2023

REPORT

FUNDING PRIORITIES FOR PEOPLE WHO USE DRUGS IN NEPAL

THE GLOBAL FUND GRANT CYCLE 7 – RECOVERING NEPAL

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CONTEXT

The national consultant, in coordination with Mainline, conducted a desk review of available published/unpublished documents in April 2023. A list of documents that informed the overall process is included at the end as *Annex 1.* The key findings of the desk review are as follows:

- At present, data pertaining to people who inject drugs are collected by or available through several agencies/sources, such as NCASC (DHIS-2), Save the Children (principal recipient), integrated biological and behavioral surveillance survey, Ministry of Home Affairs, UNAIDS data hub, etc. There are many inconsistencies in the available data. For instance, in March 2017, the mapping and size estimation of key populations conducted by the NCASC reported an estimated 34,487 people who inject drugs (maximum) in Nepal; however, in June 2020, the Ministry of Home Affairs estimated over 90,000 people who inject drugs in Nepal. In 2022, NCASC (DHIS-2) reported 401 reactive cases among people who inject drugs; however, Save the Children reported that only 33 people who inject drugs were confirmed HIV positive during the same period. There are discrepancies in data available on HIV testing and NSP coverage too. Similar inconsistencies were found in the data available for other key populations as well.
- The HIV Standard Service Package for Key Populations 2020, a national guiding document, has defined a set of prevention interventions for people who inject drugs. However, people who inject drugs are not offered a comprehensive HIV prevention package. The quality of the services is poor and degrading in that the staff ratio, DIC ratio, service delivery standards (basic requirements), and the minimum training needs for service providers have not been translated into practice. The in-reach (or outreach) workers (IRWs) are gravely underpaid and overburdened. The staff turnover among IRWs is very high. Most IRWs have been providing services without any training (except the training on community-led testing).
- The National List of Essential Medicines Nepal (2021) has included methadone, buprenorphine, naloxone, and HCV medicines (sofosbuvir, velpatasvir, and ledipasvir) as minimum medicine needs for the basic healthcare system that are most efficacious, safe, and cost-effective medicines for priority conditions. Unfortunately, people who use drugs living with HCV (mono-infected) are unable to access HCV treatment (medicines). There is a lack of political commitment to scale up harm reduction services, especially opioid substitution therapy (OST) and naloxone (including in police custody, drug treatment centers, and prisons).

- An estimated 130,424 people use drugs in Nepal, of which around 7% are women. Of the total estimation, over 90,000 (69%) are people who inject drugs[1]. More than three-quarters (76%) of people who use drugs in Nepal are below the age of 30. However, access to services among young people who use drugs is very low.
- In 2020, the IBBS survey reported that the HIV prevalence was 2.8% among male people (or men) who inject drugs and 2% among women who inject drugs.
- The survey also reported that HCV prevalence among men and women who inject drugs was 13.3% and 8% respectively, but it widely varied and was significantly higher in some of the provinces, i.e., 26.8% in Sudurpashchim, 17.7% in Koshi, 16.7% in Bagmati, and 10.8% in Gandaki province.
- The survey also reported that women who inject drugs endure a notably high STI prevalence at 10%.
- The target set by the National HIV Strategic Plan (NHSP) 2021-2026 to increase the coverage of OST services by 40% (by 2026) is far from reality. Access to and coverage of OST services for people who use drugs remain very low. Major barriers to access services identified by people who use drugs include OST sites being located within the mental health division of a hospital, few or no separate services for women who use drugs, a high-threshold enrollment process, the lack of provision for 'take-home' doses for OST, etc. Certain legal provisions restrict young people who use drugs under the age of 18 from accessing harm reduction services.
- The NSP program has been able to reach less than one-third (32%) of the total estimated people who inject drugs. The Global Fund technical brief on harm reduction for people who use drugs has recommended offering 200 needles/syringes per person per year for HIV prevention and 300 for HCV prevention to people who inject drugs. However, people who inject drugs in Nepal were distributed only 113 needles/syringes per person per year in 2022.
- As of 2022, the overall HIV testing among people who inject drugs was 46%. The overall comprehensive HIV knowledge among people who inject drugs was below 50%.
- At any time, over 5000 people who use drugs are inside drug treatment centers with little to no access to HIV prevention services.

[1] The executive summary of Nepal Drug Users Survey 2076 (Ministry of Home Affairs) states that 29.6% are people who inject drugs. However, the detailed data on the mode of drug intake (p50) reported 69.1% were people who inject drugs. The latter data – 69.1% is consistent with the province-wise disaggregated data, i.e., province 1 (63.5%), province 2 (48.4%), Bagmati (80.5), Gandaki (93.3%), Province 5 (62.6%), Karnali Province (92.2%) and Sudurpaschhim (31.1%).

- There are no harm reduction services tailored to the needs of surging amphetamine-type stimulants (ATS) users in Nepal.
- In Nepal, drug use and possession for personal use remain criminalized. Police conduct towards people who use drugs and in-reach workers remains a constantly identified barrier to accessing or delivering services.

OBJECTIVES

- Conduct a participatory consultation process to identify HIV and RSSH priorities for inclusion into the Global Fund grant cycle 7 funding request.
- Share updates (where applicable, build the capacity of) with representatives of the drug-using communities (i.e., on the CCM, the Global Fund country-level structures and processes, including the country dialogue or the funding request development process).
- Ensure the final list of funding priorities of drug-using communities is shared with the CCM Nepal and the funding request writing (both in English and Nepali)
- Support the recipient in costing the proposed interventions and activities.

METHODOLOGY

Recovering Nepal, the national network of people who use drugs and drug service organizations in Nepal, was responsible for the coordination and logistics management necessary for the entire process. Mainline, an organization based in Amsterdam, Netherlands was the technical assistance (TA) provider. The process was led by an independent national consultant.

