs in the recommended dosage on a prescription by the recognized medical practitioner for medical treatment is not an offence under this Act. [15] Moreover, consumption of narcotic drugs by persons belonging to prescribed categories in prescribed doses is also not an offence.[16] It also allows the government or any institution working under the government's supervision and control after obtaining a special license for selling narcotic drugs to sell narcotic on the recommendation of a recognized medical practitioner.[17] The Act also authorizes the government to frame rules and issue guidelines for the production of hashish from wild cannabis plants and acts done in accordance with the license issued for it cannot be deemed to constitute an offence.[18]

Penalties for drugs users as traditional provisions

The consumption of cannabis is punishable with 1 month imprisonment or fine up to Rs.2,000.[19] Similarly, the consumption of opium, coca or any other narcotic drugs made out of it is punishable with one year imprisonment or fine up to Rs.10,000.[20] If a person becomes addicted to any natural or synthetic narcotic drugs or psychotropic substances, as notified by the government, s/he will be liable for both.[21] However, all these provisions have vested discretion in the judiciary to allow an addict to undergo treatment on certain conditions. The Act puts the Onus of Proof of any prohibited act under this law on the accused. It make the accused liable to furnish proof to the effect

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[9] Sec. 2(1) of the Infectious Disease Control Act, 2020.
[10] a writ petition was filed in the Supreme Court of Nepal requesting the Court to issue an order to the government to make premarital HIV testing mandatory. The writ has however, been quashed by the Supreme Court.
[11] Sec. 96(1)(f)(4) of Local Self Governance Act, 2055 B.S.
[12] Sec. 23A, Narcotic Drugs (Control) Act, 2033 B.S. provides that the production, sale and distribution, export-import, store and consumption of certain narcotic drugs shall be regulated through the Drug Act, 2035 B.S.
[13] Sec. 17, Drug Act 2035 B.S.
[14] Sec. 4, Narcotic Drugs (Control) Act 2033 B.S.
[15] Sec. 5(a), ibid.
[16] Sec. 5(b), ibid.
[17] Sec. 6, Ibid.
[18] Sec. 4 (1), ibid.
[19] Sec. 14 (1) (a), ibid.
[20] Sec. 14 (1) (e), ibid.
[21] Sec. 14 (1) (h), ibid.

that s/he has obtained or possessed such substance under this Act or the Rules framed or orders issued hereunder. If s/he fails to do so, shall, unless otherwise established, be deemed to have committed an offence punishable under this Act.[22]Those who involved in as **conspires, attempts, abets or is an accomplice in an offence,** which is punishable under this Act, is punishable with half the punishment that is due to the actual offender.[23] For a repeat offender under this Act, in addition to the prescribed punishment, s/he will be punished with an imprisonment for a term which may extend to five years for each subsequent offence and with a fine up to Rs.1,00,000.24

The provision which punishes the abettor of the crime can be misused against the service providers or private NGOs that run NSEP or provide oral Substitution treatment without a permit. Similarly, even though none of the provisions of the Act explicitly criminalized the distribution of needles/syringes to drug users, since drug consumption is a crime, a person or organization 'facilitating' the consumption of illegal drugs through the means of distribution of safe needles and syringes could be considered as an abettor, conspirator or accomplice. In 2002, the Department of Drugs & Natural Calamities Management under the Ministry of Home Affairs and National Centre for AIDS and STD Control (NCASC) issued two separate letters that stopped free distribution of sterilized syringes. The letter issued by the Ministry of Home Affairs stated that drug consumption was a criminal offence under the law and the program of syringe exchange and injection was also considered a *crime under the law.*[25]

Policies related to IDUs in Nepal

The National Health Policy, 1991 aim to fulfill the commitment of Government of Nepal (GoN), to provide "health for all", however, it does not have any specific provision in regard to drugs user. Similarly, the 20 year Long-term National Health Plan (1997-2017) also does not focus on the emerging problem of HIV and AIDS and associated vulnerability of IDUs to it.

