Tunisian Republic

Ministry of Health
Directorate General of Health

Ministry of Justice
Directorate General of Prisons and Rehabilitation

Strategy document

National strategy for prevention, harm reduction and management of substance use disorders in the community and in prisons.
2021- 2025

"A health and human rights response to drug use"

Draft document prepared by UNODC consultants :

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PREFACE

Nine years after the revolution of 14 January 2011, Tunisia, a young democratic state, has not yet finished witnessing the political upheavals perpetuated by a lingering economic and social crisis that offers all the conditions for young people, with or without university diplomas, but without jobs, to find refuge in drugs!

Indeed, the use of illicit drugs is increasingly visible, the use of traditional or "vaping" tobacco as well as alcohol is reaching younger and younger groups and is increasingly publicly displayed by the female gender, which was previously much more discreet.

This development has taken place despite a legal context that is still rigid and repressive towards the simple user of any illicit psychoactive substance, thus perpetuating the social stigmatisation of these vulnerable people.

The lack of training for carers, the absence of dedicated structures for the care of addicts who often have specific needs, and the absence of a prior organisation or strategy for prevention and care dictated by a national "drugs" policy, This is in addition to the apprehension of users to turn to general care structures, which are usually themselves contaminated by the stigma attached to them, leading to the exclusion from the social circuit of these sick citizens, who are also in socio-economic difficulty and who often end up being locked up in penal institutions.

However, given that the vast majority of these subjects come from the "adolescents and young people" fringe, theoretically reputed to be the most productive and innovative, it is in fact a significant part of the strike force of an entire country that is excluded!

In order to prevent and avoid such a mess in Tunisia, the Ministry of Health has joined forces with the Ministry of Justice to request the support of the UNODC in building, like many other countries, the first national strategy for prevention, harm reduction and care of people with substance use disorders.

The draft strategy proposed below will necessarily involve the various ministries concerned with drug supply reduction and demand reduction, alongside stakeholders from the private sector and civil society.

The implementation of each partner's action plan will necessarily require coordination with other partners if the strategy is to achieve its target. The idea of an inter-ministerial coordination mission within the Presidency of the Government has been adopted in some countries that have been confronted with the scourge of drugs for decades.

ACKNOWLEDGEMENTS

The National Strategy for Prevention, Harm Reduction and Management of Substance Use Disorders in the Community and in Prisons 2021 - 2025 was developed on the basis of joint efforts of the Ministry of Health and the Ministry of Justice, with the participation of stakeholders including civil society and international partners.

The Ministry of Health and the Directorate General of Prisons and Rehabilitation (DGPR) would like to thank all the stakeholders who contributed to the development of this document, through participation in the workshops and review of the various draft documents. Thanks are also due to the members of the project's Monitoring and Coordination Committee for their interest and dedication which were essential at all stages of the strategy's development.

The General Directorate of Prisons and Rehabilitation and the Ministry of Health express their gratitude to UNODC for its support to Tunisia, and in particular for the development of the national strategy for prevention, harm reduction and management of substance use disorders.

They also express their gratitude to the MedNET/Pompidou Group of the Council of Europe for supporting the many training, epidemiological, prevention and care activities that have largely paved the way for the development of this strategy.

They also express their gratitude to the consultants, Dr Fabienne Hariga and Dr Nabil Ben Salah, for their efforts in ensuring the preparation of this document.

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ACRONYMS

ATIOST Tunisian Association for Information and Orientation on AIDS and Drug Abuse
ATLS MST Sida Association Tunisienne de Lutte contre les MST et le SIDA
ATUPRETAssociation Tunisienne de Prévention de la Toxicomanie
CMYAMU Mahmoud Yacoub Centre for Emergency Medical Assistance
CCC Behaviour Change Communication
CCDAG Centres de Conseil et de Dépistage Anonyme et Gratuit
CoE Council of Europe
UIC Unique identifier code
CNLS National AIDS Control Committee
CRLS Regional AIDS Centres
CSU Universal Health Coverage
DGPR Directorate General of Prisons and Rehabilitation
DMSU Directorate of School and University Medicine
DPM Directorate of Pharmacy and Medicines
DSSB Directorate of Basic Health Care
EP Peer Educator
Global FundGlobal Fund to Fight AIDS, Tuberculosis and Malaria
Gp Pompidou Cooperation Group to Combat Drug Abuse and Illicit Trafficking IBBS
Integrated Biological and Behavioural Survey (IBBS) Sero-behavioural surveys
CCM National Coordination Mechanism
INS National Institute of Health
STIS Sexually Transmitted Infections
ME Ministry of Education
MedNET Network for the exchange and coordination of drug use prevention in European and Mediterranean countries
MedSPAD Mediterranean School Survey Project on Alcohol and Other Drugs
MS Ministry of Health
SDO Sustainable Development Goals
OMNE National Observatory of New and Emerging Diseases
WHO World Health Organization
ONFPOffice National de la Famille et de la Population
NGO Non-governmental organisation
UN United Nations system organizations
UNODC United Nations Office on Drugs and Crime
UNAIDSJoint United Nations Programme on HIV/AIDS
CSOS Civil Society Organisation
PAS Syringe Access Programme
AAPA African Union Plan of Action on Drug Control and Crime Prevention
PC Key population
CEP Taking charge
PEP Post-Exposure Prophylaxis
National AIDS and STI Programme
NTPNational Tuberculosis Control Programme
PSNLS National Strategic AIDS Plan
PMTCT Prevention of mother-to-child transmission of HIV
RoR Harm reduction
M&E Monitoring and evaluation
AIDS Acquired immunodeficiency syndrome

SWOT	*Strengths/Weaknesses/Opportunities/Threats* (Strengths/Weaknesses/Opportunities/Threats)
CAT	Opioid agonist treatment
ART	Antiretroviral treatment
TB	Tuberculosis
OST	Opiate substitution therapy
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus

1 INTRODUCTION

Tunisia has for the first time adopted a strategy for prevention, harm reduction and management of drug-related disorders. This strategy covers the period 2021-2025.

2 METHODOLOGY

The development of the national strategy was carried out in different stages through a participatory approach of actors from the governmental and non-governmental social and health sectors.

2.1 Review of the situation

A national and international literature review was carried out in order to gather the necessary information to support the discussions for the development of the strategy. This literature review made it possible to outline the current situation in Tunisia and to identify the various national strategies related to the issue of drugs and health, as identified in international recommendations. The document *"UNODC (2019) Development of a national strategy for prevention, treatment and risk reduction for drug use in the community and in prisons in Tunisia.* Review of the national and international literature[1]". This document constitutes the first part of the strategy paper.

2.2 Consultations

A workshop, bringing together representatives from different government sectors as well as civil society, including community representatives, took place from 3-5 July 2019 in Tunis to develop a first draft of the strategy (see list of participants and agenda in annex). During the workshop, participants reviewed the current state of play, carried out a SWOT analysis, reviewed the international guidelines and identified specific priorities and objectives for each of the areas covered by the strategy.

On the basis of these contributions, a first version of the strategy document was developed.

The strategy was validated during a workshop, organised by the Technical Committee for the Fight against Drug Addiction and Addictive Behaviours, which was held on 26 June20 20 at the Razi Hospital in Manouba.

The overall development of the national strategy was supported by two consultants, one international and one national.

- *Prioritised actions* based on needs - assessed on the basis of strategic information - cost-effectiveness of actions and feasibility in the current country context.
- *A strategy aims to respond equitably and appropriately to the needs of all people who are affected by - or use - drugs, regardless of their age, gender, origin and legal status, including people in conflict with the law and people in prison.*

3 SITUATION

3.1 Drug use situation and health consequences

In the absence of a national observatory for drugs and dependence, and of funding for research and monitoring, data on the use of illicit drugs in Tunisia are limited and do not provide an overall picture of the situation. According to data from the World Drug Report[2], in 2013, among the population aged 15-65, the prevalence of cannabis use was estimated at 2.6%, that of opiate drugs at 0.13% and that of tranquillisers at 0.52%.

[1] Hariga F., Ben Salah N. *Development of a national strategy for prevention, treatment and risk reduction for drug use in the community and in prisons in Tunisia.* Review of national and international literature. UNODC. 2019

[2]UNODC World Drug Report - Data. https://dataunodc.un.org/drugs/prevalence_table

3.1.1 Drug use among young people in school

National MedSpad studies were conducted, with the support of the MedNET/Pompidou Group of the Council of Europe, in schools in 2013 and 2017 among young people aged 15-17 years[3].

In 2017, almost a third (31%) of secondary school students aged 15-17 reported having used a drug other than tobacco and alcohol at least once in their lifetime, compared to almost a quarter (24.6%) in 2013. This prevalence was significantly higher among boys (36.5% vs 27.7% in 2017).

In this second survey, 3.8% of students reported having used cannabis at least once in their lifetime, 3.8% glue, 3.0% non-prescription psychotropic drugs, 1.4% Ecstasy and less than 0.4% cocaine and buprenorphine (Subutex®)[4]. The figures observed in 2017 show an upward trend compared to 2013, but these figures are lower than those observed in other countries of the Mediterranean region.

Table 1 Drug use among schoolchildren aged 15-17 (MedSPAD surveys 2013 and 2017)

	2013		**2017**	
Consumption at one time	**During the course of a lifetime**	In the last month	**During the course of a lifetime**	In the last month
Cannabis	**1,5%**	0,4%	**3,8%**	1,5%
Non-prescription drugs	**2,1%**	0,7%	**3,0%**	1,1%
Ecstasy	**0,2%**	0,15%	**1,4%**	0,4%
Cocaine	**0.5%**	0.16%	**0,4%**	0,2%
Buprenorphine (Subutex®)	**ND**	NA	**0,2%**	0,1%
At least one substance other than tobacco and alcohol	**24,6% [22,6 - 26,7]**		**31,0% [29,18-32,8]**	

There are regional variations, with the highest figures generally reported in the Tunis district.

A cross-sectional study conducted in 2013 among a representative sample of 1002 students at the University of Tunis El Manar, showed a prevalence of illicit drug use of 6%, 14% among men and 1.8% among women[5].

In a tobacco use prevalence survey conducted in 2016 among a representative sample of school youth aged 13-15 years *in* Tunisia 19.2% of boys and 4.6% of girls reported being current tobacco users[6][7].