On 3 April 2023, Recovering Nepal convened a stakeholder meeting to form a steering committee - an oversight, coordinating, and decision-making mechanism for issues and priorities related to the country dialogue process. Between April to July 2023, the steering committee had four meetings in total. The list of members of the steering committees is attached as *Annex 4.*

The national consultant conducted a desk review of available published / unpublished reports and other relevant documents and, in coordination with Mainline, submitted an inception report with the findings of the desk review and a detailed process for the assignment. The consultation process comprised a series of provincial-level community consultations, a national consultation of communities of people who use drugs, and key-informant interviews in Nepal. The details of all the activities are provided in the table below. The CCM Nepal was officially informed about this TA support and progress to date.

Altogether 167 (133 male; 34 female) representatives participated in the provincial and valley community consultations. Participants in the community consultations were representatives from NSP and OST services, women-specific NSP services, drug treatment centers, TB-related services, and harm reduction service recipients. Participation of representatives from every harm reduction service site (DICs, OST sites, and extension sites in Nepal) with a mix of managerial- and field-level staff was ensured.

Table: Details of activities conducted in the country dialogue process

Activities	Description	Date & Venue	No. of participants
Itahari – Provincial-level community consultation	1-day consultation meeting covering representatives (participants) from Koshi province.	21 May 2023; Hotel Intourist, Itahari	Total - 33 (M=26; F=7)
Hetauda – Provincial-level community consultation	1-day consultation meeting covering representatives (participants) from Madhesh, Bagmati, and Gandaki provinces.	23 May 2023; Hotel Prakash International, Hetauda	Total - 43 (M=35; F=8)
Pokhara –Provincial-level community consultation	1-day consultation meeting covering representatives (participants) from Gandaki and Lumbini provinces.	28 May 2023; Hotel Zen Paradise, Pokhara	Total - 29 (M=24; F=5)
Nepalgunj – Provincial-level community consultation	1-day consultation meeting covering representatives (participants) from Lumbini, Karnali, and Sudurpashchim provinces.	2 June 2023; Hotel Kalptaru, Nepalgunj	Total - 27 (M=21; F=6)
Kathmandu – Valley community consultation	1-day consultation meeting covering representatives (participants) from Kathmandu Valley, i.e., Kathmandu, Lalitpur, and Bhaktapur districts.	5 July 2023; Bougainvilla Events, Kathmandu	Total - 36 (M=28; F=8)
Kathmandu – National community consultation	1-day national consultation meeting (Participants – steering committee members and representatives from each province) The national consultant presented preliminary results from above-mentioned community	6 July 2023; Bougainvilla Events, Kathmandu	Total - 23 (M=22; F=1)

	consultations to the participants. A prioritization exercise was held.		
Key Informant Interviews (KII)	NSP service recipient - 1 OST service recipients - 3 (including a female and a young person under the age of 25)	After each provincial-level community consultation	4 (M=3; F=1)

In each community consultation, participants were first orientated on the country dialogue process, the Global Fund country-level structure and processes, GC7 and in-country updates, and the themes for group work. Participants were divided into four groups, including a women-specific group, to discuss their issues and recommendations about the three thematic areas as below:

Themes for group discussion:

- **Community system strengthening** (issues concerning and recommendations for community-led research, monitoring, and advocacy; engagement, representation, and coordination; capacity building and leadership development of community-led organizations; and remunerations to community health workers)
- **Availability and accessibility of harm reduction services, especially NSP, OST, OD prevention (including HIV, HCV, STI, and TB testing and treatment, and other health services)** - (issues concerning and recommendations for service delivery challenges; IEC; barriers to access, including critical issues specific to women and young people who use drugs while accessing services; and capacity building and empowerment of people who use drugs.)
- **Human rights and legal/policy barriers to services** (issues concerning and recommendations for human rights-, gender-, and age-related barriers; stigma and discrimination; gender-based violence; legal literacy 'know your rights', legal support, and access to justice; and community-led advocacy.)
- **Other issues and/or recommendations**
- **Prioritization of recommendations**

The national consultant collated the results of all the group work conducted during community and valley consultations. Results were presented at the national consultation on 6 July 2023. The steering committee members and provincial representatives voted on their priorities as part of the prioritization exercise. Based on the prioritization during the national consultation, the national consultant presented the **funding priorities for people who use drugs** at the national consultation organized by CCM Nepal on 7 July 2023.

Note: *The program schedule for community consultations is attached as Annex 5.*

Note: *The questionnaire for key-informant interviews with harm reduction service recipients is attached as Annex 6.*

RECOMMENDATIONS (PRIORITIES)

#	Recommended interventions	Issues and expected impact or outcome	Additional comments
A.	**Community System Strengthening**		
1	- Increase salaries of and travel and communication costs for IRWs (field staff).	IRWs are gravely underpaid considering the geographical area they cover and the amount of work they have to undertake. Depending on various sub-recipients, IRWs' basic salary ranges from NPR 14,000 to 16,000 (USD 105 – 120) per month. The salary of IRWs who has been working for over 15 years ranges from NPR 20,000 to 23,000 (USD 150 – 175) per month. Monthly travel and communication costs provided to IRWs are NPR 3,500 (USD 26) and NPR 250 (USD 2) respectively. In comparison, the entry-level salary of IRWs employed under HIV prevention projects funded by USAID in Nepal is NPR 24,000 (USD 182). Similarly, travel and communication costs are NPR 5,000 (USD 40) and NPR 1,000 (USD 8) respectively. Considering all the above facts, the general price level, and inflation in the country, the salary and benefits offered to IRWs are not only insufficient but unfair/unjust. This has resulted in burnout, demotivation, and loss of trained human resources. Current salaries are insufficient to cover staff's basic needs, leading to stress, low motivation, and high turnover. A raise in salaries can have several benefits. 1) it provides financial stability, reducing stress and allowing employees to focus	Priority in all provinces; Priority among women;

		on their work. 2) it boosts motivation and job satisfaction, as fair compensation demonstrates value and recognition. 3) it reduces turnover, retaining experienced staff, and avoiding recruitment costs. 4) higher salaries help attract talented staff. 5) it enhances employee well-being, leading to better work-life balance and job satisfaction. 6) it contributes to a positive organizational reputation.	
2	- Conduct community-led research (participatory research partnerships) for the harmonization of data collected by/available through various projects/agencies/sources regarding people who use and/or inject drugs and harm reduction interventions' effectiveness.	At present, data on people who inject drugs are collected by or available through several agencies/sources, such as NCASC (DHIS-2), Save the Children (principal recipient), integrated biological and behavioral surveillance survey, Ministry of Home Affairs, UNAIDS data hub, etc. There are many inconsistencies in the available data. For instance, data on size estimation, HIV reactive cases vs confirmed HIV positive, coverage of HIV testing and NSP services among people who inject drugs. Similar inconsistencies were found in the data available for other key populations as well. Community-led research for data harmonization ensures improved data quality that reflects the needs and perspectives of the community. This can lead to more accurate and relevant data, resulting in better decision-making, efficient resource allocation, and policy development. A participatory research partnership model of community-led research will empower and build capacity of communities by ensuring their active participation in research design, data collection, analysis, and	Priority in province 3 (national network);

		interpretation. This will also contribute to enhanced collaboration and networking among different stakeholders, including community members, researchers, policymakers, etc.	
3	- Train harm reduction service providers, especially counselors and IRWs on counseling, motivational interviewing, outreach, overdose/abscess prevention and management, community-led testing, HIV prevention, harm reduction, etc. - Conduct refresher training and orientations for service providers on a regular basis.	The HIV Standard Service Package for Key Populations 2020 (guideline) has explicitly defined a minimum training package for each relevant staff or service providers. Both Counselors and IRWs of harm reduction services (NSP and OST) have not been trained to do their jobs effectively. Most of them are new and have been providing services without any training. Trained service providers will improve the overall quality and effectiveness of harm reduction services. It will also help them reach new clients and ensure retention of enrolled clients.	Priority in all provinces;
4	- Train community-led organizations (including drug treatment centers) on organizational development, leadership, report/proposal writing, and advocacy (especially focusing on organizational internal/operational policies). - Ensure that more priority is given to participation of women and women-led organizations.	A lot of community-led organizations, especially running rehab centers, still need support to build their capacity and leadership, especially women-led organizations or women board members and staff. Training community-led organizations will strengthen organizational capacity and create empowered community leaders. It will also contribute to an improved service delivery, networking and partnerships. Most importantly, training can help community-led organizations develop strategies for long-term sustainability.	Priority in province 3;

B	**Availability, Accessibility, and Acceptability of HIV prevention services for people who inject drugs**		
5	- Implement and scale up all the HIV prevention interventions for people who inject drugs assuring the highest attainable quality – as defined by the HIV Standard Service Package for Key Populations 2020 (guideline).	People who use and/or inject drugs are not offered a comprehensive HIV prevention intervention that has been defined by the national HIV Standard Service Package. The quality of the services is poor and degrading in that the staff ratio, DIC ratio, service delivery standards, and the minimum training needs for service providers have not been translated into practice. Availability of all the services as defined by the HIV standard service package guideline will offer a comprehensive and person-centered care to people who use drugs. Ensuring the implementation of requirements for staff/DIC ratio, service delivery standards, and the minimum training needs for service providers will significantly improve the quality of services. Adequate number of trained staffs will lead to increased reach and retention of clients.	Priority in all provinces;
C.	**Service improvement (Opioid Substitution Therapy)**		
6	- Scale-up/expand OST program in all provinces through new and extension sites or satellite clinics. (additional 6 main sites and 8 satellite sites - as proposed by NCASC in 2020)	Currently, the area to be covered by an OST site is large and quite stretched out. The OST program often faces dropouts because there is no provision of take-home doses and budget to compensate the transportation costs of service recipients coming every day from other cities/districts.	Priority in provinces 1, 3, 4, and 5; Priority among women;

	- Provide transportation costs to OST clients who must travel from other cities/districts to access the service. - Provide weekly take-home doses to OST clients who are considered stable as per the OST guidelines.	Expansion of OST program in all provinces through new sites and extension sites will increase access to services among people who inject drugs. Scaling up OST program will help achieve the National HIV Strategic Plan 2021-2026 target for OST program, i.e., enroll 50% of people who inject drugs in OST program by 2026. Increased coverage of OST will also help realize/determine its effectiveness in HIV prevention among people who inject drugs. Provision of weekly take-home doses and transportation costs for clients will significantly reduce dropout cases and help in the retention of clients.	Mentioned in direct interviews with OST clients in Itahari, Pokhara, and Nepalgunj;
7	- Train all harm reduction service providers, especially counselors and IRWs on mental health and psychosocial counseling. - Integrate services for mental health-related issues, such as mental health assessment, psychosocial counseling, career/relationship counseling, training & orientation programs, referral to psychiatrist, etc.	People who use drugs, due to the adverse experiences, such as stigma, discrimination, harassment, violence, etc. and substance abuse, are more likely to develop mental health issues which more than often lead to risky behaviors, such as harmful use of a combination of multiple drugs, unsafe sexual and injection practices, etc. The situation is worse among young women who use drugs. Integration of mental health-related services in the existing harm reduction interventions will enhance the intervention outcomes. This holistic approach to care will allow for early identification and intervention for co-occurring mental health disorders enabling timely support and long-term outcomes. It can also contribute to reduced stigma,	Priority in provinces 1, 3, and 4;

		substance abuse, and harmful behaviors leading to higher adherence and retention of clients.	
8	- Integrate HIV, STI, HCV, and TB testing and treatment services into the harm reduction interventions for people who inject drugs (specifically OST program). OR, - Increase the budget for referral (per person), including for treatment to those tested positive for STI, HCV, etc.	The present model of referral for confirmatory HIV/STI testing is time consuming and costly, not to mention without sufficient budget for referral. Clients are reluctant to go to a hospital or another service provider for HIV, STI, TB, and other confirmatory testing and treatment services. Clients do not wait for delayed results. Integrated services for people who inject drugs under one roof will increase access to testing and treatment services. More importantly, it will significantly improve the testing yield.	Priority in provinces 2, 3, 5, 6, and 7; Priority among women;
9	- Allocate the budget within the NSP and OST program to support the cost of either detoxification course or a short-term (15-30 days) rehab enrollment for at least 5-10 persons a year.	The NSP and OST program does not have any kind of support for clients who wish to move on to a life of abstinence. Oftentimes recipients who have been stable through OST program for over a year taper their dosage to a minimum possible and ask support for detoxification or enrolment in a rehab; however, they are compelled to continue taking OST as they are unable to afford the fees to go to a rehab. Many young people who use drugs avoid OST program because of the lack of exit options. Support for the safe transition from NSP and OST program to total abstinence can benefit many clients who wish to do so. More importantly, having such exit options (especially for OST clients) will help spread a positive message about	Priority in province 3; Mentioned in a direct interview with OST client in Itahari and Pokhara;

		the OST program and may increase adherence for young people who use drugs.	
D.	**Service Improvement (Needle and Syringe Program)**		
10	- Equip DICs with essential supplies to provide basic health services, including abscess treatment. - Allocate the budget for referral and treatment of abscess cases.	DICs have become merely a syringe distribution facility. In the past, DICs used to offer basic health services, including training/orientation sessions on various health, human rights, and harm reduction-related topics to people who use drugs. IRWs have encountered many untreated abscess cases. For a few abscess cases in urgent need of care/treatment, NSP program staff have been contributing money out of their pocket to ensure timely and appropriate treatment. At present, DICs do not have budget, trained staff, essential medicines/supplies, basic amenities, and educational activities. Well-equipped DICs with friendly ambiance will increase flow of clients and attract more women and young people who use drugs. Treatment support for abscess cases has been one of the most demanded services among NSP clients, so providing abscess treatment will significantly improve the overall quality of care and build community trust and relations.	Priority in provinces 1, 2, 3, 4, and 5; Priority among women; Mentioned in a direct interview with NSP client in Hetauda.
11	- Create friendly environment in DICs through activities and basic amenities, such as indoor games, entertainment (TV, wifi, etc.), newspapers, life skill/capacity building training, educational activities, refreshment (tea/snacks), etc.		
12	- Improve the quality of commodities such as condoms and syringes distributed.	Currently distributed condoms and syringes often break while in use, resulting in unprotected sex, infections, and abscesses. Clients complain about the material. Regular	Priority in provinces 2, 3, 4, and 5;

	- Conduct regular community-led quality monitoring of the commodities. - Involve communities' or national network representatives in the committees that are responsible for procurement, supply chain management, and quality control.	stock-out of supplies (methadone, buprenorphine condoms, syringes, alcohol swabs, testing kits, IEC materials, etc.) and delays in restocking has hindered smooth delivery of services. Better quality commodities will improve protection against HIV and other STIs. Materials approved by clients may improve use adherence to safer sex and injection practices. Efficient procurement, quality control, and supply chain management systems will contribute to the smooth operations/service delivery. Involvement of community representatives in those committees will play a vital role in bridging the communication gap between service providers and the committee. Since communities also play the role of watchdog/whistleblower, it may increase accountability among other members of the committee.	Mentioned in a direct interview with NSP client in Hetauda.
13	- Coordinate with drug treatment (rehab) centers and ensure that all people who use drugs frequenting rehabs are able to access voluntary HIV, HCV, STI, and TB testing, counseling, and treatment services. - Train counselors and outreach workers of rehab centers on harm reduction and related topics, including HIV/STI testing and counseling, overdose prevention and management, etc.	At any time, over 5000 people who use drugs are inside drug treatment centers with little to no access to HIV prevention services, such HIV, HCV, STI, and TB testing and treatment services. Despite this fact, counselors and outreach workers of rehab centers are not included as participants in training provided to harm reduction service providers. Better/close coordination between harm reduction services and rehab centers will ensure improved accessibility of services among people who use drugs. Since rehab center is a closed setting, access to testing, treatment, and	Priority in provinces 2, 3, and 4;

		counseling services will ensure early intervention and reduce risk for self and others. Trained counselors and outreach workers will ensure access to HIV prevention services among their clients. They will also ensure client-centered approach inside rehabs and may offer broader scope of support for people who use drugs, rather than merely focusing on abstinence.	
14	- Hire additional counselors and IRWs, especially from among women and young people who use drugs.	The number of IRWs currently employed at NSP and OST programs cannot reach the targeted number of people who use drugs, given the large program area (geographically). The normal standard staff ratio for IRWs is 1:150; however, IRWs have been reaching over 200 drug users every day with insufficient travel and communication costs (out-of-pocket spending), not to mention the burden of having to report in five different reporting system (i.e., personal diary, daily log-sheet, monthly log-sheet, OPMIS by the principal recipient, and ONHIS by the NCASC). Similarly, the staff ratio for OST counselor is 1:100; however, OST sites with nearly 200 clients have only one counselor. Both IRWs and counselors are over-burdened. This has resulted in burnout, demotivation, and loss of trained human resources. Hiring additional counselors and IRWs will reduce the workload and related stress among service providers, bringing resources to improve the quality of harm reduction services.	Priority in provinces 2, 3, 4, and 5; Priority among women;

15	- Expand NSP program in newly identified locations/hotspots through new DICs or extension sites (specifically in 10 additional districts where NCASC has already done the size estimation mapping of people who inject drugs).	While the number of IRWs (staff ratio) is already insufficient to deliver on the NSP target to reach clients, the number of DICs (ratio) in any given NSP program area is also low. For instance, the National HIV Standard Service Package for Key Population 2020 (guideline) defines that the DIC ratio is 1:500 clients and for every additional 500 clients a DIC should be established. However, in Kathmandu valley, there are at least 15 different hotspots with at least 3,500 clients, but only two DICs and two extension sites. It is the same in most of the provinces as well as with regards to women-specific NSP program. Where the ratio is correct, the geographical area to be covered by the staff is large. Expanding DICs or extension sites for NSP program in newly identified locations/hotspots will enable easy access to NSP services among people who inject drugs. It will significantly increase access and help in retention of clients.	Priority in province 3; Mentioned in a direct interview with NSP client in Hetauda;
E.	**Additional Prevention Interventions**		
16	- Include HCV testing and treatment for mono-infected drug users in the standard harm reduction service package. - Train harm reduction service providers on HCV knowledge and treatment literacy.	In 2020, the IBBS survey reported that HCV prevalence among men and women who inject drugs was 13.3% and 8% respectively, but it widely varied and was significantly higher in some of the provinces, i.e., 26.8% in Sudurpashchim, 17.7% in Koshi, 16.7% in Bagmati, and 10.8% in Gandaki province. However, there is no HCV testing and treatment support for mono-infected drug users	Priority in all provinces; Priority among women;

		and harm reduction service providers have little to no knowledge about HCV (treatment literacy). Making HCV testing and treatment available for mono-infected drug users (as recommended by WHO and the Global Fund) will benefit many who are unable to afford the diagnostics and treatment cost. This, together with trained service providers will contribute to improve HCV prevention and treatment, thereby reducing HCV prevalence among people who inject drugs.	
17	- Train harm reduction service providers on overdose prevention and management. - Make Naloxone (nasal spray and injectable) available to all harm reduction service sites and especially to all IRWs in the field.	Naloxone is not available to harm reduction services. Harm reduction service providers are not trained on overdose prevention and management. Trained service providers equipped with Naloxone will be able to intervene as and when they witness overdose cases. As IRWs are more likely to witness overdose, they will be able to prevent overdose-related deaths.	
18	- Train women drug users (especially young women) on HIV, STI and SRHR (covering menstrual hygiene, safe abortion, condom demonstration, and other SRHR topics).	Women who use drugs generally lack knowledge on sexual and reproductive health and rights (SRHR). Enhanced knowledge on SRHR among women who use drugs will increase their access to services and improve health outcomes. Training on SRHR will equip women with the knowledge and skills to protect themselves from various risks and vulnerabilities associated with their sexual and reproductive health. It will also empower women to	Priority among women;

		challenge societal stigma and discrimination and promote dignity.	
19	- Update/redesign IEC materials using a gender and age lens and disseminate through both offline and online mediums (apps, social media, etc.). - Use virtual/online platforms to reach women and young people who use drugs.	Harm reduction services still depend on traditional IEC materials and methods of reaching people who use drugs due to which it is challenging to reach young people. IEC materials distributed by harm reduction services in Nepal were designed at least a decade ago and haven't been updated ever since. They are not youth/gender-friendly. In most cases, IEC materials are out of stock and there is no budget to reprint. More gender-sensitive and youth-friendly IEC materials will attract attention of women and young people who use drugs. More importantly, use of online platforms to disseminate them and reach women and young people who use drugs will increase access to services.	
20	- Establish gender-sensitive and youth-friendly harm reduction services: ▪ Train all service providers on gender-sensitive and youth-friendly harm reduction services. ▪ Hire additional counselors and IRWs from among women and young people who use drugs and train them. ▪ Create low threshold harm reduction services to increase access, i.e., low age-related barrier, less paper work during enrollment, use of pseudo names/initials,	Women and young people who use drugs generally are unwilling or uncomfortable or do not feel safe while accessing targeted interventions designed and provided by male (adult) service providers. Therefore, both NSP and OST services have hard time reaching women and young drug users. In many cases, those who are willing to enroll into OST program are unable to do so because of the requirements, especially identification documents and presence of family member. Women and young drug users do not want to engage their families, as that would mean disclosure about	Priority in provinces 1, 4, 5, 6, and 7; Priority among women;

	consideration for enrollment without presence of spouse/family member, etc. ▪ Address women-specific needs and offer services such as separate restroom, breastfeeding room, menstrual hygiene kits, abortion-related services, nutrition support to infants of women drug users, etc. ▪ Adjust opening hours and location as per demand (need) of women and young people who use drugs (with travel cost for those who have to travel from other cities or districts) ▪ Ensure privacy and confidentiality, especially by IRWs and counselors, (i.e., soundproof counseling rooms separate from rest of the other dispensing, program and admin offices) ▪ Establish gender/youth-friendly complaint mechanisms for unprofessional/unethical/ discriminative actions by service providers and broader human rights abuses outside service facility.	their drug use. Many do not have identification documents. Furthermore, women find the opening hours inconvenient, as they are more likely to engage in household activities during those hours. Given the extremely low access to existing harm reduction services among women and young people who use drugs, establishing a gender-sensitive and youth-friendly services will increase the access among the group. It will also enhance effectiveness of existing services and contribute to reduced stigma and discrimination experienced/perceived by women and young people who use drugs.	
21	- Train service providers on harm reduction for Amphetamine Type Stimulants (ATS) users. - Develop IEC materials on harm reduction for ATS.	The current harm reduction services for people who inject drugs (both NSP & OST) are primarily focused on people who use and/or inject opioid-based substances, while many people who use drugs (including young people who use drugs) in urban cities have shifted from opioids to Amphetamine Type Stimulants (ATS), such as crystal meth	Priority in provinces 3 and 4;

		(ice) and Yaba. Most harm reduction service providers have little to no knowledge about harm reduction for ATS users. Training on harm reduction for ATS will equip service providers with relevant knowledge, skills, and evidence-based practices/resources, thereby enhancing their ability to engage, support, and connect clients/individuals who use stimulant drugs to appropriate services. This can also contribute to improved data collection and monitoring of stimulant drug use trends and associated harms. Overall, it will expand the scope of existing harm reduction services and ultimately, reduce the harms associated with stimulant drug use.	
22	- Improve the interface and speed of the One National HIV Information System (ONHIS).	Since the introduction and piloting of ONHIS database, most IRWs have not been able to go to field visit to deliver harm reduction services. At present, IRWs have to record their service delivery-related information in at least 2-3 different reporting systems, including ONHIS. The ONHIS interface is not user-friendly and performs very slow. User-friendly and fast performing ONHIS reporting system will improve efficiency of the system, thereby making it easier for everyone to use.	Priority in province 3, 4, and 5;
23	- Include capacity building training (Life skill training, leadership, vocational training, etc.) for OST service recipients and recovering people who use drugs (clients of rehab centers).	OST service recipients are unable to resume their school/college. Most do not have capacity/skills to find a job or advocate on their issues. They expect support in the form of job placement or small income generating support.	Mentioned in a direct interview with OST client in Nepalgunj;

		Offering capacity building training and income generating support to OST clients and recovering people who use drugs will empower them. With enhanced skills, they may have access to a broader range of opportunities, including educational, employment, and personal growth prospects.	
24	- Expand OST program (Buprenorphine) in rehab centers as a long-term opioid dependence treatment option for people with chronic opioid dependence.	People who use drugs inside rehab centers are unable to access OST services (especially buprenorphine). Expanding OST program in rehab centers will contribute to increased retention and treatment outcomes. It ensures stability among clients and may lead to changes in current rehab practices.	
F.	**Addressing human rights- and policy-related barriers**		
25	- Conduct advocacy for the drug law reform (Narcotics drug control act 1976). - Conduct a national campaign for decriminalization of people who use drugs (specifically for drug use and possession of drugs for personal use).	In Nepal, drug use and possession for personal use remain criminalized. Widespread stigmatizing attitudes, discriminatory actions, arbitrary arrests, coercive treatment, gender-based violence, and other forms of human rights violations are some of the serious concomitants of a criminal/punitive drug law. Studies have associated enforcement of criminalizing drug laws with poor coverage of services and risky behaviors among people who use drugs, such as hasty drug use and injection practices, which often lead to sharing of needles/syringes, overdose, and drug use in unhygienic, unventilated, and isolated areas/spaces, among others. Access to and coverage of OST	Priority in all provinces;

		services (as well as NSP) for people who use drugs remain very low. Police conduct towards people who use drugs remains a constantly identified barrier to accessing services. Advocacy for drug policy reform through national campaign and other activities will start a discourse that aims to shift the focus from punitive measures towards a public health approach. While it is a long-term advocacy, the discourse in itself can lead to increased public receptivity and policies that prioritize harm reduction, prevention, treatment, and support for individuals struggling with substance use disorders. More importantly, it will ensure continuation of prevention and harm reduction services for people who inject drugs and help preserve the gains of the investments of the last two decades.	
26	- Advocate to amend / revise the OST guidelines, especially to ensure a low-threshold enrollment, low age barrier, provision of take-home doses, and scale up / expansion of OST program.	The current OST guideline makes it difficult to enroll people who use drugs under 18 years of age and those who do not have proper identity documents (such as, birth certificate, citizenship card, etc.) Successful advocacy to revise the OST guidelines will end the systematic barrier to access. In other words, it will significantly increase access of women and young drug users to OST services.	Priority in all provinces; Priority among women; Mentioned in a direct interview with OST client in Itahari;
27	- Conduct coordination meetings, media-sensitization, community awareness, and harm reduction orientation	Local police and public are either unaware or unsupportive of the harm reduction services (NSP & OST). Strict policing has caused drug use hotspots to shift frequently. In some	Priority in provinces 5, 6, and 7;

	program with/for police, media, and public on a regular basis. - Allocate the budget for coordination meetings and other above-mentioned activities. - Use social media to create awareness and positive support towards harm reduction services.	provinces, the local police, anti-drug mothers' group, and general public continue to have negative attitude towards drug users and harm reduction services. IRWs and NSP service recipients have been arrested for carrying syringes and alcohol swabs with them. Since, police have started random drug testing for vehicle drivers (in general), there have been a few cases when an OST client has tested positive and arrested. Many service recipients have been harassed and unnecessarily interrogated on their way to or back from DICs. Time and again, the women-specific DIC has been visited by local police and asked for information about service recipients. Meanwhile, media keeps spreading misinformation about harm reduction services, especially about the OST program. While activities like community awareness and coordination meetings with local stakeholders are essential, the Global Fund Principal Recipient keeps cutting these activities. Community awareness and coordination meetings with local stakeholders will enhance collaboration and provide a platform for sharing knowledge, experiences, and best practices. It will contribute to creating an enabling environment for service providers and clients - leading to uninterrupted access.	
28	- Build capacity of people who use drugs on human rights and legal literacy.	People who use drugs (and more specifically young and women) lack knowledge on human rights and the redressal process. They are unable to defend themselves from abuse,	Priority in all provinces;

	- Provide no-cost paralegal services for people who use drugs (via NSP and OST programs) - Establish a human rights complaint mechanism in harm reduction service sites in order to document human rights violations among people who use drugs.	violence, harassment, etc. When arrested, people who use drugs do not have access to any kind of legal counseling and services. In any case, they are unable to afford such services. Human rights training and legal literacy will increase awareness of rights among the community and empower them to assert their rights and advocate for their needs. It will improve access to healthcare, reduce stigma and discrimination, and prevent human rights abuses. The training may inspire people who use drugs to engage in policy and advocacy efforts, as they can contribute their lived experiences and expertise to shape policies and programs.	
29	- Train all harm reduction service provider on (causes and consequences of) stigma and discrimination and on stigma reduction.	Women who use drugs are reluctant to access harm reduction services due to fear of societal stigma and discrimination associated with drug use. In some provinces, service recipients participating at the consultation mentioned that they experienced discriminative actions from OST service providers. None of the harm reduction service providers attending the community consultation had ever received any training on stigma and discrimination. Training service providers on stigma and discrimination will increase awareness and understanding of service providers regarding the experiences and challenges faced clients, reduce stigmatizing attitudes and behaviors, and improve overall quality of care and community relations. It will also	Priority in province 3; Priority among women;

		create an enabling environment in service sites and increase access.	
30	- Train all harm reduction service provider on a gender-sensitive approach and gender-based violence (GBV). - Allocate the budget for GBV program and activities. - Provide legal counseling and legal service fees support for drug users (especially women).	Women who use drugs continue to face intimate partner, domestic violence, and sexual harassments. There is no program to address gender-based and intimate partner violence. The GBV-related activities under the human rights grant (matching fund/catalytic fund) has also been cut. There are no services such as legal counseling and legal service fees support for women who have suffered GBV. Training on gender-based violence will equip service providers with a deeper understanding of GBV and enable them to effectively identify signs of GBV among their clients and respond non-judgmentally. The training will enhance support system and integrate prevention and education strategies into their work. GBV-related activities, including legal services, will empower both service providers and clients to respond and redress effectively.	Priority in province 1 and 3; Priority among women;
31	- Advocate with the relevant government agencies to ensure the right to vital registration (especially for women and young people who use drugs) is upheld. - Allocate budget to support women who use drugs with the cost associated with the registration process.	Many women who use drugs face challenges in the process of vital registration, such as birth certificate, marriage certificate, citizenship card, etc. (right to recognition everywhere as a person before the law). Successful advocacy for vital registration of people who use drugs, especially women, will help uphold their rights to a legal recognition. It will significantly improve access to care and dignity.	Priority among women;

ANNEXES

Annex 1: References

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Annex 2: Excerpt from "The Global Fund technical brief on harm reduction for people who use drugs" (Priorities for investment and increased impact in HIV programming, Allocation period 2023-2025)

The Global Fund technical brief on harm reduction for people who use drugs is a guiding tool that helps applicants to the Global Fund plan for and scale-up effective HIV and hepatitis C programming for people who use drugs, particularly those who inject drugs. In the brief, the Global Fund explicitly recommends countries' funding requests support the achievement of the Global AIDS Strategy 2021-2026, which includes the '30–60–80 targets' emphasizing the role of community-led organizations in HIV response.

The brief also highlights the key targets of the Global AIDS Strategy 2021-2026 that by 2025:

- 90% of people who inject drugs have access to comprehensive harm reduction services integrated with or linked to hepatitis C, HIV and mental health services.
- 50% of people who inject drugs and are opioid dependent have access to OST.
- 80% of HIV prevention services, 30% of testing and treatment services, and 60% of programs to address societal enablers for people who inject drugs are community-led.
- Less than 10% of people who inject drugs or living with HIV experience stigma or discrimination, less than 10% of women who use drugs or living with HIV experience gender inequality/violence, and less than 10% of countries have punitive legal or policy environments that lead to denial or limitation of services.

To accelerate efforts towards meeting the above targets, the Global Fund has recognized harm reduction and human rights as 'program essential'.

The priority harm reduction interventions both in the community and in prisons and other closed settings are:

- **Needle and syringe program (NSP)** that offers people who inject drugs the recommended quantity of sterile injecting equipment without confidentiality violations, without requirements for 1:1 exchange, and without requirement for identity documents and police interference.
- **Opioid substitution therapy (OST)** that is easy to start (low-threshold) and continue for as long as necessary, and is complemented via take-home doses, and that can be integrated with HIV, hepatitis B and C, and TB testing and treatment.
- **Overdose (OD) prevention** with the distribution of naloxone to those most likely to witness an OD (people who inject drugs, their families, and friends) along with training on use.

Funding requests can include programs for people who use/inject drugs and their sexual partners rather than only people who inject drugs. Some of the additional prevention interventions for people who use drugs and their sexual partners include:

- **Hepatitis B and C prevention, testing, and treatment** for people who use drugs and people in prisons – regardless of HIV status.
- **Harm reduction for drugs other than opioids,** such as stimulants and new psychoactive substances – whether injected or not – and often used to enhance sex (referred to as chemsex).
- Other interventions, including **Sexual and reproductive health (SRH) services, including condoms, STI testing and treatment; HIV testing; PrEP/PEP**

Human rights program essentials are:

- **HIV programs integrate interventions to reduce human rights- and gender-related barriers to services** (e.g., inclusion of legal services at harm reduction sites or inclusion at NSP programs of services for women who use drugs in all their diversity).
- **Reducing of stigma and discrimination in healthcare and other settings** (e.g., community-led monitoring to document human rights violations).
- **Legal literacy (know your rights) and access to justice activities** (e.g., legal trainings for people who use drugs).
- **Support for efforts, including community-led efforts, to analyze and reform harmful laws and policies,** such as criminal penalties for drug use, possession of harm reduction equipment/drugs for personal use, and other harmful laws and policies (e.g., community-led advocacy for legal and policy reform).

Annex 3: Excerpt from "The National HIV Strategic Plan (NHSP) 2021-2026"

Nepal's HIV response is guided by the National HIV Strategic Plan (NHSP) 2021-2026, which is grounded on the principles of advancing human rights, health equity, gender justice, and meaningful engagement of key populations and people living with HIV. It explicitly identifies the critical need to reduce the disparities in access to prevention, treatment and care services by addressing issues around human rights, gender-based violence, stigmatization and discrimination which continue to hinder access to HIV services for children, adolescents, young women, and key populations. The targets of the NHSP are guided by global goals and targets, including but not limited to the Global AIDS Strategy (2021-2026). The central strategy for achieving the 95-95-95 targets is to identify, reach, test, treat, and retain (IRTTR).

Key populations, including women and young people, remain the main focus of the National HIV Strategic Plan (2021-2026). The national response mainly aims to accelerate and scale up comprehensive HIV prevention programs, including harm reduction interventions for people who use drugs and their sexual partners. Some of the priorities set out in the NHSP that are relevant to people who use drugs are:

- Implement the differentiated services delivery (DSD) approach to ensure that the most vulnerable groups are reached, such as women who inject drugs also involved in sex work, and gay men injecting drugs.
- Continue and expand primary prevention intervention, especially for key populations, including harm reduction (NSP and OST) for people who inject drugs.
- Ensure gender-specific barriers are addressed throughout all HIV programs.
- Strengthening and scaling up of OST services through advocacy with the concerned ministries and partners to create enabling environments.
- Advocacy for dispensing take-home doses for stable clients.
- Integrate gender-specific services into prevention programming, including GBV prevention, and access to care and legal services for GBV survivors.
- Expand community-led testing, self-testing, index testing, online to offline and social risk network referral testing.
- Addressing social protection services for key and vulnerable populations, including income generation opportunities for people living with HIV and key populations.
- Further build the capacity of CSOs in scaling up outreach services, community-involved monitoring, documentation, and advocacy for domestic resource

mobilization.

- Addressing cross-cutting issues of stigma and discrimination, gender and human rights- related barriers to access services.
- Enabling policy environment at all levels.
- Establish youth-friendly services, particularly for key populations.

Annex 4: List of members of the steering committee and technical experts

SN	Name	Role	Email ID
1	Bishnu F. Sharma	CEO, Recovering Nepal (Steering committee coordinator)	bishnu@recoveringnepal.org.np
2	Ujjwal Karmacharya	CCM Member (Representative of people who use drugs)	ujjwalkarmacharya@gmail.com
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4	Prashant Sharma	President, Federation of Drug Demand Reduction (Network of drug treatment centers)	fddrfederation@gmail.com
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6	Binod Gurung	Sathi Samuha (NSP service provider)	bnod36@gmail.com
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9	Rajesh Didiya	National TB Network	tbnetworknepal@gmail.com
10	Aaswin Thapa	OST service recipient	harmreduction69@gmail.com

Technical Experts

10	Rafaela Rigoni	Lead Expert (Mainline, TA provider)	r.rigoni@mainline.nl
11	Bikas Gurung	National Consultant	bikasg369@gmail.com

12	Gaj B. Gurung	Research and Policy Analyst, Harm Reduction International (Volunteer – Expert on Global Fund-related topics)	Gaj.Gurung@hri.global

Annex 5: Community consultation – Program schedule

Time	Activities	Objectives	Materials	**Facilitator** (may change depending on provincial or national consultations)
9.30 –10.00	Registration, welcome & Introduction Opening remarks - Recovering Nepal (President or CEO or member of the steering committee assigned for provincial consultations) - Add others	. welcome and create enabling environment for everyone.	Microphone	Recovering Nepal (members/focal person for this assignment at provincial-level) & all participants
10.00 –10.15	Ground Rules, Roadmap & Objectives (Plenary)	. help participants establish their own ground rules. . share objectives of the event.	Flipcharts, markers, masking tape, laptop & projector	Assigned member of the steering committee (TBD)
10.15 –11.15	The Global Fund, country dialogue process, and opportunities for people who use drugs in the Global Fund grant cycle 7 (Plenary/presentation/Q&A)	. introduce participants to the Global Fund and guide them through the country dialogue process and opportunities it offers for people who use drugs.	Flipcharts, markers, laptop & projector	Bikas Gurung
11.15 –11.30	Cigarette and coffee break			

11.30 –12.00	Preparation for group work (Plenary/presentation/Q&A)	. prepare participants for the next session (group work)	Laptop, projector, flipcharts, markers & masking tape	Bikas Gurung
12.00 –13.00	Lunch break			
13.00 –14.30	Group discussion on key issues of people who use drugs and recommendations or solutions/desired situation (Workshop/group work) Participants to be divided into 4 - 5 groups consisting of at most 5 members in each group. Themes for discussion: - **Community system strengthening** (issues concerning and recommendations for community-led research, monitoring, and advocacy; engagement, representation, and coordination; capacity building and leadership development of community-led organizations; and remunerations to community health workers) - **Availability and accessibility of harm reduction services,**	. identify key issues and recommendation of people who use drugs on three thematic areas.	Flipcharts, markers & masking tape (preferred to provide laptop for each group & group discussion template)	Bikas Gurung & support (TBD)

	especially NSP, OST, OD prevention (including HIV, HCV, STI, and TB testing and treatment, and other health services) – (issues concerning and recommendations for service delivery challenges; IEC; barriers to access, including critical issues specific to women and young people who use drugs while accessing services; and capacity building and empowerment of people who use drugs.) - **Human rights and legal/policy barriers to services** (issues concerning and recommendations for human rights-, gender-, and age-related barriers; stigma and discrimination; gender-based violence; legal literacy 'know your rights', legal support, and access to justice; and community-led advocacy.) - **Other issues and/or recommendations**			

14.30 –14.45	Cigarette Break			
14.45 –16.00	Group discussion on key issues of people who use drugs and recommendations (Plenary/presentation by each group and interaction) Each group will identify at most 3 priorities from their discussion/presentation.	. offer participants sufficient time to present their group work. . hold interactive discussion to identify further issues as well as cross-cutting ones.	Flipcharts, markers & masking tape (laptop & projector)	All groups (10 - 12 mins each)
16.00 –16.30	Cigarette & afternoon snacks break			
16.30 –17.00	Review of the day and closing	. revisit each session and summarize key points for participants. . acknowledgements and closing.		Bikas Gurung, RN (member of the steering committee and provincial member/focal person)

Annex 6: Checklist (questionnaire) for key-informant interviews – Harm reduction service recipients

1. What are the main challenges you (and/or people who use drugs) face while accessing services?
    - Service facilities and providers-related
    - External barriers, including legal and human rights-related
    - Capacity and knowledge level among people who use drugs

2. How do you think the quality of available services can be improved? What needs to be improved/changed?
    - Quality of commodities
    - Infrastructure and basic amenities
    - Competency of service providers (esp. counselors and outreach workers)
    - IEC

3. What is necessary for the existing harm reduction services (NSP, OST, OD, HCV, etc.) to improve accessibility and service delivery, especially considering less assisted populations such as women and young people who use drugs?
    - Integration of harm reduction services into one another
    - Infrastructure, operating protocols, etc.
    - Gender-specific and youth-friendly services

4. In your perspective, what would be the main priorities for action considering your recommendations? Please list three priorities and justify why you see them as priorities.