New Insights into the Drug and Drug Service Situation in Nepal

Summary from a Needs Assessment Study

September 2009

gtz German BACKUP Initiative

COOPERATION NEPAL GERMANY

RECOVERING NEPAL

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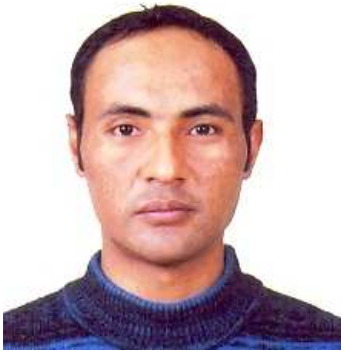

Foreword

The national response to drug use & HIV/AIDS began quite early in Nepal through Harm Reduction Initiatives, which has remained the mainstay of the national program. However the quality, coverage and the continuity of the response has always remained a challenge. A Wide range of non-government and community organizations throughout the country are providing the services. However, comprehensive mapping of services has not been undertaken until now to identify the nature and scope of services being provided to people who use drugs and living with the diseases.

This Needs Assessment findings addresses those gaps by comprehending the drug scenario, service interventions and capacity of agencies that are currently working directly with people who use drugs. The picture drawn by this report through its findings provides us all with guidance on how to develop new and effective policy and programs for people who use drugs to address those gaps.

It is hoped that the recommendations of this report can form the basis for developing a more informed, cost-effective and comprehensive National policy and plan for Drug use and HIV/AIDS in Nepal, as well as for identifying capacity building opportunities and linkages to enable agencies to make more effective use of the global health financing systems in the future.

I would like to take this opportunity to sincerely thank the GTZ Back Up Initiative who funded this assessment. I would also like to acknowledge the work that has been done by Dr. Ashish Sinha, the lead consultant, and his team members: Mr. Madhav Prasad Adhikari and Mr. Ujjwal Karmacharya, who spent their time and energy to produce this result.

Special thanks to all the agencies, our partners - with whom we work and to individuals who have contributed their time by participating in the study. We thank you for discussing and bringing out crucial issues with the assessment team.

Anan Pun
Chair
Recovering Nepal
Kathmandu

Foreword

"Drug injecting spreads HIV rapidly…and jump starts the epidemic in the sex trade[1]." These were the striking messages in a recent report presented to UN Secretary General Ban Ki-moon titled *"Redefining AIDS in Asia: Crafting an Effective Response."* Sharing syringes and needles when injecting drugs is the easiest way of HIV getting transmitted. Infected drug injectors can introduce the virus into the sex trade in two ways: as buyers (male injectors buy sex from sex workers whom they infect), or as sellers (female drug injectors sell sex to male clients, whom they infect).

Recovering Nepal is pleased to present this publication highlighting the drug scenario and service interventions in 15 Districts with high concentration of drug users in Nepal.

This is the first time that an in-depth study has been conducted which provides a synthesis of Nepal's drug situation identifying immediate problems and needed public health interventions. The study gives an overview from the Eastern, Kathmandu Valley, Western and Far-Western regions of the country and is an important step in the process to empower drug users and mitigate negative consequences of drug use including blood borne infections. This document is a monumental step forward in providing information to create an enabling environment towards universal access to harm reduction interventions for drug users in Nepal.

The broad goal of this exercise was to identify needs of service providers working with drug users and to comprehend the drug scenario of the district and its respective regions. Specifically, the objective of the needs assessment was to draw findings based on which, capacity development activities would be devised to enable service providers to make more effective use of the global health financing systems such as resources from the Global Fund in the future.

Key findings and recommendations show that with some exceptions, essential services such as needle syringe exchange, residential drug rehabilitation and drop-in centers were regarded as not well accessible for drug users. This topic also has a female face: key stakeholders expressed that in all regions, more than 80% of female drug users remained hidden from current services . This gender gap calls for further analysis and identification of service models targeting women and girls, which would help establish best practices for interventions that target female drug users.

At the national level, the study recommends that Government and development partners' policies, strategies and programs related to drug and drug led harms should be based on ground realities and needs of the target population.

Recovering Nepal presented a draft of this report to a wider group of key stakeholders at the National Harm Reduction Conference held in Kathmandu in August 2009. The findings and conclusions were discussed with conference participants and their feedback is incorporated in this report.

I hope you find this report helpful for your work with drug-using populations and service providers. Free copies may be ordered from Recovering Nepal (ashish72@ntc.net.np). In addition, the report is available for download at the Recovering Nepal website (www.recoveringnepal.org.np).

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21 October 2009

[1] „Redefining AIDS in Asia: Crafting an Effective Response;" Report of the Commission on AIDS in Asia; Oxford University Press; March 2008.

Background

Recovering Nepal (RN) is a network of organizations working with drug users (DUs) in Nepal. It aims to influence policies that improve the quality of lives of drug users, reinstate their rights and create a supportive environment. RN works to empower drug users and mitigate negative consequences of drug use including blood borne infections and create an enabling environment for universal access to meaningful services for DUs in Nepal.