[3] Ministry of Health - National Institute of Public Health - Co-operation Group on Drug Abuse and Illicit Trafficking MedSPADII Results of the national survey MedSPAD II (Mediterranean School Survey Project on Alcohol and Other Drugs) https://rm.coe.int/2017-ppg-med-41-medspad-tunisia-report-fra/16808cbf44

Ministry of Health - Directorate of School and University Medicine, Pompidou Group (2014). MedSPAD survey in Tunisia RESULTS OF THE NATIONAL SURVEY August 2014 (Conducted in November 2013) Council of Europe. Strasbourg (2014) https://rm.coe.int/resultats-de-l-enquete-nationale-aout-2014-realisee-en-novembre-2013-r/168075f761

[4]Buprenorphine used in oral form as an agonist drug for the treatment of opiate dependence does not yet have the AMM in Tunisia, is obtained through trafficking and is diverted from its intended use, solubilised in a rudimentary way and injected by the venous route).

[5] COE Pompidou Group (2014) Tunisia DRUG SITUATION AND POLICY. https://rm.coe.int/situation-et-politique-en-matiere-de-drogues-par-pr-hajer-aounallah-sk/168075f2a5

[6]Global Youth Tobacco Survey, 2017. https://extranet.who.int/ncdsmicrodata/index.php/catalog/355

[7]Ministry of Public Health, UNFPA (2017) Review of national health programmes targeting adolescents and youth in Tunisia. http://www.santetunisie.rns.tn/fr/toutes-les-actualites/729-revue-des-programmes-nationaux-de-sant%C3%A9-ciblant-les-adolescents-et-les-jeunes

3.1.2 Intravenous drug use

3.1.2.1 The size of the population

There are no data on the prevalence of injecting drug use for the whole country. With the support of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF), *Integrated Biological and* Behavioural Surveys (*IBBS*) were conducted in 2009, 2011, 2014 and 2017.

In 2017, the estimated number of intravenous drug users was 9,800 in the governorates of Tunis and Bizerte alone (IBBS 2017).

The first population size estimate conducted in 2009 (including Tunis, Bizerte, and Sousse/Monastir) indicated a figure of 7,000 injecting drug users. In 2015, a mapping of the IDU population conducted in the coastal regions identified hotspots frequented by IDUs. This mapping identified a high number of sites identified as hotspots compared to sites identified as hotspots for other key populations (CPs). Once again, the Greater Tunis area is identified with the highest number of hot sites. The mapping also revealed that intravenous drug users have few relationships with other key populations (CPs). The study also reports that a significant number of intravenous drug users are engaged in sex for money.

A new population size estimate was conducted in 2014 in the governorates of Tunis and Bizerte. These data were updated in 2017 for these two regions (see Table 2 Results of sero-behavioural surveys among the population of).

No women were included in the surveys and estimates conducted in 2011, 2014 and 2017 and there is no information on female intravenous drug users.

3.1.2.2 Substances consumed intravenously

On the basis of the survey results, the main substance injected is buprenorphine (Subutex®), reported to have been used in the last month by 96.7% of respondents in 2017. The other much less frequent drugs are mainly morphine (14.7%), cocaine (3.9%) and heroin (2.4%).

3.1.2.3 Age of first injection

The data collected in 2017 indicate that almost a fifth (19.6%) of respondents injected drugs before the age of 15, and almost half between the ages of 15 and 19. These figures are stable compared to those collected previously.

3.1.2.4 Risk behaviours for HIV and hepatitis

According to the IBBS data, intravenous drug users report little sharing of injection equipment. In 2014 and 2017, 88.6% and 90.9% of respondents (compared to 78% in 2009) reported using a sterile syringe during the last injection. The low percentage of reported sharing of injecting equipment at the last injection - or in the last month (80%) - is surprising given the increased prevalence of HIV, and these figures should be interpreted with caution.

Table 2 Results of sero-behavioural surveys among the population of intravenous drug users

	2009	2011	2014	2017
Population size (localities)	7000 (Tunis, Bizerte, Sousse/Monastir)	7000 (Tunis, Bizerte)	9000 (Tunis, Bizerte)	9808 (Tunis, Bizerte)
Condom use at last sexual intercourse	35%	19.30%	22.2%	25.9%
Use of a sterile syringe for the last injection	78.30%	87.70%	88.6%	90.9%
Sex in exchange for money			6.5%	3%

Furthermore, condom use is low, with only a quarter of respondents having used a condom during their last sexual encounter. In 2017, 3% of injecting drug users in the survey reported having sex for money.

3.1.3 Claims for treatment for addiction

In the absence of substitution treatment (OST), injecting drug users turn to the various withdrawal options available that are not suitable for the treatment of opiate dependence. The results of the IBBS 2017, showed that slightly less than a third (32.5%) of intravenous drug users have undergone detoxification in various specialised or non-specialised, private or public care structures

The number of detoxification attempts, among those who tried at least once, ranged from 1 to 20, with an average number of 2.4

3.1.4 Health consequences

The use of illicit psychoactive substances can have a variety of adverse health consequences such as infectious (local or general), cardiovascular or toxic.

3.1.4.1 HIV prevalence

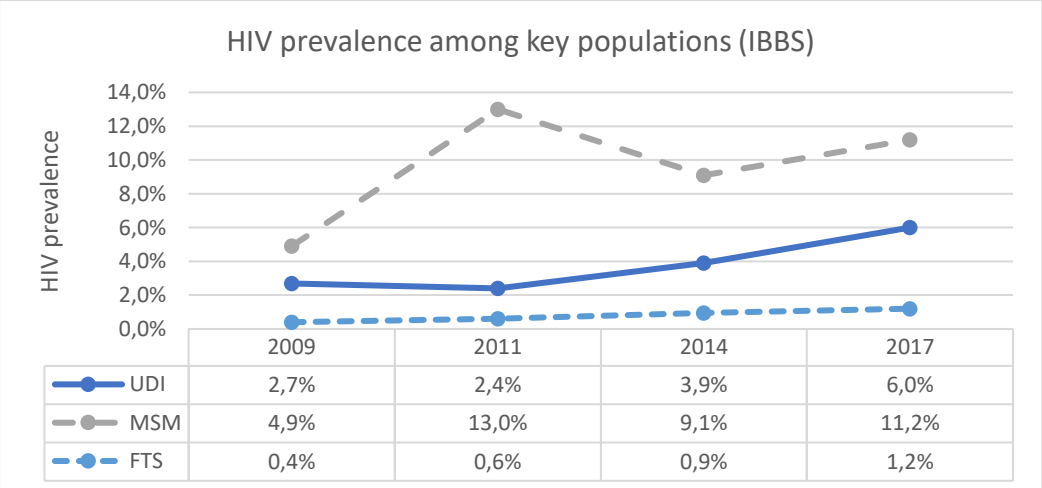
Tunisia has about 3,000 people living with HIV or HIV prevalence <0.1%, with epidemics concentrated in key populations (CPs): men who have sex with men (11.2%), injecting drug users (6%) and female sex workers (1.2%). Since 2010, the number of new HIV infections has increased by 12% and the number of deaths by 242% (UNAIDS, 2018).

HIV prevalence is increasing among all CPs, but among injecting drug users the increase is highest, from 2.4% in 2011 to 6% in 2017.

Table 3. Prevalence of HIV, hepatitis B and C infections among injecting drug users I (IBBS)

	2009	2011	2014	2017
Prevalence of HIV infection	3.1%	2,9%	3,9%	6%
Prevalence of HBV infection	3.1%			
Prevalence of HCV infection	29.1%			29%

Figure 1 HIV prevalence among injecting drug users and other key populations (2009 - 2017)



3.1.4.2 Hepatitis B and C

The National Viral Hepatitis Prevalence Survey (ONMNE), conducted in 2014-2015 shows that the prevalence of hepatitis C in the general population was estimated at 0.87% (one third of cases are reported in the North West region) and that of hepatitis B (HBsAg surface antigen carriers) was 1.8%.[8] According to the same survey, the prevalence of hepatitis C antibodies (anti-HCV) among intravenous drug users was 3.7% [1.8 to 7.5%] and 2.7% [1.3 to 5.6%] among non-injection drug users. The probability of drug users being carriers of hepatitis C antibodies was 10.8 compared to the general population (adjusted Odds Ratio 10.8 [3.93-29.61]).

According to the IBBS surveys, the prevalence of hepatitis C was 29% among injecting drug users in 2017 and stable compared to 2009. The prevalence of hepatitis B in 2009 was estimated at 3.1%. (See Table 3. Prevalence of HIV, hepatitis B and C infections among injecting drug users I (IBBS).

In addition, these same surveys have shown the low coverage of vaccination against hepatitis B in this population of intravenous drug users (0.8% in 2014 and 2.3% in 2017).

3.1.4.3 Tuberculosis

Tunisia is an intermediate endemic country with a recorded incidence of 29/100,000 inhabitants in 2017, of which 38% is pulmonary tuberculosis (TB) and 62% extra-pulmonary TB. The prevalence of multidrug resistance is estimated at 0.8% among new cases and 12% among retired cases.

The prevalence of TB among prisoners is estimated to be 300/100,000 prisoners, but there are no precise data. There are no data on TB among intravenous drug users.

In 2016, there were an estimated 28 new cases of TB among people living with HIV (20 in 2015 and 18 in 2014) and 9.9% of PLHIV newly enrolled in antiretroviral therapy (ART) had active TB (UNAIDS, 2018).

3.1.4.1 Drug-related deaths

There are no data on deaths due to overdose or other drug-related causes.

3.1.5 Drug users detained in prison

Law 52-92 on narcotics obliges courts to impose a minimum sentence of one year's imprisonment - five years for repeat offenders - on anyone convicted of using or possessing an illicit drug. In May 2017[9], Article 12 of Law 52-92 was abolished, allowing judges to use their discretion in the case of a first offence and to allow the accused to benefit from mitigating circumstances, without an automatic prison sentence. Nevertheless, the law remains essentially punitive and is responsible for the large number of drug users in prison.

In October 2017, 20,755 people (incarceration rate 181/100,000 inhabitants) were detained in 27 facilities, including 2.8% women and 52% remand prisoners. (World Prison Brief[10]) This total number of people in prison is a slight decrease compared to 2013 (around 25,000).

However, the proportion of people detained for drug-related offences (Law 92-52) remains stable and is estimated at around 30% of all prisoners. According to data from the Ministry of Justice in February 2017, the number of prisoners under Law 92-52 is 6854.

According to the results of the IBBS surveys, about four-fifths of intravenous drug users have had at least one experience in prison (see Table 4 Intravenous drug users and prison experience (IBBS)).

[8] National Observatory of Emerging Diseases. April 2016. Presentation of the results of the National Survey on the Prevalence of Viral Hepatitis A, B & C in Tunisia, 2015-2016 https://www.infectiologie.org.tn/pdf_ppt_docs/congres2016/1/22042016_Resultats-Enquete-Nationale-des-hepatitesViralesTunisie.pdf

[9] Law No. 2017-39 of 8 May 2017, amending Law No. 92-52 of 18 May 1992, on narcotics https://legislation-securite.tn/fr/node/55814

[10] World Prison Population Brief. Tunisia. http://www.prisonstudies.org/country/tunisia accessed 4 April 2019

A fifth of the respondents (21.8%) reported having injected drugs in prison and about 7% having had sex.

Table 4 Intravenous drug users and prison experience (IBBS)

	2009	2011	2014	2017
Staying in prison			80.7%	77%
Injection in prison			18.4%	21.8%
Sex in prison			7.8%	6,7%

There is no accurate data on the prevalence of HIV and hepatitis in prisons. Data from programmes implemented in prisons in 2015 indicated a prevalence of 0.1% for HIV.

4. PURPOSE, OBJECTIVES, VISION AND VALUES

The aim of this document is to provide a common framework to guide, coordinate, monitor and evaluate all prevention, harm reduction and drug use disorder activities and initiatives for both the community and the prison population.

The Vision

The Tunisian Republic aims to implement an effective and equitable health system for the entire population. This strategy embraces this vision, based on national and international principles, and aims to reduce the risks associated with drug use ~~by 50% by 2030~~ by ensuring universal access to prevention, harm reduction and treatment services and quality care.

General objective

The main objective of Tunisia's strategy for [prevention, harm reduction and treatment of drug use disorders in the community and in prisons] is to promote health and improve the well-being of the whole community, families and individuals through the prevention and management of health problems related to drug use, by reducing exclusion and facilitating the integration of people affected by drug use into the social and health system

Values

Health is a fundamental and inalienable human right

Drug-related risks are a public health problem that requires a health and social sector response based on scientific evidence, human rights and gender-specific needs.

General principles

The following general principles underpin the development, implementation and monitoring of the strategy

- *Evidence-informed strategy and actions: implementing* interventions that have been scientifically evaluated to be effective by international standards
- *A person-centred strategy: it emphasises* respect for the individual, his or her needs and resources, to make him or her an actor in his or her own health
- *Participatory and multi-sectoral:* ensuring the meaningful engagement of all stakeholders, including civil society and communities, in its development, implementation, monitoring, evaluation and review.

5. GUIDING PRINCIPLES

5.1 National benchmarks

The right to health is recognised by the ***Tunisian Constitution*** and by several international legal instruments ratified by Tunisia. Article 38 of the new Tunisian Constitution, adopted by the National Constituent Assembly in January 2014, states that

"Every human being has the right to health. The state guarantees prevention and health care to every citizen and ensures the necessary means for the safety and quality of health services. The State shall guarantee free health care for those without support or sufficient resources. It shall guarantee the right to social coverage in accordance with the law.[11]

The ***National Health Policy Project to 2030***

The project, which is still under development, aims to bring Universal Health Coverage (UHC) [12]to the Tunisian population. Three main axes have been identified to achieve UHC: (1) Putting the citizen at

[11] http://www.legislation.tn/sites/default/files/news/constitution-b-a-t.pdf

[12] Defined as "the whole population has access to the preventive, curative, rehabilitative and health-promoting services they need. These services are of sufficient quality to be effective, without their cost causing particular financial hardship to users".

the centre of the system; (2) Making access to health services more equitable; and (3) Ensuring the protection of citizens' health through multisectoral approaches, concrete measures and coordination and monitoring mechanisms, (particularly in the field of addictions) in order to develop a basis for health promotion and the development of the individual and collective skills required for it.

The National Strategic Plan for the Response to HIV/AIDS and STIs 2019-2022

The 2018-2022 AIDS and STI[13] strategic plan, which focuses on key populations including injecting drug users and people in prisons, includes harm reduction for injecting drug user populations. It has four outcomes:

1. New HIV infections are reduced by 60% by 2022
2. HIV-related mortality is reduced by 60% by 2022
3. The quality of life of PLHIV and vulnerable populations is improved through the integration of human rights and gender
4. The national HIV response is sustainable and coordination is strengthened towards accelerating HIV elimination by 2030

The National Hepatitis C Elimination Plan 2016-2030 [14]

The national plan includes targeted testing of high-risk areas and populations, including drug users and people in prisons. The goal of the national plan is that 90% of drug users who are carriers of the hepatitis C virus know their status, 90% of those diagnosed with hepatitis C are treated for hepatitis C and 90% of those are cured in a sustained manner.

The National Strategy for Mental Health Promotion (SNAPSAM) 2013[15]

This strategy identifies three main areas

- Issue 1: Mental Health is perceived and undertaken by decision makers, professionals and citizens as an investment that supports development

Under this issue are objectives related to the rights of people affected by mental health problems, the need for a multi-sectoral approach and capacity building of civil society on mental health promotion issues. There are also objectives related to a better knowledge of the extent of the problems through the production, analysis and use of data for monitoring and evaluation and also to "better identify the risk factors for health and improve the methods of diagnosis and care" through the establishment of a scientific council for mental health and a research programme integrating epidemiological studies, on vulnerable populations, quality, health promotion, drug addiction, violence, addictive behaviours, social determinants as well as economic studies

- Issue 2: Mental health promotion, focused on the needs of the population, is undertaken jointly and effectively by all actors

Its objectives include improving access to information, counselling and support services (2.2) by strengthening specific programmes, particularly for populations vulnerable to addiction and substance abuse, through coordination with those responsible for the national strategy to combat drug addiction in order to integrate issues relating to mental health and the prevention of drug addiction through the strengthening of universal prevention and care provision (2.2.1.3)

- Issue 3 The health system provides comprehensive and quality care for patients with mental disorders/illnesses, including first-line diagnosis and referral, access to comprehensive

[13] Ministry of Health. Direction des Soins de Santé de Base (DSSB). National Programme for the Fight against AIDS and Sexually Transmitted Infections. (2018) *National Strategic Plan for the response to HIV/AIDS and STIs 2018-2022*.

[14] Ministry of Health. National Observatory of New and Emerging Diseases (OMNE). Registre des Hépatites Virales: Plan National d'Élimination de l'Hépatite Virale C. http://onmne.tn/fr/dossiers_thematiques.php?id_rub=4&id=122

[15] Republic of Tunisia. Mental Health Promotion Unit. (20013) The National Strategy for Mental Health Promotion (SNAPSAM)

outpatient care, with social support, combating stigma, and encouraging deinstitutionalisation, notably by reducing psychiatric hospitalisation.

5.2 International benchmarks

The Prevention, Harm Reduction and Care Strategy 2021-2025 is aligned with various global and regional international instruments.

- The *United Nations Universal Declaration of Human Rights, 1948*[16]
- *The international conventions on narcotic drugs*. The "Single Convention on Narcotic Drugs" of 1961, as amended by the "Protocol of 1972 amending the Single Convention on Narcotic Drugs of 1961", has largely established the control system with a view to the welfare and health of mankind. The third convention, the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988, essentially addresses the problems of drug trafficking. These three international conventions on narcotics are enshrined in various Tunisian laws enacted in 1964, 1976 and 1990[17].
- The *2030 Agenda for Sustainable Development* (SDP) and its 17 Sustainable Development Goals (SDGs) adopted in September 2015 by the United Nations General Assembly. Three goals, SDGs 3.3, 3.5 and 3.8, are directly related to prevention, treatment and harm reduction related to drug use. Other specifically relevant goals include MDG 5 on achieving gender equality and empowering all women and girls; MDG 10 on reducing inequality; and MDG 16 on promoting peaceful and inclusive societies for sustainable development, providing access to justice for all and building effective, accountable and inclusive institutions at all levels.
- The Outcome Document[18] of the *United Nations General Assembly Special Session on the World Drug Problem* (UNGASS 2016). "Our shared commitment to effectively address and combat the world drug problem" adopted in April 2016. This declaration stresses the importance of a human rights-based and health-oriented drug policy and recalls the three conventions that form the basis of international drug policy. It provides recommendations organised in seven chapters. The 2021-2025 strategy is particularly aligned with Chapters 1 and 2. 4.
- The Political Declaration "Accelerating the response to combat HIV and end the AIDS epidemic by 2030" adopted in June 2016 at the UN *High Level Meeting to End AIDS where* Member States reiterated their commitments to the UNAIDS Strategy 2016-2021 to end AIDS by 2030 and committed to "accelerate the response to HIV and AIDS by 2020".
    - Reduce the number of people newly infected with HIV to less than 500,000 per year.
    - Reduce the number of people dying from AIDS-related causes to less than 500,000 per year.
    - Eliminate HIV-related stigma and discrimination.
- The *United Nations Standard Minimum Rules for the Treatment of Prisoners* (Nelson Mandela Rules) adopted in December 2015, in particular the chapters on the organisation and provision of health care and the chapter on human rights. A/RES/70/175. https://undocs.org/fr/A/RES/70/175.
- The United Nations *Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders* and comments. (GA resolution 65/229, annex) https://www.unodc.org/documents/justice.../UNODC_Bangkok_Rules_FRE_web.pdf.

Policy developments at regional level

Agenda 2063, 'The Africa We Want' adopted by the African Union in 2015. The AU's First Ten-Year Implementation Plan for Agenda 2063[19], which calls under Aspiration 1 for "A prosperous Africa based

[16] https://www.un.org/fr/universal-declaration-human-rights/index.html

[17] Law n°64-26 of 28 May 1964 ratifying the 1961 single convention on narcotics.; Law n°76- 41 of 12 May 1976 ratifying the protocol amending the 1961 single convention on narcotics. ; Law n°90-67 of 24 July 1990 to ratify the United Nations Convention against illicit traffic in narcotic drugs and psychotropic substances.

[18] https://www.unodc.org/documents/postungass2016/outcome/V1603302-F.pdf

[19] https://www.un.org/fr/africa/osaa/pdf/au/agenda2063-frameworkf.pdf

on inclusive growth and sustainable development" under Goal 3 "Healthy and well-nourished citizens". Healthy and well-nourished citizens'. The targets for 2063 include

- (a) Achieve universal access to quality health care and services by 2063 ;
- b) Eliminate all communicable diseases by 2030;

(c) Reduce to zero deaths from HIV or AIDS, malaria, tuberculosis by 2030

The African Union Action Plan on Drug Control and Crime Prevention (AUPA) 2019-2023. The AUPA has 8 chapters, the first of which is III Key priority areas A. Implemented drug demand reduction measures and address drug-related health problems, which includes the following four objectives

- A.1 Prevent drug use among all age groups, men and women, and young people at risk, by applying scientific evidence on prevention.
- A.2 Strengthen capacity for drug use disorder treatment, rehabilitation, recovery and social reintegration.
- A.3 Reduce the harm associated with drug use.
- A.4 Implement alternatives to punishment for drug use, promote proportionality in sentencing for drug offences, and provide services for drug users in conflict with the law.

6. STRATEGY

The national strategy for the prevention, reduction of harm and management of substance use disorders in the community and in prisons is structured around four vertical and two cross-cutting areas.

Vertical areas	**1. Health promotion and drug prevention**
	2. Harm reduction related to drug use
	3. Therapeutic management of substance use disorders
	4. Support for socio-professional integration
Cross-cutting areas	**5. Creating an enabling environment for access to services**
	6. Generate, analyse and use strategic information

In addition to the document review, which, based on the available data and information, provides an overview of the drug use situation and response,[20] the participants in the development workshops carried out an analysis of strengths, weaknesses, opportunities and risks (SWOT analysis - Strengths, Weaknesses, Opportunities, Threats) for each of the areas.

6.1 Health promotion and drug prevention

The analysis of the situation made it possible to highlight the achievements and identify the priorities for the strategic plan.

6.1.2 SWOT analysis

The 2017 review of programmes targeting adolescents and young[21] people had already identified, among the weaknesses, the coverage limited to a restricted age group, to the school environment, limited geographically, the lack of evaluation and monitoring, and the lack of coordination and linkage with care structures and the lack of involvement of other governmental and non-governmental actors.

During the consultation workshops participants identified the strengths, weaknesses and opportunities described in the table below.

Table 5Prevention - SWOT analysis

Forces	Weaknesses
• The "Life skills development for the promotion of healthy lifestyles /Substance abuse prevention in schools" programme for secondary school students (13-15 years) • First year of awareness raising and training of Scout peer educators (PEs) (16-18 year olds) in drug use prevention throughout the country	• Coverage of the life skills development programme limited to in-school youth, aged 13-15 years • Geographical coverage of the life skills development programme limited to Greater Tunis

[20] See Hariga F., Ben Salah N. *Development of a national strategy for prevention, treatment and risk reduction for drug use in the community and in prisons in Tunisia.* Review of national and international literature. UNODC. 2019

[21] Ministry of Public Health, UNFPA (2017) Review of national health programmes targeting adolescents and youth in Tunisia. http://www.santetunisie.rns.tn/fr/toutes-les-actualites/729-revue-des-programmes-nationaux-de-sant%C3%A9-ciblant-les-adolescents-et-les-jeunes

• Development of a population of school doctors and teachers trained in the prevention/promotion of youth health (training under the Colombo Plan project supported by the US State Department) • The 2017 review of programmes targeting adolescents and young[22] people, • National Campaign Project - "No to Drugs" project	• One-off actions that are not sustainable and have no follow-up. • No evaluation of the school-based drug prevention project and no follow-up of prevention interventions; • Lack of substance use prevention/life skills development project for out-of-school youth • The impact of addiction strategies and programmes is unsatisfactory in terms of prevention, access to or continuity of care; No link with health centres for the possible management of drug-related disorders; • The lack of data for epidemiological surveillance and the lack of monitoring and evaluation of programmes and interventions; • Weak training in peer education and lack of involvement of other actors; • The lack of effectiveness of national and regional awareness and information campaigns.
Opportunities	**Risks**
• The National Multisectoral Strategy for Adolescent and Youth Health Promotion 2020 - 2030 ("NAYSPS 2020 -2030"), • The Ministry of Education and the Ministry of Public Health's strategy to combat smoking, alcohol and drugs in schools. • Development of a peer population, possible extension to vulnerable out-of-school populations, and in conflict with the law, • Possibility of public-public, public-civil society partnership (outreach) including other governmental actors (MS, MJS, MAS, MFFAdPA, Med) to replicate the project based on life skills development through sustainable agreements and partnerships • The mental health promotion strategy	• Lack of political commitment and funding • Lack of coordination and communication between different sectors and stakeholders including civil society and government agencies.

6.1.2 Objectives

The main objective of the field of prevention is the reduction of risk behaviour among young people.

Prevention aims to reduce the risks of drug use through a comprehensive approach to health promotion and increasing the skills of young people in schools and in vulnerable situations. It also aims to provide early support to young people in difficulty, in particular through easy access to health professionals trained in counselling (brief therapies) in the context of problems linked to drug use.

6.1.3 Priority fields

The domain has five specific fields:

[22] Ministry of Public Health, UNFPA (2017) Review of national health programmes targeting adolescents and youth in Tunisia. http://www.santetunisie.rns.tn/fr/toutes-les-actualites/729-revue-des-programmes-nationaux-de-sant%C3%A9-ciblant-les-adolescents-et-les-jeunes

a. Quality of prevention programmes: Establishment of a coordinated prevention programme

The strategy places particular emphasis on strengthening the quality of programmes. To strengthen prevention and early detection programmes, the strategy provides for better coordination between the various actors, for example by setting up a coordination committee. The strategy also provides for the development of guidelines based on international evidence and recommendations, adapted to the different environments, as well as the development and implementation of a programme and intervention monitoring and evaluation plan. The various initiatives carried out will be evaluated before being generalised.

b. Promoting the general well-being of young people in schools (skill increases)

The approach based on strengthening individual skills as well as the healthy school projects will be generalised throughout the territory. The implementation is based on a peer approach, environmental measures but also easy access to professional advice for screening and treatment through brief therapies, for example, for substance use disorders.

c. Promoting general well-being and reducing risk behaviour among young people in vulnerable situations

A special effort will be made to provide out-of-school youth, whether or not in conflict with the law, with health promotion, prevention and early detection services in their living environments. The implementation strategies will be similar to those for young people in schools, using existing structures. One of the axes also targets the children of drug-using parents by strengthening parenting skills and supporting these children.

d. Information, education, communication general population.

In order to raise awareness among the general population, two lines of work have been identified. The first is the joint development by all governmental and non-governmental actors of an information website on substances, risks and advice services available in the country. The second is to work with the media to improve the quality of the information they provide.

e. Promotion of well-being within families

The strategy plans to provide parents with easy access to quality information through various channels such as the website and school activities. In addition, activities to promote health and improve well-being in the workplace will complement this focus.

The analysis also identified three priority populations:

- The school population,
- Young people in vulnerable situations (out of school, in conflict with the law or from disadvantaged backgrounds); and
- (Fragile) families.

MAIN OBJECTIVE	**Reduction of risk behaviour among young people** **Impact indicator**: 10% reduction in the prevalence of drug use among young people in school by 2030 (Source: MEDSPAD) (Note: Contribute to1. a 10% reduction in the prevalence of key risk behaviours among adolescents and young people by 2030; Adolescent and Youth Health Promotion Strategy)

Table 6 Logical framework area 1 Health promotion and substance use prevention among young people

AREA 1: Health promotion and drug prevention among young people					
PRIORITY FIELDS	**RESULTS/** EFFECTS	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
1.1 Coordination, quality, monitoring and evaluation of prevention programmes ***(Note: this area is a suggestion from the consultants)***					
	1.1.1. Improved coordination between prevention programmes at national and regional level			**MS**	MS (DMSU), M Education, MAS, NGOs
KEY ACTIVITIES • Establishment of a scientific and coordinating committee on the prevention of substance use disorders • Organise work plan and quarterly meetings of the Scientific and Coordination Committee • Networking of health promotion and drug use prevention stakeholders at national and regional level					
	1.1.2 Increasing access to effective, quality, evidence-based prevention programmes	The prevention programmes put in place are based on scientific evidence of their effectiveness according to international standards (UNODC/WHO)	1,000%.		

AREA 1: Health promotion and drug prevention among young people					
PRIORITY FIELDS	**RESULTS/** EFFECTS	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
	KEY ACTIONS • Development of a national technical guide based on international UNODC and WHO guidelines and quality criteria for school-based prevention services • Development of a national technical guide on international UNODC and WHO guidelines and quality criteria for prevention services for children in conflict with the law • Capacity building for prevention workers in schools and out-of-school settings				
	1.1.3. Increase in the number of pilot projects and programmes evaluated and monitored	Number of evaluations of new projects and projects monitored (reports)	100%		
	KEY ACTIONS - Develop and implement national standards and a quality monitoring system for health promotion - prevention services for young people (quality assurance) - Conducting project reviews - Development of an annual monitoring and evaluation plan - Conducting evaluations of pilot projects and the programme - Prepare reports and disseminate evaluation reports				
1.2. Promotion of health and general well-being among young people in schools					
	1.2.1 Increase in the number of young people in schools who have benefited from health promotion/risk behaviour prevention programmes and environments	• *The percentage of pupils who have acquired life skills, according to curricula to be defined, at the end of each cycle of study (primary, secondary and high school). (PNS Santé 2030) %*	Base Target	DMSU-ME	MS (ONFP, INSP, DSSB) MFFEPA, MI, MALE, Meq, MF, MJS, MC MSONG, MAS-MC-MAffLocEnv, ONG N& I;

AREA 1: Health promotion and drug prevention among young people					
PRIORITY FIELDS	**RESULTS/** EFFECTS	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
		of pupils having benefited from the "Healthy School" project			Parents' associations
	Key activities 1.2.1.1 Expansion of the 'Life Skills Development' pilot project to all school children 1.2.1.2 Generalisation of the "Healthy School" project (generalisation of the pilot project set up in Gabes)				
	Awareness raising/education 1.2.2. Increased access to objective and quality information for pupils and parents	• N. (or%) of schools that have adopted the student peer educator approach • N. (or%) of pre-schools that have conducted at least three parenting education sessions	**20%, 40% and 40%.**	DMSU-INSP-ME	MS (DMSU, ONFP, INSP, DSSB....) - ME- MFFEPA-ONG-MJS-MAS-MC-MAffLocEnv, ONG N& I
	KEY ACTIVITIES 1.2.2.1 Training and awareness raising of peer educators on drug use through leisure activities (cultural, artistic, sports...) ???? duplication / generalisation of the project carried out in 2019 ??? 1.2.2.2 Proposal for the evaluation and possible resumption of the scouting project as a peer outreach action for different priority populations Parenting education in pre-school settings				
1.3. Vulnerable young people (conflict with the law; school dropouts; precarious environments)					
	Awareness raising/education **1.3.1**. Increased access to objective and quality information for out-of-school youth and youth in conflict with the law	• N. (or%) of youth spaces with peer prevention programmes/year • N. (or%) of injecting drug users who have implemented peer prevention programmes/year			**MS, MAS, NGO**

AREA 1: Health promotion and drug prevention among young people					
PRIORITY FIELDS	**RESULTS/** EFFECTS	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
	Key activities 1.3.1.1. Training and sensitisation of out-of-school youth as peer educators on drug use and harm reduction 1.3.1.2. Training and sensitisation of young people in conflict with the law (CDI/ juvenile reform and rehabilitation centres) peers on drug use and harm reduction				
	1.3.2. Increase in the number of out-of-school youth and youth in conflict with the law who have benefited from health promotion/risk behaviour prevention programmes and environment	of delegations with a "Friends of Youth" area N. of young people per delegation reached by youth spaces	Basis : Target: Basis :	ONFP	MJS MC ONG:ATUPRET ATIOST ATL Min Aff Sociales CDIS
	KEY ACTIVITIES 1.3.2.1. Increase the number and improve the quality of youth-friendly spaces to make them more attractive (have a centre/delegation, improve geographical, psychological and temporal accessibility to these spaces.) 1.3.2.2. Implementation of peer prevention programmes among vulnerable groups and in the CDIS 1.3.2.3 Increase the number of adequate and attractive sports facilities, improve the geographical, psychological, temporal and financial accessibility to these spaces). (No or little evidence or sometimes -) 1.3.2.4. Increase the number of cultural spaces staffed by competent personnel in various disciplines and attractive improve the geographical, psychological, temporal and financial accessibility to these spaces...) (no or little evidence or sometimes -) 1.3.2.5. Establishment of low-threshold information and reception services in Youth Friendly Spaces for early diagnosis and brief therapies *(Note: J&A health promotion strategy: 2. By 2030, early diagnosis of more than 40% of pathologies related to risk behaviour)*				
	OUTCOME/EFFECTS	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**

AREA 1: Health promotion and drug prevention among young people					
PRIORITY FIELDS	**RESULTS/** EFFECTS	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
	1.3.3 Creation of a favourable family environment for a balanced development of children of women (parents?) drug users	N. of children of drug users receiving support (ratio) of children of drug-using mothers in care centres who receive specific psycho-socio-educational support	Base ? Target ?	?	MS, MAS, MFFS, NGOs (scoot, ATL) ???
	KEY ACTIVITIES 1.3.3.1. Specific socio-psychological support and education of children of drug users through (occupational therapists, psychologists, special educators, social workers) *1.3.3.2. Develop and implement a programme of parenting skills enhancement sessions (minimum 10 sessions)*				
1.4. **Information, education, communication general population**					MS, MJS, MAS, MFFES, ME, ONG....
	1.4.1. **Increased access to objective and quality information on drugs for young people, consumers, families, teachers and the general public**	N. of visits to the information website N journalists (or media) reached	Basis : Target:	**MJS**	MS, MJS, MAS, MFFES, ME, ONG....
	KEY ACTIVITIES 1.4.1.1. Establishment of a virtual information platform (joint platform of the different actors in the field of drug use prevention and care) 1.4.1.2. Raising awareness and encouraging media actors to take positive action on BCC and the fight against drug use: objective, non-stigmatising and non-incentivising information				
	OUTCOME/EFFECTS	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
1.5. ***Families, general population?***	***Improving family mental well-being***				*MAS (ISSTS)-MJS-MS-MFFES-Media*

AREA 1: Health promotion and drug prevention among young people					
PRIORITY FIELDS	**RESULTS/** EFFECTS	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
	1.5.1 Increase in the number of families reached by information and awareness programmes	*Number of activities carried out in the workplace*			
	KEY ACTIVITIES 1.5.1.1. *Key Intervention 1: Awareness raising (BCC) via media, social networks, via student peer educators, via frontline health facilities and via pre-schools* 1.5.1.2. *Key Intervention 2: Carrying out awareness-raising actions in the workplace, reducing occupational stress (adjusted working hours, agreement to take part in sports activities at a reduced price) raising the awareness of company managers/decision-makers: promotion of the mental well-being of workers = promotion of health = promotion of the national economy.*				

6.2 Reducing the risks associated with drug use (HIV, hepatitis B & C, STIs, overdoses)

Limited to injecting drugs, include injection points: local infectious complications, include other products, diversify kits including filters, rely on civil society. Information system

6.2.1 SWOT analysis

The situation analysis highlighted the achievements of harm reduction in Tunisia, in particular access to prevention kits (injection material, condoms), peer prevention and improved access to rapid and anonymous HIV testing via NGO programmes.

The weakness of geographical coverage (and difficulty of access for women), as well as the fragility of the partnership, particularly with regard to work in prisons, were identified as the main weaknesses. Amongst the risks, problems with the policies and attitudes of the law enforcement agencies, particularly towards peer educators and harm reduction workers, were identified as a major risk to ensuring adequate access to harm reduction services.

Table 7 Risk reduction: SWOT analysis

FORCES	**WEAKNESSES**
• Interventions in community settings (Greater Tunis, Nabeul, Gafsa, Bizerte, Djerba, Kasserine) • Prevention kit distribution programmes • Interventions in prisons (27 prisons and 5 rehabilitation centres) • IEC and testing activities for HIV/AIDS and HCV requested by prisoners • PE training in prisons • Several RDR NGOs in the community • Community screening campaigns by civil society	• No national coverage for community interventions • Interruption of activities in prisons in 2016 • Fragile partnership between prison administration and NGOs • Only one NGO (ATIOST) in prisons • Lack of peer educators/social-health advisors among professionals in public structures (even if it is in the framework of a partnership with civil society).
OPPORTUNITIES	**RISKS**
• Global Fund grant • The National Hepatitis C Elimination Plan (2016-2030) • National Strategic Plan for the Response to HIV/AIDS and STIs 2019-2022	• Confrontations between peer educators or association staff and law enforcement

6.2.2 Objectives

The overall objective is to reduce the transmission of HIV, HCV, HBV, tuberculosis (TB) and sexually transmitted infections (STIs) and to improve universal access to prevention, treatment, care and support for drug users in the community and in prison, including continuity of care and treatment in prison and community.

6.2.3 Priority fields

Four priority areas have been identified

a. Coordination, monitoring and evaluation

The establishment of an intersectoral policy and coordination is necessary to establish harm reduction as a health strategy in Tunisia and to ensure better coordination at national and regional level and to set up a quality assurance and monitoring and evaluation system.

b. Comprehensive package of HIV and hepatitis prevention interventions for drug users

This first area of the harm reduction strategy aims in particular to increase the coverage of access to high-impact harm reduction actions for the prevention of HIV and hepatitis transmission among intravenous drug users. These actions are, in order of priority: access to sterile injection equipment and access (PAS) to opiate substitution therapy (OST). The strategy also aims to ensure better access, particularly geographical access, by ensuring a better match between supply and demand. To address gaps in geographical coverage, NGOs not yet involved in RoR will eventually be identified and coached by RoR NGOs. (Details on opiate substitution therapy are covered under Area 3, Therapeutic care).

c. HIV and Hepatitis C testing, diagnosis, care and follow-up

The second priority area is access to HIV and hepatitis testing among intravenous drug users and the link with treatment and follow-up for people living with HIV and people with hepatitis B or C. Particular efforts will be made to ensure better access to testing and diagnosis through the implementation of new testing strategies such as community-based testing. Diagnosis based on rapid diagnostic tests in accordance with the latest recommendations of the World Health Organisation (WHO) should facilitate HIV treatment. Measures will be taken to physically accompany and support those diagnosed to HIV and hepatitis treatment centres for antiretroviral treatment (ART). The protocol of the national hepatitis C elimination plan will be implemented and will aim to reach intravenous drug users, nasal drug users and people in prisons. Rapid screening and diagnosis of HCV will be offered to users of care centres (ATIOST (Chams, Tunis, Mohammedia, Hammam lif, Menzel Bourguiba); ATL MST Sida Tunis; ATL Sfax; low-threshold reception centres (Mellassine, Nabeul, Zahroouni) and all the anonymous and free advice and diagnosis centres (CCDAG). People whose PCR confirms the diagnosis will be accompanied to the hepatitis C treatment centres and the strategy will be evaluated.

d. Harm reduction services responding to the needs of female intravenous drug users

Specific services to comprehensively address the needs of female injecting drug users and female injecting drug users' mothers and their children will be opened in the areas of greatest need to ensure access for these women to RoR interventions but also to sexual and reproductive health care, including prevention of mother-to-child transmission of HIV and syphilis (PMTCT) and social and legal services and support for themselves and their children. A care programme for women drug users who have experienced violence will be set up, including psychosocial support, legal aid, birth control and access to HIV testing and post-exposure treatment (PEP).

Actions relating to the establishment of a supportive legal and policy environment essential for access to harm reduction interventions are included in the area 5.

The priority target populations are

- Intravenous drug users in the community and in prison
- Women who use intravenous drugs

The overall objective is to reduce the transmission of HIV, HCV, HBV, TB and STIs and improve universal access to prevention, treatment, care and support for drug users in Tunisia Impact indicator: 50% reduction in the number of new HIV infections among injecting drug users

Table 8 Logical framework domain 2 Reduction of drug-related harm

AREA 2: RISK REDUCTION					
PRIORITY FIELDS	**RESULTS/ EFFECTS**	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
1. Coordination, monitoring and evaluation	1.1. Improved inter-sectoral coordination of DRR	MSP/PNLS document detailing the national intersectoral policy and coordination mechanisms for the RoR programme	1	NACP/MSP	DGPR MSP Thematic NGOs, CSOs, MNTOs, NTPs (UN specialized agencies: UNODC UNAIDS WHO)
	- Establishment of a national steering committee for RoR policies and programmes within the Ministry of Health, including the Ministry of Justice (prison administration), heads of RoR structures and civil society organisations, development partners - Establishment of a RoR coordination committee - Annual plan development Organisations quarterly coordination meetings - Strengthening partnerships with NGOs and non-thematic NGOs				
	1.2 Improving the quality of community and prison-based RoR interventions	Guides No. of courses			
	- Develop, based on international guidelines, national standards and protocols for the quality and ethics of RoR interventions (PAS, OST, outreach work, etc.) - Develop training plan and build capacity for community systems, infrastructure development systems and partnership building				
	1.3 Improved monitoring and evaluation of community and	Number of RoR projects monitored or evaluated (report)	100%	PNLS MSP	NGO, DGPR, OMNE

AREA 2: RISK REDUCTION					
PRIORITY FIELDS	**RESULTS/ EFFECTS**	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
	prison-based RoR programmes and projects				
	KEY ACTIVITIES - Develop and implement a quality assurance plan and system - Conducting supervisions - Development of an annual monitoring and evaluation plan - Conducting evaluations of pilot projects and the programme - Prepare reports and disseminate evaluation reports				
2 Universal access to the comprehensive package of HIV and Hepatitis prevention interventions for drug users	2.1 Increased coverage of priority prevention interventions (SSP, Condoms, BCC, OST[23]) for HIV and hepatitis prevention	Number (or %) of all intravenous drug users covered by PAS Number of syringes distributed per intravenous drug user per year (disaggregated by gender) Number (%) of injecting drug users dependent on opiates on OST (disaggregated by gender and setting)	80% 200 30%	MSP /PNLS	NGO DGPR OMNE
KEY ACTIVITIES • Mapping intravenous drug use and access to harm reduction services • Extension of RoR services to underserved areas through partnerships with NGOs _ training and coaching of these NGOs • Acquisition and distribution of injection equipment (injection kits) for intravenous drug users • Establishing/strengthening coverage of peer-to-peer BCC activities in the community and in prisons • Condom procurement, distribution and promotion (community and prison) • Piloting the prison needle exchange programme ? • (For OSI see area 3)					

[23] For OST, see domain 3 Therapeutic management

AREA 2: RISK REDUCTION					
PRIORITY FIELDS	**RESULTS/ EFFECTS**	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
3 Access to diagnosis and care for HIV and hepatitis	*3.1* Increased coverage of priority interventions: HIV and hepatitis testing in the community and in prisons	N and % of injecting drug users who have been tested for HIV in the last 12 months and know the result (disaggregated by gender/region and setting) *(IBBS)* N and % of injecting drug users who have been tested for HCV in the last 12 months and know the result (disaggregated by gender/region and setting) *(IBBS)*	*80%* *80%*	MSP /PNLS	*NGO* *DGPR*
KEY ACTIVITIES • Establishment, expansion and promotion of community-based testing with RDT for HIV and hepatitis • Implementation of HIV and hepatitis testing and counselling in prisons (training; infrastructure; guides) ; • Piloting self-tests ? • Alignment of national HIV and hepatitis testing and diagnosis guidelines with the latest WHO recommendations • HCV screening (TROD and PCR if TROD+) among intravenous drug users in care centres (Atiost (Chams, Tunis, Mohammedia, Hammam-lif, Menzel Bourguiba); ATL MST Sida Tunis; ATL Sfax; low-threshold reception centres (Mellassine, Nabeul, Zahroouni) and all CCDAGs • Evaluation of the acceptability of the HCV screening strategy					
	3.2 Increased access to antiretroviral treatment for HIV for injecting drug users and to hepatitis B and C treatment and follow-up	of injecting drug users living with HIV on antiretroviral treatment (disaggregated by gender and setting/region) of injecting drug users on treatment for hepatitis C (disaggregated by gender and setting/region)	*80%* *80%*		

AREA 2: RISK REDUCTION					
PRIORITY FIELDS	**RESULTS/ EFFECTS**	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
KEY ACTIVITIES • Strengthening resources and capacities (peer educators; social-health assistants) for information, support and accompaniment of intravenous drug users living with HIV or hepatitis C in community and prison care • Develop and implement a system to ensure continuity of HIV and hepatitis C treatment and care for injecting drug users upon release from prison • Analysis of barriers (research) to ECP and development of pilot projects facilitating access and adherence to ART for injecting drug users					
4 Harm reduction services that meet the needs of women who use intravenous drugs	*4.1 Increase women's access to comprehensive care, including gender-based violence.*	of female injecting drug users accessing specific harm reduction services (Disaggregated by setting (community and prison) /regions)	*50%* *50%*	*NGO* *MSP PNLS* *MAS* *M Family*	
KEY ACTIVITIES Action research and needs mapping of harm reduction services for female injecting drug users Expansion of the number of RoR services offering services and support specifically for women injecting drug users and their children Establish a system for continuity of care and support for women between the community and prison Development and implementation of a protocol for the care of female drug users who are victims of gender-based violence					

6.3 Therapeutic management of substance use disorders

6.3.1 SWOT analysis

The analysis of the situation highlighted the existence of primary health centres for the treatment of drug use disorders as a strength. These centres are easily accessible and offer consultations by appointment several times a week. Other strengths include addictionology consultations (CMYAMU, RAZI Hospital, Tahar SFAR Hospital in Mahdia) and the existence of a pool of doctors and psychologists qualified in addictionology. Among the weaknesses are the lack of information on these management strategies or care pathways, the lack of networking between the various players (addictology centre) and the fact that none of these structures offers a low threshold reception service without an appointment. In addition, these facilities are more difficult to access for women. The care on offer is solely outpatient. One of the main shortcomings of the treatment and care system is the lack of treatment adapted to opiate dependence: no opiate substitution treatment (OST), also known as opiate agonist treatment

The Global Fund grant that covers the financial needs to initiate a substitution treatment programme is an opportunity for the country to implement such a programme.

The risks include the marginalisation of the drug-dependent population, the lack of support from the supervisory authorities for the development of OSTs and the legal context, in particular the lack of authorisation for the marketing of methadone as a medicine.

Table 9 SWOT analysis Treatment

FORCES	**WEAKNESSES**
• Accessible structures, close to sensitive neighbourhoods, not stigmatised, close appointments, frequent consultations (3 times a week); consultations provided by 3 permanent doctors, possibility of hospitalisation if indicated; significant activity (8/Consult, 100/month); respect of confidentiality • Accessible to all / 1st line structures / NGOs / by appointment • Addictology consultation/CMYAMU/Hospital RAZI/Hospital Tahar SFAR Mahdia • Doctors/psychologists qualified in addiction medicine	• 9h/1f: lack of accessibility (pre-arranged appointment), lack of information, lack of networking, no stand-by • Outpatient only, • Lack of specific treatment for opiate dependence (Agonists) • Lack of qualified personnel
OPPORTUNITIES	**RISKS**
• Ease of access • Diversifying the supply of care, generalising the experience • Global fund budget for methadone purchase; recruitment	• Marginalisation and lack of social security coverage, the violence of this population • Lack of support from the supervisory structures, • Text of law clarifying the notion of agonist drugs and distinguishing them in the list of narcotics

6.3.2 Objectives

The general objective of the field is to offer a complete, adapted, accessible, sustainable and quality care service, in accordance with scientific, ethical and deontological recommendations, to drug users in order to improve their physical and psychological health and their social integration.

The priority groups identified are people in precarious situations, young people, women and people who inject drugs.

6.3.3 Priority fields

Three priority areas for action are identified:

a. Coordination, quality assurance, monitoring and evaluation

The establishment of coordination and implementation of a policy for the provision of quality care services, based on scientific evidence, respectful of human rights and adapted to the various problems of the individual in a comprehensive care perspective. The quality of programmes, whether implemented by governmental or non-governmental organisations, will be improved through the development of therapeutic management guidelines for people suffering from addiction problems in the community or in prison. These guidelines, developed on the basis of international guidelines and scientific evidence, will include quality criteria including ethical and deontological standards for addiction treatment in the community and in prison. Formative supervision will be provided by the Ministry of Health. And evaluations of services will be conducted, with community participation and including patient satisfaction. An inventory of effective service provision according to the specific needs of different drug user groups will be conducted to assess resources and needs in different regions of the country.

Particular attention will be paid to developing procedures and a communication system to ensure continuity of care, including treatment and support, for people entering prison, people released from prison or people transferred within the prison system.

The whole programme will be evaluated at least every two years.

b. Expanding access to quality comprehensive care

In order to improve access to comprehensive services, networks will be set up in the main cities in the different regions of the country, with the aim of improving access to services in the various sectors concerned (prevention, harm reduction, treatment and occupational integration).

These networks will be formed after conducting the mapping and will include representatives of governmental and non-governmental organisations, including the prison sector, as well as representatives of the community. This communication will enable stakeholders to become more aware of the existing resources in their geographical area, to improve referral and counter-referral and to collectively identify solutions to possible problems encountered by the public who use these services.

This is the approach chosen in the proposal for a national strategy for the management of addictions, validated by the Ministry of Health in May 2019. This strategy is based on interregional addiction centres. Each centre is centred on a psychiatry-addictology service (with its own addictology day hospital) and interacts with :

- A complex addiction care service (intensive care, infectious diseases, pneumology, hepatology, internal medicine),
- A reception and harm reduction centre for drug users (CARRUD) which offers different services classified in :
  - & - risk reduction,
  - & - social support,
  - & - brief psychotherapies,
  - & - or group activities

These centres may be attached to (or have partnerships with) front-line health structures in order to provide medical care and may be public (e.g. regional delegations of the ONFP), or belong to civil society (ATIOST, ATL MST Sida, ATUPRET) or be the seat of a collaboration between the two

- A rehabilitation and social reintegration centre like those in Jebel Oust and Tyna,
- And screening services such as basic health care centres, school and university medical centres, anonymous screening centres (CCDAG), occupational health services, CDIS, protection centres for abused women)

Efforts will also be made to make the public more aware of the various social and health resources available in their region for people with substance use problems.

c. Develop and implement a plan to expand outpatient opioid substitution therapy (or opioid agonist therapy: OAT) for women and men in the community and in prisons.

A programme of opioid substitution or opioid agonist treatment in the community and in prison will be piloted for six months and then extended to all regions, with priority given to those with a high prevalence of buprenorphine injection. A protocol and procedural guidelines for outpatient CAT in the community and in prisons will be developed on the basis of international recommendations. To develop a protocol for the implementation of the CAT pilot project. Treatment personnel in state centres as well as in NGO treatment centres will be trained. The pilot programme will be evaluated 6 months after its implementation and based on an expansion plan, the programme will be extended to other regions and centres. The procedures will cover the continuity of CAT for people in prison

Main objective:

To provide comprehensive, appropriate, accessible and sustainable care that respects scientific, ethical and deontological recommendations and is of high quality for drug users with the aim of improving their physical and psychological health and their social integration.