National Policy and strategy on Narcotic Drugs Control, 2006

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, 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. This policy has adopted various strategies like supply control, demand reduction, treatment & rehabilitation, harm reduction, research & development and collaboration, partnership & resource mobilization etc.

The Government of Nepal, in consultation with the United Nations International Drug Control Program (UNDCP), has also formulated a five year (1992-96) **Master Plan for Drug Abuse Control** with the revision of narcotics legislation, expansion of treatment and rehabilitation services, policy formulation in the field of preventive education and information etc. It also proposed two plans, one for 'legislation and law enforcement' and the other for 'treatment, rehabilitation and other demand reduction activities'. It also noticed the lack of availability of detoxification and rehabilitation centers in Nepal. However, the Plan overlooked the linkages of drug abuse with the HIV epidemic, and considered it as an independent problem. The **National Drug Demand Reduction Strategy** (1996-99) was drafted under the Drug Abuse Demand Reduction Project in cooperation with UNDCP in February 1996 "*tocreate, using socio-culturally acceptable strategies, a national climate in which the non-medical use of drugs is virtually non-existent*". The strategy noted the growing nature of drug problem in Nepal, and in the context when drugs were seen as a law and order problem to be dealt by the Ministry of Home Affairs and the Police department. The strategy also emphasised on the need to integrate HIV prevention in drug education and information campaigns. Significantly, the national strategy ***accepted drug maintenance/substitution as a treatment option***. Notably, the ***strategy document recognised the problem of drug dependency in prisons*** and proposed to provide a range of services including oral substitution. It further expressed the need to provide separate facilities for drug dependent women.

National Drug Demand Reduction Campaign – The **National Drug Demand Reduction Strategy** (1996-99) was drafted under the Drug Abuse Demand Reduction Project in cooperation with UNDCP in February 1996. The overall objective of the Strategy is "*to create, using socio-culturally acceptable strategies, a national climate in which the non-medical use of drugs is virtually non-existent*". The strategy noted the growing nature of drug problem in Nepal, and in the context when drugs were seen as a law and order problem to be dealt by the Ministry of Home Affairs and the

[22] Sec. 12, ibid.
[23] Sec. 17, ibid.
[24] Sec. 16, ibid.
[25] *HIV/AIDS and Human Rights: A Legislative Audit* (Forum for Women Law & Development, 2nd edition, June 2004, Kathmandu), p. 16.

Police department, it sought to create a multi-sectoral response by involving other ministries. The policy also form a participatory and autonomous campaign for wider sensitization and awareness on narcotic drugs prevention and control. The campaign also includes providing qualitative treatment, humanitarian services and necessary human resources.

Young women who use drugs have unique needs frequently ignored by conventional HIV programs. This is due to age[26] 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. [27,28] Age, gender and drug use often make young women more stigmatized than their male counterparts.[29] 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.[30] 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. [31,32] Because of the overlap between drug use and sex work, they also are more vulnerable to experiencing police abuse and harsh law enforcement. [33]Young people who use drugs and sell sex are ignored by most donors and programmers. Culturally embedded power imbalances between men and women also expose young women who use drugs to violence and abuse.[34] Gender and cultural norms also influence 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.[35] Young women who use drugs face immense reproductive rights issues. Young pregnant women who use drugs experience harsh treatment from healthcare workers and are often given misleading information about drug use and pregnancy.[36,37] Young mothers cannot access services for fear of losing custody of their children to relatives or the state. Young women may experience forced sterilization or pressure to have an abortion from healthcare workers and family alike.[38] 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.