RN entered into a partnership with the German BACKUP Initiative to conduct a needs assessment for organizations working on drug and drug led harms in Nepal. BACKUP stands for "Building Alliances – Creating Knowledge – Updating Partners" to fight AIDS, Tuberculosis and Malaria and other priority diseases. It was established by the Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH in 2002, shortly after the creation of the Global Fund. The BACKUP Initiative offers needs-oriented technical support to different types of organizations to enable them to make effective use of global health financing in responding to these diseases.

The information shared in this summary are selective findings from a needs assessment study conducted in 15 districts of Nepal from January 19th to February 8th 2009. The purpose of this exercise was:

- to identify needs of service providers (SPs) working with DUs and
- to comprehend the specific drug scenario of the districts and thus the five regions.

In addition, the objective of the needs assessment was to draw findings based on which, capacity development training activities would be devised to enable SPs to make more effective use of the global health financing systems in the future. RN would like to share these selective findings so that it can help key actors better position themselves to be able to devise meaningful interventions in the future. The findings in this summary include discusses (1) 'Summary of findings' – a synopsis of key findings from the 5 development regions of Nepal and Kathmandu valley (Kathmandu valley is analyzed separately from the central region); (2) Regional characteristics – qualitative summation of district findings for respective regions and Kathmandu valley; and, (3) Conclusions and way forward on the basis of the findings. It should also be noted that regional characteristics are qualitative and thus cannot be used for comparative purposes.

Methodology

The 15 districts selected were in accordance to Nepal government's ranking of 15 districts with high concentration of 'hard drug users[2]' in Nepal (see Table). The study was divided into two prongs. The first focused on the service providers (SPs) and tried to get a first hand insight on the functioning of their organizations and the impact of their services. The second level of analysis comprehended the perspective of the target population (recovering, current and female DUs) on the drug scenario and the quality of service interventions in the district. This publication presents mainly the findings from the second prong.

The needs assessment utilized the following tools to collect data: a) survey questionnaire filled by SPs; b) focus group discussions (FGDs) with current, recovering and female drug users (FDUs) c) ethnographic observation of critical sites, organizations and actors; and, d) semi structured interviews with key community leaders. FGDs with FDUs were held in 5 of 15 districts where locating a sizeable group of FDUs was possible. Sessions with FDUs were mostly facilitated by local experts who were familiar and had prior rapport with FDUs in the community.

[2] Hard Drugs are defined by Central Bureau of Statistics (CBS) report as all form of synthetic opiates and chemical substances that are treated as illicit drug by law (CBS. "Summary Report of the Survey on Hard Drug Users in Nepal – 2063". June 2007). All national players including the international agencies and related government agencies working on HIV and AIDS have accepted the CBS/MoHA figure over other DU population estimations.

The study on SPs opted for a 'complete enumeration' approach– inviting all SPs within the networking of RN to partake in the survey. This was possible due to a manageable number of SPs working in drug and drug led harms in almost all districts. Further, this was also made possible by a strong networking presence of RN to be able to get in contact with the SPs. An exception however was made for Kathmandu and Lalitpur districts, where the size of SPs were considerably larger than other areas. A 'judgmental sampling technique' was used for these two districts. This technique was selected for the following reasons: to bring in justifiable representation of various types of SPs (ranging from drug treatment to harm reduction services to home based care services, etc.); and to bring in good quality data from SPs who have considerable experience in the field. The above criteria were discussed with the RN regional secretariats, which formally approached the SPs in their respective regions. With the exception of few non-responses, altogether, 145 SPs were included in the SP survey.

Table: Population of Hard Drug Users by Area by Sex

No.	Name of district	Region	Hard drug user population		
			Total	Male	Female
1-3	Kathmandu valley (Kathmandu, Lalitpur, and Bhaktapur districts)	Central	17458	15580	1878
4	Kaski	Western	5112	4794	318
5	Jhapa	Eastern	3523	3378	145
6	Sunsari	Eastern	3186	2854	332
7	Rupandehi	Western	2588	2454	133
8	Chitwan	Central	2071	1880	191
9	Morang	Eastern	1316	1267	50
	Parsa	Central	1301	1212	89
11	Makwanpur	Central	481	462	19
12-15	Kailali, Kanchanpur, Banke, and Kavre	Western, Farwestern, Central	9274	9074	200

Source: Summary Report of the Survey on Hard Drug Users in Nepal – 2063. Central Bureau of Statistics / Ministy of Home Affairs. June 2007

FGDs were conducted with current, recovering and female drug users and SPs working in areas of drug and drug led HIV for each district. The study used the 'purposive sampling' technique to locate participants for FGDs. This was done through RN regional representatives and their networks in the districts. The total number of FGD participants were 681 [current DUs (n) = 284; recovering DUs (n) = 313; and FDUs (n) = 84]. The DUs contacted for this study were capable in every aspect in relating and answering to issues the study investigated. The FGD responses presented in this fact sheet are given or agreed by most to several participants.