Table 10 Logical framework domain 3: Therapeutic management and continuity of care

DOMAIN 3: Comprehensive and continuous therapeutic management of substance use problems					
PRIORITY FIELDS	**RESULTS/** EFFECTS	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
3.1 Coordination, quality assurance, monitoring and evaluation	3.1.1 Strengthening the quality and monitoring and evaluation of ECP programmes			Ministry of Health: DEP	DPM; Central Pharmacy; DSSB; Ministries of Social Affairs; Ministry of Youth, Women and Family; DGPR, civil society; NGOs
ACTIVITIES					
3.1.1 Set up a scientific and ethical coordination unit involving various governmental and non-governmental actors in the psycho-medical-social sector 3.1.2 Develop clinical guidelines for comprehensive therapeutic care (biological, psychological and social) for the community and prison and define quality criteria? 3.1.3 Develop training plan and build capacity of stakeholders 3.1.4 Develop a monitoring and evaluation programme and plan 3.1.5 Conducting monitoring and evaluation of the programme and services					
3.2. Access to comprehensive care for substance use problems.	Increased access to comprehensive care for substance use problems.	• Number of people receiving health care for a problem related to the use of psychotropic substances (M/F/region/setting)		MSP	DSSB, DGPR, ONG
Activities 3.2.1. Carry out comprehensive therapeutic care mapping and assess human and logistical needs for optimal coverage of the demand for care (in the community and in prison) 3.2.2. Developing mechanisms to support continuity of treatment and care for people leaving prison					

DOMAIN 3: Comprehensive and continuous therapeutic management of substance use problems					
PRIORITY FIELDS	**RESULTS/** EFFECTS	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
3.2.3. Develop in each region a network of stakeholders in the field of addiction (prevention; harm reduction, treatment and vocational integration) including the governmental sector and NGOs (including interregional addictology networks) 3.2.4. Disseminate information on JEP offers in each region					
3.3. Opiate substitution therapy (OST) or opioid agonist therapy (OAT)	3.3 .1. Increasing access to opioid substitution therapy	of intravenous drug users (women and men) on OAT	30% of female and 30% of male intravenous drug users on OAT (end 202)2	Ministry of Health	DPM; central pharmacy; DSSB; DGPR, civil society; NGOs PNLS
Activities 3.3.1.1. Develop protocol for implementation of CAT pilot project 3.3.1.2. Develop clinical procedural guidelines for outpatient CAT based on international guidelines (community and prison) 3.3.1.3. Obtaining marketing authorisation and securing methadone supply for pilot project and expansion 3.3.1.4. Training of government and non-government professionals on CAT 3.3.1.5. Revision of the law? 3.3.1.6. Implementation and evaluation of the pilot project after six months 3.3.1.7. Establish procedures for the continuity of substitution treatment between community and prison (entry, transfers and exit) 3.3.1.8. Develop and implement plan to expand outpatient CAT treatment for women and men in the community and in prisons.					

6.4 Support for socio-professional integration

6.4.1 SWOT analysis

The analysis of the situation revealed the existence in the various governorates of services to support socio-occupational integration - in particular the structures dependent on the Ministry of Social Affairs (MAS) - but poor coverage of NGO services linked to precarious drug users and a lack of clear channels and mechanisms for referring users to integration support services. Socio-economic support for people living with HIV is also a model on which actions towards drug users can be developed.

As with the other areas, weak monitoring and evaluation were identified as a risk to ensuring adequate provision.

Table 11 SWOT analysis Support to socio-professional integration

FORCES	**WEAKNESSES**
• Existence of a favourable infrastructure: structures under the DSS • Directorate of Social Promotion • CDIS: Centre for Defence and Social Integration • Social Observation Centre and Manouba • Guidance centres and social orientation • Social welfare centre • NGOs (drug abuse, rehabilitation) • School and university medical centres • To benefit from experience in the treatment and support of PLHIV • Microcredit for NGOs	• Centralized/concentrated NGO work in the capital and coastal cities • Lack of human and financial resources • Lack of a clear circuit and reference system for DUs (structures and services) • Sometimes it is personal and relational work (but collaboration exists)
OPPORTUNITIES	**RISKS**
• - Coverage in all governorates • - Political will (strategy development) • - New solidarity law (financing of small projects with support for entrepreneurship training)	• - Political instability • - Budgetary constraints • - Lack of follow-up

6.4.2 Objectives

The general objective of the field is to improve the socio-professional integration of users of psychoactive substances

6.4.3 Priority fields

The priority populations are drug users in prisons (prisons and "rehabilitation houses") and drug users released from prison, as well as female drug users.

Two priority fields have been identified:

a) Psychosocial vulnerability

This area aims to provide drug users, whether in care or accompanied in support structures or in prison, with social security coverage for better security and life skills to facilitate their integration into society. Particular attention will be paid to the needs of women, notably through housing and food aid in order to eliminate the situation of women living on the streets.

b) Economic vulnerability

In order to reduce economic vulnerability, income-generating activities (IGAs) will be developed for drug users in need and able to work. Financial support will be provided to those who are unable to work.

Table 12 Logical framework area 4: Social support and reintegration into employment

AREA 4: SOCIAL SUPPORT AND VOCATIONAL REHABILITATION					
PRIORITY FIELDS	**RESULTS/ EFFECTS**	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
4.1 Psychosocial vulnerability of drug users	4.1.1. Increase in the number of injecting drug users benefiting from life skills programmes	Number of drug users who received life skills training sessions (disaggregated by gender and living situation) Number of sessions organised in prisons per year Number of sessions organised in ECP structures per year	150 users per year	NGO MS MAS	Ministry of Justice
KEY ACTIVITIES - Organisation of workshops on occupational activities within the structures and in the prisons: - Organisation of artistic workshops, plays in CEP structures and in prisons - Organisation of group dynamics sessions in ECP facilities and in prisons - Support for the educational reintegration of DUs: Implementation of pre-discharge programmes for intravenous drug users and intravenous drug users living with HIV					
	4.1.2. Increase in the number of intravenous drug users covered by social security	Proportion of intravenous drug users (M/F) covered by social security (source IBBS)	*???*	*MAS*	*SAMU Social, NGO*
KEY ACTIVITIES - Promote and facilitate the integration of drug users into the social security system (منظومةالأمان الاجتماعي) - Raising drug users' awareness of the social services available in their area (street work) - Organising the care of homeless people (SAMU Social)					

AREA 4: SOCIAL SUPPORT AND VOCATIONAL REHABILITATION					
PRIORITY FIELDS	**RESULTS/ EFFECTS**	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
	4.1.3 Increased social support for female DUers (including housing assistance)	*Number of homeless female intravenous drug users*	*0*	NGOs (Beity, Espoir, Jasmin) MFFEA	
KEY ACTIVITIES • Organise the provision of support to homeless DU women (provision of accommodation; food; psychological support • Facilitate access for DU women to support programmes that specifically address their needs • Providing care for people who have experienced domestic violence.					
4.2. Economic vulnerability of drug users (men and women)	4.2.1 Increasing access for injecting drug users to income-generating activities (IGAs) in each region	Number of drug users (M/F) included in AGR by region and year Number of IGAs implemented for drug users (M/F) in each region per year		Ministry of Employment and PS	Ministry of Social Affairs, Ministry of Justice, NGOs
KEY ACTIVITIES - Vocational training for drug users - Creation of income-generating projects					
	4.2.2 Increase in the number of destitute unemployed injecting drug users receiving financial support	Number (or %) of intravenous drug users receiving financial support from the state		**MAS**	**NGO**
KEY ACTIVITIES - Advocacy Organise support for intravenous drug users to access economic aid					

6.5 Area 5: Create an enabling legal, policy and practice environment for access to health

6.5.1 SWOT analysis

The SWOT analysis revealed that the legal framework is a major barrier to accessing prevention, harm reduction, treatment and support services for drug use problems. Harm reduction is tolerated but not officially recognised and does not receive public funding. Lack of communication or poor communication contributes to the climate of stigma and discrimination experienced by drug users, especially women.

Table 13 SWOT analysis Creating an enabling environment for access to health

FORCES	**WEAKNESSES**
- Existence of anonymous and free screening centres (CCDAG) - Free health care for people in prison	• *Discriminatory legal framework :* o *Addiction to psychoactive substances (narcotics) is still considered a crime despite its classification by the WHO and DSM IV and V as a disease.* o *Law 92-52 criminalises the simple use of drugs and thus leads to stigmatisation, discrimination and violence against drug users* o *Law 92-52 requires carers to declare the names of users who come to them. This discourages users from seeking help and carers from taking an interest in this pathology. Hence the unavailability of effective care centres based on scientific evidence.* • *Exclusion of migrants from national programmes* • *Harm reduction is not recognised and is not institutionalised.* • *Punitive approaches by the police, particularly with regard to condom and/or needle possession, are a major obstacle to harm reduction, including HIV/hepatitis prevention* • *No equivalence of care in prison (RoR)* *(Lack of suitable facilities* *Lack of geographical accessibility of services* *Lack of communication on the subject* *Lack of information on existing services)*
OPPORTUNITIES	**RISKS**
• The implementation of an addiction strategy • (Universal coverage) • Reform of laws 52/230/ • Mobilisation CSOs • Mobilisation of independent national bodies • CEC and Master in Addiction Medicine • Partnerships between NGOs / Health M • Capacity building of health and administrative professionals in hospitals/prisons/associations • Global Fund grant on human rights	• Political instability

6.5.2 Objectives

The overall objective is to ensure an environment conducive to comprehensive and quality care for drug users

6.5.3 Priority fields

The specific fields are

a. Stigmatisation by health professionals

A training of trainers programme will be set up to provide ongoing training for as many health workers as possible on issues related to stigma and the human rights of all patients and on gender issues. In parallel, compulsory training modules will be introduced into the curriculum of health profession students.

b. Legal framework and practices for drug users' access to services

The strategy focuses on advocating for a revision of laws that constitute barriers to access to prevention, counselling, treatment and harm reduction for drug users, such as mandatory reporting by health workers, risks of incarceration, or obtaining a marketing authorisation for methadone substitution treatment. In order to eliminate arbitrary or counterproductive punitive practices by police and other law enforcement agencies, training and partnerships between the health and security sectors will be established.

NOTE: suggestion of the consultants. In line with the recommendations of the African Union, community-based management of substance use problems will be prioritised over incarceration which, according to the international guidelines of the WHO and UNODC and the scientific evidence behind them, has been shown to be ineffective or even counter-productive. A system of alternatives to incarceration through outpatient care, support and treatment and harm reduction services will be developed and implemented.

c. Changing attitudes and perceptions towards drug users

The stigmatisation of drug users in the media contributes to the discrimination experienced by drug users in different areas of society. The drug user is seen by the general population as a delinquent, which hinders or prevents access to advice, care and support and leads to exclusion, including self-exclusion.

The overall objective is to ensure an environment conducive to comprehensive and quality care for drug users

Indicator :

Table 14 Logical framework area 5: Creating a legal, policy and practice environment that supports access to health

AREA 5: Creating an enabling legal, policy and practice environment					
PRIORITY FIELDS	**RESULTS/ EFFECTS**	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
Stigma and discrimination in health services	5.1 Reducing the level of stigma in health services Increase in the number of health professionals who have received training against stigma and discrimination towards DU)	(Stigma index 2.0 or other specific survey) *Number of health professionals trained*		MSP, M education Universities?	NGOs, civil society organisations
KEY ACTIVITIES - Training on discrimination and human rights for health care providers: Training a pool of trainers - Include training in addiction in the university curriculum (doctors, nurses, psychologists) - Integrate human rights training, stigmatisation into the university curriculum (doctors, nurses, psychologists)					
Legal framework for access to care for drug users	*5.2 Reducing legal barriers to access to treatment and harm reduction*	Number of articles of law reformed to support this access (Text of law) (? reduction in the number of incarcerations for drug use)		MSP, ME, MES, MJ, M. youth, MFF, MAS, NGO	*M Justice* *Parliament*
KEY ACTIVITIES - Revision of discriminatory legislation Law 52 69 230 254 - Advocacy for changes in the law towards broad access to care. - Raising awareness among parliamentarians - Review of laws to facilitate OST and alternatives to imprisonment - Development of a legal framework that facilitates and supports the RoR work of NGOs - Revision of laws to allow registration of DU community organisations - Organise training on rights and regular access to legal aid for women and men drug users - Develop and implement a system of alternatives to imprisonment					

<table>
<tr><th colspan="6">AREA 5: Creating an enabling legal, policy and practice environment</th></tr>
<tr><th>PRIORITY FIELDS</th><th>RESULTS/ EFFECTS</th><th>INDICATOR/SOURCE</th><th>TARGET</th><th>Main responsible</th><th>Partners</th></tr>
<tr><td colspan="6"></td></tr>
<tr><td>Attitudes and practices of law enforcement</td><td>5.3 Reduction in the number of punitive practices by law enforcement (confiscation of prevention materials, injection kits, condom arrests)</td><td>No. of law enforcement trainings and evaluations
Coverage through a proximity approach</td><td></td><td>M Interior
DGPR</td><td>NGO</td></tr>
<tr><td colspan="6">KEY ACTIVITIES
- Training/awareness raising for prison staff and prison officers HIV and hepatitis Drug use, discrimination, stigma and violence and their consequences
- Sensitisation and training of community law enforcement officers (police) on HIV and hepatitis Drug use, discrimination, stigma and violence and the importance of attitudes and practices in responding to HIV - Develop local partnerships with police forces to protect service users and facilitate access to services.
- Training and/or awareness raising for magistrates and judges
- Provide legal aid/assistance to intravenous drug users, ideally integrated with health services
- Identification of RoR champions in law enforcement and in prison</td></tr>
<tr><td>Reducing the stigma of drug users in the general population</td><td>5.4. Drug users are no longer considered offenders</td><td>Recognition as a disease by the CNAM</td><td></td><td>- ME, MES, MJ, M. youth, MFF, MAS</td><td>NGO</td></tr>
<tr><td colspan="6">KEY ACTIVITIES
- Establish a partnership with all actors involved in the development of a national communication strategy; MoE, MoES, MoJ, M Youth, MFF, MAS
- Develop communication strategy
- Training / media awareness</td></tr>
</table>

6.6 Area 6 Generate, analyse, disseminate and use strategic data

6.6.1 SWOT analysis

Table 15 SWOT analysis domain Strategic information

FORCES	**WEAKNESSES**
• MEDSPAD • IBBS (HIV programme) • The unique identifier code of RoR and screening interventions and the databases developed by some associations • The National Narcotics Bureau (quantities of drugs seized and number of people charged with drug trafficking).	• Lack of coordination between drug stakeholders • Lack of a national observatory to combat drug abuse • *Lack of national data on drug use* • *Lack of data* on treatment and care requests • *The criminalisation of drug use does not encourage the demand for care* • Lack of a health information system and data collection in prison - lack of data on HIV, hepatitis in prison • Limited amount of research
OPPORTUNITIES	**RISKS**
• The reintegration of the national mental health programme into the DSSB. • To have the approach and effective interventions of NGOs at the level of drug users • Involvement of the Directorate of School and University Medicine to obtain data on drug use in the school and university environment • Creation of a national digital platform that collects national data on drug addiction: ongoing experience with the national register for the collection of addiction cases admitted to care facilities	• Misuse of data (confidentiality) • Difficulty of coordination between stakeholders

1.1.1 Description

3.1.6 Objectives

The overall objective is to have and analyse strategic data on drug use and its consequences and use them to develop priorities for interventions

3.1.7 Priority fields

a. Information system for monitoring the situation related to psychoactive substances

The aim is to set up a system for compiling, analysing and disseminating data on drug use collected in the various sectors concerned in order to obtain a regular (annual or biennial?) overview of the evolution of the situation in the country. These reports should ensure that data are disaggregated by gender and region.

b. Data collection systems

The information system will build on existing data collection systems and if necessary support the development of new instruments. For example, obtaining data on the situation in prisons will require the development of a specific health information system. Similarly, a system should be developed to collect data on people treated for substance use disorders.

c. The use of data

Programme and service managers will receive training on data quality and also on how to use the data collected at each level to improve services and programmes. Protection of personal data must be the rule

d. Develop and implement a research programme

A research agenda (empirical or operational) will be developed based on the information gaps. Research will be conducted in partnership with universities, civil society organisations and government departments.

The overall objective is to have and analyse strategic data on drug use and its consequences and to use them to develop and evaluate priorities for interventions in operational strategies and plans

Table 16 Logical Framework Area 6: Generate, analyse, disseminate and use strategic data

AREA 6: Generate, analyse, disseminate and use strategic data					
PRIORITY FIELDS	**RESULTS/ EFFECTS**	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
1. Information system for monitoring the situation related to psychoactive substances	- Improved availability of consolidated data on drug use and its health consequences (including social and security issues)	An annual report on psychoactive substances and health and social consequences and response in the country A periodic report on trends	1 per year 5 years	MS	PNLS NGO
KEY ACTIVITIES - Establishment of a unit responsible for the consolidation, analysis and dissemination of strategic data (observatory) - Inventory of data sources (socio-health, justice, interior sectors) - Development of indicators - Data quality control - Data consolidation - Analysis and preparation of an annual report					
2. Data collection systems developed	2.1. Increase in strategic data sources contributing to the information system	Number of data sources/indicators used in the drug information system		MS	ME NGO SNB
- Support continued MEDSPAD surveys and monitoring of drug use among young people in school - Support data collection of mapping and IBBS among people who inject drugs - Strengthening the unique identification code system as a tool for monitoring the use of harm reduction and testing services by injecting drug users - Development and implementation of health information systems (HIV, hepatitis, drug use) in prisons - Development of a data collection system on treatment and care requests for substance use problems - Training of data collectors - Collection of data from the police/justice on prosecutions and convictions for substance use					

AREA 6: Generate, analyse, disseminate and use strategic data					
PRIORITY FIELDS	**RESULTS/ EFFECTS**	**INDICATOR/SOURCE**	**TARGET**	**Main responsible**	**Partners**
3. Use of the data	Services and programmes are adapted according to the analysis of data from the services/programmes			MS; ME; DSMU; MAS ; NGO	
KEY ACTIVITIES - Strengthening the capacity of governmental and non-governmental stakeholders to collect and use data from services to review their functioning (community and prison) Development of new strategies and programmes responding to the needs of drug user populations					
4. Search	Increasing knowledge about drug use and consequences	Information from research projects	One report/theme per year (per 2 years?)	MS,	Universities, research institutes, DGPR, ME, NGOs, CSOs, UN?
KEY ACTIVITIES - Develop an empirical and/or operational research plan on priority themes - Mobilising funding - Conducting, analysing and disseminating results					

7. Framework for implementation

The National Strategy for Prevention, Harm Reduction and Management of Illicit Substance Use Disorders in the Community and in Prisons sets out the objectives for the period 20-202215.

The implementation of the strategic plan is coordinated at national level by the Ministry of Health. The Ministry of Health is responsible for coordinating the development of the operational plan and the monitoring and evaluation framework.

In addition to government partners, this strategy recognises the essential role of civil society organisations as partners in the implementation of all areas of the strategy, both in the community and in prisons.

7.1 Development of a budgeted operational plan

The National Strategy will be translated into an operational plan, to be finalised in the first quarter of 20021, which will detail the important elements of its implementation:

- The framework for the development and implementation of the operational plan ;
- Priority measures ;
- The skills of the actors ;
- The calendar ;
- The estimation of the resources needed and their financing by the actors involved.

After the first stage of implementation, an interim evaluation will be carried out in 2023 and the strategy adapted if necessary for the second stage.

7.2 Monitoring and evaluation framework

In addition to the indicators of the strategy, the operational plan will be accompanied by a framework for the annual monitoring and evaluation of the implementation of the plan.

The Ministry of Health will be responsible for coordinating the monitoring of the indicators and reporting on progress and challenges and any suggestions.

8 Financing the strategic plan

Sources of funding

The planned measures will be integrated as far as possible into existing structures and financed within the resources available.

As Tunisia is a country in transition for the Global Fund, external funding for risk reduction will gradually decrease and probably disappear by 2025. It is therefore crucial to develop alternative, preferably domestic, mechanisms for funding civil society organisations, which are the prime movers in implementing effective interventions.

In addition, resources will be sought through the implementation of the strategy for universal health coverage.

ANNEXES

Annex 1: Monitoring and Coordination Committee

Members of the Monitoring and Coordination Committee for the development of :

"The National Strategy for Prevention, Treatment of Drug Dependence and Harm Reduction in the Community and in Custodial Settings in Tunisia" (26 June 2019)

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Annex 2: List of participants in the consultation workshop for the development of the National Strategy - Tunis: 3-5 July 2019

#	Name	Organization
1	Basma Ghariani Abichou	
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6	Rtimi Badr	
7	Sarra Slimen	
8	Radhia Halouani	
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10	Taher Ben Hassine	
11	Kammoun Ramzi	
12	Dr Samira MARAI	Former Minister of Health
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44	Olfa SAIDI	WHO - UNDP Tunis

45	Dr Dhouha HALLAB	ONFP - MS
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