Prevention

Drug use prevention programmes are effective when they respond to the needs of a community, involve all the relevant sectors and are based on scientific evidence; effective programmes should also incorporate strong monitoring and evaluation components. Such programmes are also cost effective.[39] It has been shown that, good programmes for the prevention of drug use among youth can save a tremendous amount of resources as well as minimizes the vulnerability of young people to HIV infection and susceptibility to drug addiction . For prevention, the national strategy proposed the inclusion of drug education information in the school curriculum for grades 6 to 10 in formal as well as non-formal educational institutions by involving the Ministry of Education. The strategy also emphasised on the need to integrate HIV prevention in drug education and information campaigns in schools and development of appropriate Information, Education and Communication (IEC) materials for demand reduction is another approach.

National HIV/AIDS Strategy (2002-06)

The National HIV/AIDS Strategy (2002-06) recognized the importance of intervention among IDUs and the implementation of the NGO-run 'Harm Reduction Programme' including needle-exchange for IDUs. It also state that the harm reduction approach gives drug users options to reduce the risk of HIV infection and hence espouses positive/affirmative rather than punitive strategies.

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[26] Fletcher A, and Krug A. (2012). Excluding Youth? A global review of harm reduction services for young people. In The Global State of Harm Reduction. London: Harm Reduction International.
[27] Oleárniková, J. (2006). Rola alkoholu a drog pri domácom násilí [The role of alcohol and drugs in domestic violence]. Kosice: Záujmové združenie žien Fenestra. Retrieved April 15, 2012, from http://www.infodrogy.sk/index.cfm?module=ActiveWeb&page=WebPage&DocumentID=1442
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[30] HAARP. (2010). An analysis of gender issues in harm reduction and HIV programming in South-East Asia. AusAID.
[31] Open Society Institute. (2007). Women, harm reduction, and HIV. Open Society Institute.
[32] Pinkham, S. Malinowska-Sempruch, K. (2008). Women, harm reduction and HIV. Reproductive Health Matters, 16(31):168-181.
[33] Eurasian Harm Reduction Network. (2010). Women and drug policy in Eurasia. Vilnius: EHRN.
[34] Gorshkova ID, Shurigina II. (2003). Violence against women in Russian families. Paper prepared for conference. Moscow State University, Lomonosov Women's Soviet. 15-16 May 2003. At www.womenmsu.msu.ru/apendix/bookall.pdf.
[35] UNDOC. (2006). HIV/AIDS prevention and care fo female injecting drug users. Vienna: UNODC.
[36] Pinkham, S. Malinowska-Sempruch, K. (2008). Women, harm reduction and HIV. Reproductive Health Matters, 16(31):168-181.
[37] Babakian G. (2005). Positively Abandoned: Stigma and Discrimination against HIV-Positive Mothers and Their Children in Russia. New York: Human Rights Watch.
[38] Open Society Institute. (2011). Against her will: Forced and coerced sterilization of women worldwide. New York: Open Society Institute
[39] https://www.unodc.org/unodc/en/prevention/

National HIV/AIDS Strategy (2011-16)

The National HIV/AIDS Strategy (NSP) (2007-12) has attempted to meet universal access targets and has also specifically mentioned IDU programs in the prevetion section. It stipulated harm reduction as well as protection of human rights of individual, treatement, care and support which includes strategy on stigma and discrimination reduction, community and home based care, expension of ART etc. It mentioned that the successful harm reduction is based on a policy, legislative and social environment that minimizes the vulnerability of IDUs to HIV infection to help avoid the negative health consequences of drug injecting and improve health and social status. It has also internalizes WHO Harm reduction approaches which focuses on the prevention of HIV and other infections through sharing of non-sterilized injection equipment and drug preparation. In addition, the draft strategy has incorporated Oral Substitution Therapy.

Gaps / barriers

Lack of implementation of policy and program:-One of the major barriers for meeting the goal of addressing the IDU problems in Nepal is the lack of implementation of the existing plan and policies. As reflected above, Nepal has various plan and policies in regard to addressing the issues of IDUs, however, none of these policy are substantially implemented. Not meeting the targets set by the plans and policies and non-implementation of strategies are the major setbacks in Nepal.