The settings of the metropolis, service entities, crucial drug interaction areas, and the India-Nepal border areas were observed by the research team which provided useful insights in understanding the various obvious and subtle processes of drug dynamics in the district. Such observations provided insights on the cultural practices of DUs and SPs, the work of SPs and the drug scenario unique to the region/district.

Summary of Findings

Important aspects of the drug situation in Nepal

A majority of DUs in the districts were IDUs. However, in border towns like Birgunj (Parsa district), Nepalgunj (Banke district), and Kakaribhitta (Jhapa district), oral use was also equally prevalent. Oral to injecting was the usual shift pattern or progression in the career of DUs. In some areas, novice users, as indicated in Eastern and Western region, were also going straight to injecting due to easy availability of injecting drugs in the region.

- The widespread drug for IDUs was available in a 'set' - a set is a cocktail fix of buprenorphine with antihistamines and sedatives. Although numerous, a typical combination could be a cocktail of 2ml buprenorphine with 2 ml each of Phenergan (antihistamine), Avil (antihistamine), Alegic (antihistamine), and Diazepam (sedative). The buprenorphine brand available in majority of districts was Lupijesic ('lupes' or 'lupi' in street parlance). Respondents reported of severe physical discomforts with the use of a 'set'. Also, there was consistent reporting of abscess cases in almost all regions using Lupijesic.
- Of the 15 CBS districts with high concentration of DUs in Nepal, 9 shared borders with India and one had close proximity to the Nepal India border. Drugs were 'easily' available (access and price wise) at the border areas between Nepal and India. Injectable drugs in form of a 'set' were available at Rs. 60(per set) at the Jogbani border (Indian town bordering Eastern region). One didn't have to walk for more than 150 meters across the border to purchase drugs. Brown sugar was available in border towns of Birgunj and Nepalgunj for Rs. 100 per quarter/gram and in Kakaribhitta for Rs. 200 per quarter/gram. In Kavre, brown sugar (locally known as Chiang Mai brown) was brought from the Khasa (Chinese) border. Reportedly 'good', it was available for Rs. 200 per quarter/gram.
- Even though drugs were easily available in all regions, shortage situation was prevalent during *bandh*/strike days. In all probability, *bandh* (district shutdown) periods are when risk behaviors could significantly increase due to closure or difficulties in accessing medical shops and drop-in centres (DICs) and because of difficulties in finding transportation.
- DUs in almost all regions reported of harassment (and in few cases physical assault) from law enforcement agency and youth organizations affiliated with political parties.
- In addition to alcohol and cannabis, commercial inhalants were also finding its way among school and college population, this was reported especially in the Far-western region.

Accessibility of existing service interventions

- Services were comparatively accessible for DUs of municipality areas, however, for DUs of semi-urban, highway and rural areas, services were very difficult to access.
- Services were also difficult to access for DUs with weaker economic background. Many lacked knowledge and awareness on existing services in their areas.
- Except for Kathmandu valley, districts were short of services for DUs. Primary health care (PHC) and free rehabilitation treatment scheme were high in demand in most of the districts.
- Condom distribution was the most accessible service for DUs in the districts. However, few respondents from Kathmandu district opined that though condom was easily available it

was not the priority of DUs. With some exceptions, essential services such as needle syringe exchange program (NSEP), residential drug rehabilitation (DRC) and drop-in center (DIC) were regarded as not adequately accessible (for reasons mostly attributable to high cost, difficult transportation access, unfriendly services and limited services and coverage) for DUs.

- Key stakeholders opined that FDUs who remained hidden from current services were above 80 percent for all regions.

Organizational sustainability, structure, and link with national drug policies

- Almost all service organizations were donor funded. They could face closure if funding stopped. The major donor agencies currently funding drug and drug led HIV projects were: Department for International Development (DFID), The Global Fund (TGF), United Nations Development Program (UNDP), United Nations Office on Drugs and Crime (UNODC), and Save the Children (SC).
- A majority of organizations seemed to have a basic organizational structure; however, organizational as well as programmatic planning was one of the most neglected aspects. Lack of good governance, especially lack of technical and managerial competence, organizational capacity, and decision making and implementation process was also seen as an area needing intervention.
- Most of the SPs were not aware of what the national priorities on drug and drug led harms were and the majority was not aware of the National Drug policy 2063 and the draft strategy, 2065 .

Regional Summation: Far-Western Region				
Drug of choice in the area	'Set*' *[a 'set' is a cocktail fix of buprenorphine with antihistamines and sedatives. Although numerous, a typical combination could be a cocktail of2ml. buprenorphine with two ml. each of Phenergan (antihistamine), Avil (antihistamine), Alegic (antihistamine), and Diazepam (sedative)].* Synthetic Opioid: Lupigesic (buprenorphine), Proxyvon, Spasmenton Codeine: Phencydyl, Corex Antihistamine: Phenergan Sedative: Diazepam, Nitrosun Opiates: Brown sugar Commercial inhalant: Tipex (ink whitener).			
Mode of taking drugs & pattern shift	The general mode of taking drugs amongst DUs is injecting. However, taking drugs orally is also common, especially corex . There has been increase in the number of teenagers (school/college going students) taking drugs orally in the area. Tipex sniffing is also popular amongst college going boys and girls.			
Immediate health consequences	Blood clotting and vein damage; overdose deaths ; swelling; hydrosol; fever; weakness; abscess; physical pains; problem with sight; tuberculosis; ulcer			
Services Accessed by DUs (least to most, on a scale of 1 to 10)	*Treatment/Rehabilitation*	4 (Only Kailali had a treatment center)	*DIC*	4
	Detoxification	NA*	*OST*	NA*
	Needle-syringe exchange	5	*CHBC*	NA*
	Primary Health Care	3	*Condom Distribution*	8
7. Proportion of DUs hidden from existing services	Male	60 % to 70 %		
	Female	Majority of participants couldn't estimate the hidden population of the female drug users. Few put the figure to be around 50%.		

Service accessibility (transportation and cost wise)	Services were not so easily available in the area and that it was expensive. This was more prominent for users living in semi-urban or rural settings. Services were however accessible for the users living in the city area at least in terms of transportation, if not in terms of cost.
What services are easy for DUs to access and why?	
Barriers for DUs in having their needs met?	Unemployment Stigmatization Undermining the capacity of DUs Lack of family/community sensitization No job opportunities for (ex) DUs Lack of care and concern towards DUs from SPs (they just work for money not for us) Poverty
What are the most difficult problems faced by DUs in this area right now?	Harassment from Police and the general public Increase in number of non-users working in this field leading to loss of opportunities for (ex) DUs Lack of coordination amongst organizations working in the issue Lack of coordination with police administration Limited services No reinforcing factors to quit drugs Lack of support from organizations, family/community No abscess management Access to services like free treatment, OST, etc. are not available in the region
What services do you think are the most important for DUs at the moment?	PHC Abscess Management NSEP Detoxification – home based After care Psychosocial Counseling Free Treatment is must IGPs / jobs for (ex) DUs Abscess Management Rehabilitation Centre Support group OST program Awareness Programs for communities and students
Needs not met	Community sensitization Prevention program for teens Employment for recovering DUs. Coordination PHC Services not accessible for economically marginalized DUs and female DUs Harm reduction programs Hepatitis intervention Abscess management Free treatment Needs of wage laborers who use drugs – information awareness, access to services Referral mechanism for drug treatment & rehabilitation as there is none in the district
Suggestions for service providers to make services more effective	Proper management of NSEP Medical services esp. PHC should be free of cost Understand issues of DUs and work for their benefit Ensure capacity development of the existing services (esp. Rehabilitation centre) Skill development training and jobs for (ex) DUs An enabling environment for (ex) drug users to use their skills Family counseling programs and awareness programs for the communities Treatment center should have medical services/PHC with medical doctors Rehabilitation of alcoholics Facilitate community-based rehabilitation programs Establish home-based care programs Staffs should be present in DIC during office time Establish rehabilitation centre Programs should focus on creating jobs for recovering drug users Start OST program.

*Note: This information is a qualitative summation of district findings resulting from FGDs conducted in selective district(s) for respective regions. Districts for Far-Western region include Kanchanpur and Kailali districts. * NA stands for 'not available for DUs'. However, this does not necessarily imply that the service is not available in the region/ district.*

Regional Summation : Eastern Region

Drug of choice in the area	'Set' *[a 'set' is a cocktail fix of buprenorphine with antihistamines and sedatives. Although numerous, a typical combination could be a cocktail of 2ml. buprenorphine with two ml. each of Phenergan (antihistamine), Avil (antihistamine), Alegic (antihistamine), and Diazepam (sedative)].* Synthetic Opioid: Lupigesic (buprenorphine), Proxyvon, Codeine: Codeine based Cough syrup Antihistamine: Avil Sedative: Diazepam, Nitrosun Opiate: Brown sugar			
Mode of taking drugs & pattern shift	Around 80% are injecting, oral to injecting is the usual shift pattern. Brown sugar is orally used. Currently, many are going straight to injecting (easy availability)			
Immediate health consequences	Major abscess with rotting away of skin and tissues after one month. Easily torn or puncturing of wounds when abraded. This was particularly evident with use of a particular 'buprenorphine' brand named 'Lupijesic' in Jhapa district. However, abscess was evident in all districts.			
Services Accessed by DUs (least to most, on a scale of 1 to 10)	*Treatment/Rehabilitation*	5	*DIC*	4
	Detoxification	3	*OST*	NA*
	Needle-syringe exchange	6	*CHBC*	2
	Primary Health Care	3	*Condom Distribution*	9
Proportion of DUs hidden from existing services	Male	Around 30 % from urban & 75% are out of services in rural areas		
	Female	90%		
Service accessibility (transportation and cost wise)	For the DUs of urban areas the services are accessible, however for DUs of semi-urban, and high-way areas services are inaccessible			
What services are easy for DUs to access and why?	Condom and NESP are comparatively easy to access because of mobilization of outreach workers, and can be accessed in medical shops as well.			
Barriers for DUs in having their needs met?	Centralized services; for DUs of semi-urban and high-way areas services are inaccessible			
Most difficult problems faced by DUs	Abscess treatment Difficulties in accessing syringes Location of DICs not appropriate for all DUs Attitude of former DUs not supportive to current users Irregularity in services (no services in holidays) FDU-family reintegration Limited options of services Lack of free-treatment – long waiting list Police harassment			
Most important services for DUs at the moment?	Free Drug treatment service; NSEP; PHC; OST FDUs- Female friendly drug treatment and reintegration into family			
Needs not met (service gaps)	Community sensitization Prevention program for teens IGP for recovering DUs PHC Service accessibility for economically marginalized DUs and female DUs Hepatitis intervention Abscess management Free treatment Needs of wage laborers who use drugs – information awareness, access to services Referral mechanism for drug treatment & rehabilitation			
Suggestions for service providers to make services more effective	Proper utilization of funds Transparency in free quota of treatment and scale up of service Proper planning, monitoring and evaluation of plans and program of the district No nepotism and favoritism while providing services to target group Income generating activities for both the current and former users; Interaction program among service providers and target population in regular interval Increase program coverage in semi-urban, highway and villages as well Early intervention while people are not IDUs; special care for DUs, Launching of OST program			

*Note: This information is a qualitative summation of district findings resulting from FGDs conducted in selective district(s) for respective regions. Districts for the Eastern region include Morang, Sunsari, and Jhapa. * NA stands for 'not available for DUs'. However, this does not necessarily imply that the service is not available in the region/ district.*

Regional Summation : Kathmandu Valley

1. Drug of choice in the area	‘Set’ *[a ‘set’ is a cocktail fix of buprenorphine with antihistamines and sedatives. Although numerous, a typical combination could be a cocktail of2ml. buprenorphine with two ml. each of Phenergan (antihistamine), Avil (antihistamine), Alegic (antihistamine), and Diazepam (sedative).*]. Synthetic Opioid: Lupigesic (buprenorphine), Cough syrup Antihistamine: Avil Sedative: Diazepam, Nitrosun Opiate: Brown sugar, Heroin Cannabis: Marijuana, Hashish				
2. Mode of taking drugs & pattern shift	Around 30 to 40% oral and 60 to 70% injecting, usual progression from oral to IV				
3. Immediate health consequences	Abscess, vein shrinking, vein ‘collapse’				
4. Services Accessed by DUs (least to most, on a scale of 1 to 10)	*Treatment/Rehabilitation*	4	*DIC*	6	
	Detoxification	2	*OST*	1	
	Needle-syringe exchange	7	*CHBC*	2	
	Primary Health Care	3	*Condom Distribution*	5 (few respondents from KTM district opined that though easily available condom wasn’t the priority of DUs)	
5. Proportion of DUs hidden from existing services	Male	Around 45 %			
	Female	NA			
Service accessibility (transportation and cost wise)	Accessible				
6. What services are easy for DUs to access and why?	NSEP and condom distribution services are easy for the DUs to access because there are no rigid criteria About 60% of IDUs are in contact with outreach workers and peer educators.				
Barriers for DUs in having their needs met?	Stigma and discrimination Lack of awareness and orientation among young DUs regarding existing services Lack of interest among DUs regarding services and their rights Lack of sensitization and education among community and law enforcement agencies on fundamental issues of DUs Lack of coordination among key Stakeholders Inadequate and un-trained Human Resources in the service fields Insufficient program coverage specifically targeting DUs.				
Most difficult problems faced by DUs	YCL and Police harassment (sensitization) insufficient program coverage in Bhaktapur district.				
Most important Services for DUs at the moment?	Free treatment quota for comprehensive rehabilitation package (primary care, daycare and aftercare) Prevention programs 24 hours Drop In Center service Proper detoxification facilities (including home based detoxification & counseling services) Decentralization and upscaling of OST.				
Needs not met (service gaps)	Most of the organizations in the districts are run by recovering DUs hence, both the target group and the SPs are well aware of the overall scenario. However, there is a huge communication gap (service orientation) among the DUs and SPs				
Suggestions for service providers to make services more effective	Increase outreach sites and design target specific intervention strategies to reach different groups of DUs Sensitize the key stakeholders (particularly, Police and Young communist league) regarding comprehensive drug treatment and the concept of Harm reduction Upscale services for the DUs in Bhaktapur District				

*Note: This information is a qualitative summation of district findings resulting from FGDs conducted in selective district(s) for respective regions. Districts for Kathmandu Valley include Kathmandu, Lalitpur and Bhaktapur. * NA stands for ‘not available for DUs’. However, this does not necessarily imply that the service is not available in the region/ district.*

Regional Summation : Central Region

Drug of choice in the area	'Set' *[a 'set' is a cocktail fix of buprenorphine with antihistamines and sedatives. Although numerous, a typical combination could be a cocktail of2ml. buprenorphine with two ml. each of Phenergan (antihistamine), Avil (antihistamine), Alegic (antihistamine), and Diazepam (sedative)].* Synthetic opioid: Lupigesic , Tidigesic, Proxyvon Codeine: Codeine based Cough syrup Antihistamine: Avil Sedative: Diazepam, Nitrosun Opiate: Brown sugar Cannabis: Ganja, Hash			
Mode of taking drugs & pattern shift	70% are injecting & 30% are oral users (both male and female). Oral users ultimately turn into injecting, however, these days many are going directly into injecting. But, there is a considerable number of oral DUs in Parsa who hardly inject due to easy and cheaper availability of drugs in the district. One dose (quarter of a gram) of Brown Sugar only costs around hundred rupees in Raxwal, the Indian border town.			
Immediate health consequences	Abscess, Vein shrinking			
Services Accessed by DUs (least to most, on a scale of 1 to 10)	*Treatment/Rehabilitation*	2	*DIC*	2
	Detoxification	NA*	*OST*	NA*
	Needle-syringe exchange	3	*CHBC*	NA*
	Primary Health Care	2	*Condom*	6
Proportion of DUs hidden from existing services	Male	60 % in rural areas and around 35 % in urban areas		
	Female	95		
Service accessibility (transportation and cost wise)	For the DUs of urban areas the services are comparatively accessible, however, for DUs of semi-urban and rural areas services are very difficult to access.			
What services are easy for DUs to access and why?	Condom, NESP and drug treatment are comparatively easy to access because of the higher numbers of SPs in this area, or there are no rigid criteria, but the demand of these services are higher			
What are the barriers for DUs in having their needs met?				
Most difficult problems faced by DUs	Harassment from YCL and Police (sensitization) Insufficient programme coverage specifically targeting Drug Users Sexual abuse for FDUs Discrimination and stigmatization in the society Lack of comprehensive Services Location of service centers aren't appropriate			
Most important Services for DUs at the moment?	Scale up of free Drug treatment service, scale up NSEP and PHC in strategic areas Decentralize OST 24 hours DIC services; Prevention programs			
Needs not met (service gaps)	Detoxification, PHC, post rehabilitation care, OST needs Limited drug treatment services Post rehabilitation care services for DUs Unaware of the need for OST program Prevention program among DUs, who are in the early stage of drug use Needs of FDUs and the street based I/DUs Vigilance to constantly monitor needs of target population.			
Suggestions for service providers to make services more effective	Increase outreach sites and design target specific intervention strategies to reach different groups of DUs Program coverage should focus in urban outskirts, semi-urban areas and villages as well Sensitize the key stakeholders (particularly, Police and Young communist league) and the community on comprehensive drug treatment and concept of Harm reduction Frequent interaction among service providers and target population Early intervention to prevent DUs turning into IDUs Female friendly services in place Skill development and micro-entrepreneurship should be incorporated into existing services Transparent management of free Treatment services Scale up services			

*Note: This information is a qualitative summation of district findings resulting from FGDs conducted in selective district(s) for respective regions. Districts for Central region include Kavre, Parsa, Makwanpur, and Chitwan. * NA stands for 'not available for DUs'. However, this does not necessarily imply that the service is not available in the region/ district.*

Regional Summation : Western Region

Drug of choice in the area	'Set' *[a 'set' is a cocktail fix of buprenorphine with antihistamines and sedatives. Although numerous, a typical combination could be a cocktail of2ml. buprenorphine with two ml. each of Phenergan (antihistamine), Avil (antihistamine), Alegic (antihistamine), and Diazepam (sedative).* Synthetic Opioid: Lupigesic (buprenorphine), Codeine based cough syrup Antihistamine: Avil Sedative: Diazepam Opiate: Brown sugar			
Mode of taking drugs & pattern shift	60 to 70% are Injecting. Most start with oral and then turn into injecting and some directly go for injecting.			
Immediate health consequences	Abscess			
Services Accessed by DUs (least to most, on a scale of 1 to 10)	*Treatment/Rehabilitation*	4	*DIC*	3
	Detoxification	*NA	*OST*	*NA at the time of field research
	Needle-syringe exchange	2	*CHBC*	3
	Primary Health Care	2	*Condom*	8
Proportion of DUs hidden from existing services	Male			
	Female	95		
Service accessibility (transportation and cost wise)	For the DUs of urban areas services are easily accessible, however for DUs of semi-urban or rural areas services are difficult to reach due to transportation cost and or distance			
What services are easy for DUs to access and why?	Comparatively, condom and NESP is easy to access than other services.			
Barriers for DUs in having their needs met?	Inappropriate location of services			
Most difficult problems faced by DUs	Police harassment FDU-drug treatment and rehabilitation Limited options of services No services on holidays for NSEP Inappropriate location of DIC.			
What services do you think are the most important for DUs at the moment?	FDUs- Female friendly drug treatment and child care center OST Increased coverage of NSEP PHC services			
Needs of TP being unnoticed by SPs				
Needs not met	Drug treatment and rehabilitation for FDUs OST Employment Trainings and capacity development Comprehensive Package for IDUs and leadership development for effective and efficient implementation of IDUs program Involvement of IDUs at local level planning and program implementation			
Suggestions for service providers to make services more effective	Free quota of treatment should be managed transparently and at the same time scaled up as well Advocate for launching OST program Incorporate income generating activities for both current and former users in regular programs			

*Note: This information is a qualitative summation of district findings resulting from FGDs conducted in selective district(s) for respective regions. Districts for Western region include Kaski and Rupandehi districts. * NA stands for 'not available for DUs'. However, this does not necessarily imply that the service is not available in the region/ district.*

Regional Summation : Mid-Western Region

Drug of choice in the area	Opiate : Brown sugar Synthetic Opioid : Proxyvon Codeine syrup : Corex Opium : Morphine Sedative : Nitrosun				
Mode of taking drugs & pattern shift	Most commonly used mode is Oral (pulling Brown Sugar) Very few (only around 1 %) inject drugs primarily due to easy access and cheaper price (100 rupees/qtr of gram) of Brown Sugar. Banke district of Mid-western region shares border with India.				
Immediate health consequences	Abscess Burning Vomiting Physical weakness Sleeping disorder Mental disorder Respiratory Problem				
Services Accessed by DUs (least to most, on a scale of 1 to 10)	Treatment/Rehabilitation		5	DIC	5
	Detoxification		NA*	OST	NA*
	Needle-syringe exchange		3	CHBC	NA*
	Primary Health Care		5	Condom	--
Proportion of DUs hidden from existing services	Male	Identified	800 to 900		
		Hidden	60 – 70 % of estimated total users (i.e. 1500)		
	Female	Identified	8 (including recovering)		
		Hidden	80 – 90 %		
Service accessibility (transportation and cost wise)	Affordable and easier in terms of transportation and cost as well				
What services are easy for DUs to access and why?					
Barriers for DUs in having their needs met?	Lack of resources and lots of barriers in mobilizing resources by SPs Poverty Lack of information about SPs Lack of concern of police administration Recovering users not able to act as role model for current DUs Stigma and discrimination Lack of support from family/society Lack of motivation for undergoing treatment				
Most difficult problems faced by DUs	Limited services for larger number of DUs Lack of medical and treatment services Expensive drug treatment No services like free treatment, OST, etc. available in the region				
Most important Services for DUs at the moment?	Free or affordable treatment Enhanced quality of existing services OST After care Relapse prevention program Support group Rehabilitation centre with better infrastructure and facilities Advocacy and sensitization program Awareness programs				
Needs not met (service gaps)	Existing services not enough Services not accessible for economically marginalized DUs and female DUs Community sensitization Prevention program for teens Hepatitis intervention Abscess management Free treatment Needs of wage laborers who use drugs – information awareness, access to services Referral mechanism for drug treatment & rehabilitation.				
Suggestions for service providers to make services more effective	Free or affordable drug treatment Programs for PLWHA in the area Organizations should provide services to everyone not only to their preferred clients Continuation and sustainability of the existing program Action oriented programs for rural areas and marginalized communities Promote and start community-based care Provide skill development programs and employment opportunities				

*Note: This information is a qualitative summation of district findings resulting from FGDs conducted in selective district(s) for respective regions. District for Mid-Western region include Banke. * NA stands for 'not available for DUs'. However, this does not necessarily imply that the service is not available in the region/ district.*

Conclusion & Way Forward

Considerations for improving existing service interventions to increase quality and coverage

- There is need for services to be scaled up in all districts. However scaling up is not the only answer, the services also have to be sustainable, of good quality and accessible to the target population, especially to those who are economically marginalized.
- Alongside rapid population growth and urbanization, drug use is now moving to semi-urban, highway and rural areas where access to services is minimal. Interventions should be devised so that services are equally available to target population residing in these areas. Strategic location of services is crucial so that they are accessible to DUs located in all locations of the district. Service planning and base-line assessment is essential before starting services.
- With increasing health consequences among IDUs, PHC facilities need to be strengthened and up scaled in all 15 districts.
- With few exceptions, vital services such as DRCs, NSEP and DIC were not regarded by recovering and current DUs as highly accessed services in the regions (for reasons mostly attributable to high cost, difficult transportation access, unfriendly services and limited services and coverage). It is vital that service providers rethink their strategy of reaching out to service users as these services are core drug abuse interventions of Nepal. It is imperative that concerned stakeholders, including the government assess ways to make services such as these more accessible to DUs.
- Findings showed that DRCs played a vital role in comprehensive service delivery (from abstinence to harm reduction). The study thus finds it imperative that support be provided to DRCs to make them more accessible for DUs, especially to those who are economically marginalized.
- Free treatment was high on demand; however, many DUs felt that previous free treatment programs were 'misused' by SPs and that many had to 'pay' even though it was free treatment. Mechanisms for such services should be transparent. Also, advocacy for free treatment scheme must be strengthened at the national level due to its demand in almost all regions.
- Improved coordination and communication among SPs and their donor partners was needed to avoid duplication of efforts, to increase service coverage in the district, and to inform the target population on the services available.
- Mechanisms should be in place to cater services for DUs in holidays and *bandh* days as risk behaviors can significantly increase in such period.

Neglected issues that need to be addressed by new or additional interventions

- The 'quality' of drug is an important issue to consider due to severe health consequences of injecting drugs. The threat now is not just on needle sharing, but the drug itself. Quality of drug should also be taken into consideration when devising harm reduction interventions (including monitoring).
- Youth were in risk of drug use in all districts, and unfortunately, there were no sustaining prevention efforts in any of the districts. Drug prevention programs are needed for both in-school and out of school youth and adolescents in the districts.

- Demand for information on Hepatitis was high in the districts. With research indicating high prevalence of Hepatitis among IDUs, a national level program on Hepatitis prevention/care is therefore needed.
- Border vigilance could be a useful intervention for RN. It could set a rapid response team (under its regional secretariat) to monitor and report on the quality and health consequences of drugs in border markets (the *'nakas'*). A strong supervision and monitoring setup in the regional secretariats would be required for this.
- A strong national level M&E system is needed to comprehend the efficacy of services on drug and drug led harms in the nation. Such a system could provide useful information and feed back to enhancing services nationally. It could also contribute towards maintaining a national level database on types of services available in the country. Such a system could also provide useful feedback in developing realistic and proactive national policies and intervention strategies on drug and drug led harms in the country.
- More sensitization and active dialogue with law enforcement agencies and youth organizations of political parties are needed to prevent possible infringement on the safety and rights of DUs.
- There was very minimal involvement of the government on drug abuse interventions in the districts. The role of government is crucial to sustain efforts in the event of decrease of HIV related funds in the districts. The government can utilize its existing regional and district level resources and infrastructures, such as in health, and in income generating skills programs. The government could also mobilize some funds set for marginalized youth (Ministry of Youth and Sports) and provide subsidized food stuff for residential programs through government food depots.
- It is vital that SPs look for ways to diversify their funding base. Almost all service organizations working in drug led harms are donor funded. They will most will likely face closure if funding stops.

Addressing the gap between national policies and local realities

- National policies, strategies and programs related to drug and drug led harms should be based on ground realities and needs of the target population. Donor funded projects shouldn't bar programs (like free treatment scheme) if they don't fall on their agenda.
- A national debate involving major stakeholders from the districts needs to begin under the aegis of the Ministry of Home Affairs to make national policies and strategies proactive and to bring ownership of SPs on national programs and policies. Dissemination and awareness of National Strategies and Policies (many SPs were found unaware on this) should be kept in priority so that district plans and programs align with National priorities and that such efforts are owned by SPs in the districts.

Key considerations on working with Female Drug Users

- Key stakeholders felt that FDUs who remained hidden from current services were above 80 percent in all regions of Nepal. This reality calls for specific targeting or reorientation of services and for creating a friendlier space to ensure secure environment for FDUs to be able to access such services.

a) Immediate Problems of FDUs

- Social reintegration was a crucial challenge for FDUs. Respondents argued that 'double discrimination' of FDUs (one being a woman and the other being a FDU) was real and that these issues made it very difficult for FDUs to reintegrate in the family / community.
- Many respondents lamented on the lack of female focused/friendly treatment services for FDUs and many felt that they were not comfortable in accessing services geared primarily for male DUs.
- Many respondents and SPs regarded that sexual abuse of FDUs was pervasive and that many have been a victim of sexual abuse in their drug career.
- Recovery for many married FDUs depended on the well being of their husbands, who at most times were also drug users. It was hard for married FDUs to maintain sobriety when their husbands were actively using drugs.

b) Need for targeted interventions

- There was a need for more study and identification of female oriented service models, which would help establish best practices for all FDU related interventions.
- Child care should be a priority service to go alongside any female interventions
- Family/social reintegration was an important area to design service interventions
- Appropriate income generation trainings were needed for FDUs who might have dependants (especially children) on her income.
- Currently there are only two FDU-drug treatment and rehabilitation services in the country. This service needs to be scaled up.
- Peed led intervention was regarded by stakeholders as an effective mechanism to reach out to FDUs and to bring them to services.

c) Capacity Development

- Capacity development of organizations working with FDUs and of potential FDUs with leadership capabilities was deemed important to fast-track interventions for FDUs. Many SPs agreed that interventions with FDUs lagged behind considerably compared to male interventions. A major area to focus was to have capable female leaders, role models or a network of concerned SPs to take forward the female movement. The following specific areas were identified by FDUs as essential for their capacity development for working with FDUs in Nepal: Leadership development for those with leadership potential; advocacy and strategic planning to strengthen the female movement and services.

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Human Rights

abstinence

oral substitution therapy

Harm Reduction

safe needle/syringe

social integration

Health Rights

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