Lack of global commitment to harm reduction programs:-Even though there are three major conventions regarding drugs, all of these conventions are basically focused on drug control. Even the objective of these conventions is "Parties to the Convention are concerned with the **health** and **welfare** of mankind, these instruments does not create effective mechanism for its member states and parties accountable for taking positive actions or harm reduction approach for reducing the vulnerabilities of drug users.

No effective implementation of international human rights instruments:- Nepal is a party to various international human rights instruments under which it is accountable to take all necessary measures to protect individual's human rights including right to dignified life, equality and non-discrimination, equal protection of law, special measures for marginalized groups etc. Many of these human rights are also been endorsed by the Constitution of Nepal, however, when it comes to MARP or PLHA, they are suffering various kinds of stigma and discrimination and in the absence of state's actions to address these, their rights are violated.

Lack of right based approach:-Lack of right based approach in interventions made to address IDU problem is another barrier that obstruct in effectively addressing the issue. Even though there are certain policies, which adheres the concept of protecting and promoting human rights of vulnerable population or target group or making right-based interventions, this never turns in to a reality. Programs which are designed to reduce the vulnerability of IDUs like syringe exchange program and oral substitution therapy were not been continued time and again. As a result, IDUs get prone to more vulnerability bringing more problems to be addressed.

Lack of conceptual clarity:-Due to the lack of clarity amongst the governmental officials about the linkages between the harm reduction approach and HIV prevention to drug users, the government officials perceive these kinds of harm reduction programs as a means to encourage crime relating to drugs.

Non-sensitive approach of judiciary:-Drugusersare strictly considered as "criminals" rather than a "victim" by our judiciary.Even though law allowed judges to divert drug users from criminal justice system and lead them towards treatment and rehabilitation, this benefit is rarely been applied by the Supreme Court of Nepal. Moreover, in few of the cases, while using their discretionary powers, the Court has penalized drug users with the strict maximum penalties.

Double standard:-Even though **v**arious policies for addressing the drug problems and related vulnerabilities of drug users has internalizes the increasing trend of human rights violation of drug users, and has somehow attempted to tackle the situation in a positive manner, these policies still uses biased terminologies, like drug addicts, which reflect the existence of double standards amongst the policy makers.

Legal Barrier:-While some harm reduction services are delivered by civil societies, legal barriers still exist which have the potential to disrupt these, or to result in legal reprisals for implementers and those who access the services.

Not following international Guideline:- While a number of harm reduction services for IDUs have been identified, they are not being projected in policies, strategies and national action plans as per the scale requirement recommended by WHO, UNODC and UNAIDS

Lack of M&E System:- M&E systems strengthening related to harm reduction is inadequately reflected in National M&E framework which resulted in inadequate planning and delivery of services and has little ability to measure and manage the quality and effectiveness of those services

Lack of Meaningful involvement:- The details of greater and meaningful involvement of people who use drugs are not identifiable, and as such, it is unclear if people who use drugs contribute to policy development and decision making

Lack of comprehensive services: Very little importance is given regarding harm reduction services in closed settings i.e. prisons and ODT [other drug treatment] facilities

Lack of gender sensitivity in services: 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. The 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 including legal ID and documentation.

Commitments and Recommendations

Policy Reform:- Legal and policy reform is essential to facilitate delivery of comprehensive harm reduction services as per the recommendation by WHO, UNODC and UNAIDS

Development of strategic and action plan:- Development of National Harm Reduction Strategy and coasted plan of actions Drug strategy should move towards a state of synergy with National HIV and AIDS strategies.

Need for more awareness raising programs:- HIV and drug education in school curriculum for grades 6 to 10 and information about HIV/AIDS in the health education book for grades 9 & 10 is one of the effective means of raising awareness of the school going children. However, it doesn't reach up to the non-school going children, so IEC materials having information about drugs and harm reduction program, HIV and other preventive measures need to be developed and disseminated widely to the non-school going children. Similarly, awareness programs should also target law and policy makers, and its implementing agencies.

Conceptual clarity:-National and international body related to drugs are guided by control and criminal perspective. There is necessary to clarified harm reduction and OST, Syringe exchange evidence in preventing HIV among drugs users.

Supportive legislation:-Various programs related to drugs users can only be effective if supportive legislation, policies are in place. Moreover, it is also necessary to prevent marginalization of drug users, eradicate stigma and discrimination, and ensure respect for human rights. Legislation should cover access to correctional settings, to sterile injection equipment, OST etc as essential components of comprehensive HIV prevention and care.

Drugs programs as Comprehensive HIV Program:-The drugs related program should be come with as essential components of comprehensive HIV prevention and care. More over all drug users including all marginalized populations have equitable access to quality HIV prevention, medical care, and highly active antiretroviral treatment. Also approach to drug use as a health and social matter also requires some effective implementation of policy and programs and compatibility with global programs:

Meaningful involvement:-there should policy or legal framework which state meaningful involvement of drug users at all levels of planning and policy, and financial support for their organizations.

Monitoring Mechanism:-there should be a set up which can check the standard of law and policy, institutional mechanism, stigma and discrimination This set up also can measure human rights violations of drug users like degrading drug treatment programs, diversion from criminal justice system.

Harm reduction approach:-there should be global policy toendorse and promote harm reduction as an approach consistent with those treaties and monitor global delivery of substitution treatment and HIV prevention measures for drug users;Ensure that effective community protection against HIV is not ignored in the name of drug control and law enforcement;

National Harm Reduction strategic Guideline:- there is clear gap harm reduction guideline in the country although Nepal is pioneering introducing harm reduction program. Country most develop clear and specific National Harm Reduction guideline to provide guidance to deliver quality of the service in the country.

Gender Sensitivity:- We must start having honest conversations about reaching young women who use drugs that moves away from a victimization approach and instead focuses on the critical question of *how do we provide young women with the best possible health care ?* We 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 and they must allowed to feel safe and supported to discuss their issues and be encouraged to speak and address the human rights violations they frequently experience. We must create an environment that is friendly for young women and must also have links with women's shelters, domestic violence and rape prevention services.

Appendix- History of Oral Substitution

A Methadone Maintenance Clinic (MMC) was initiated as a pilot program at Patan Mental Hospital, Lagankhel for the first time, In 1995 rendering Nepal to be the first country to implement the MMT program in the south Asian region. Even though the program implementation had satisfactory results, in the absence of policy guidelines to run such a clinic as well as the lack of coordination between the Ministry of Home Affairs and Ministry of Health and Population; it was discontinued in 2002, as Methadone comes under a Schedule A of the Drug Act, 2035 B.S., it requires the approval of Ministry of Home Affairs for importation into the country .

With the support of International Nepal Fellowships (INF), in Pokhara, another oral drug substitution program using Buprenorphine was run by an NGO, NauloGhumti. However, this project was also stopped after the withdrawal of permission from the Ministry of Home Affairs. Again, on the 15th of 2007, the Ministry of Home Affairs officially launched a new OST (Methadone Maintenance and Treatment Program, MMT) through support from United Nations office on Drugs and Crime (UNODC), in TU Teaching Hospital and later expanded to Kaski and Lalitpur districts.

Moreover, this time the government allowed the private sector/NGO to operate OST, which allowed an NGO named Youth Vision to successfully pioneer the Buprenurphine OST services. In 2013 Ministry of Home affairs endorsed a Policy guidelines on OST. Furthermore, MoHA has authorized MoHP to provide Technical Assistance in implementing MMT program to other districts under the Global Fund. This is positive initiative enabled the Ministry of Home Affairs and Ministry of Health and Population two ministry related IDUs sharing responsibilities. Even with the delegation of authority, the scaling up of MMT has not been effective as anticipated.

Concern institution: