

HIV/AIDS Prevention Among Injecting Drug Users in Kathmandu Valley

Report for The Centre for Harm Reduction

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1. Introduction

Background

HIV/AIDS represents a serious threat to Nepal. HIV is spreading rapidly in many parts of Nepal, including Kathmandu Valley (KV). A major US study recently predicted that HIV/AIDS will most likely continue to expand in the developing and transitional world for the next 20 years at least, and predicted that South Asia would be one of the worst affected regions during this period (CIA 2000). Unless the epidemic is quickly brought under control and new HIV infections decrease markedly, the demographic situation in Nepal is likely to change significantly: with reductions in the most productive sectors of the population. This will place increasing economic strains on the country as the proportion of elderly and youth increase compared with the working population: 30,000 people infected with HIV in the late 1990s will soon be turning up in hospitals and clinics with signs of AIDS. This is the beginning of an AIDS epidemic that threatens to occupy much of Nepal's medical resources and funding for several decades.

It is estimated by national experts in Nepal that more than 35,000 people had acquired HIV infection in Nepal by September 2000, and this figure is likely to rise rapidly in coming years unless massive efforts are made to prevent HIV transmission. The official statistics show 1778 HIV cases at the end of November 2000 (NCASC 2000). However, the stigma attached to a HIV positive status, the cost of testing, and the perception that there are no services for HIV-positive people, are likely to lead to under-reporting and avoidance of voluntary HIV testing.

Transmission among drug users and sex workers is the engine driving the Nepali HIV epidemic; the Ministry of Health of Nepal stated in 2000 that the factor determining the existing HIV epidemic in the country is the risk behaviour of injecting drug users (IDUs) and sex workers (NCASC 2000).

Looking specifically at the situation in Kathmandu Valley, it is now estimated that more than 50% of IDUs there are HIV-positive (HMG Nepal 2000). As there remain large groups of uninfected IDUs (and a constant stream of uninfected youth beginning to inject each year), and as the virus is spreading so quickly among IDUs, prevention efforts need to concentrate on effective approaches to preventing transmission among drug users.

In addition, injecting drug users with HIV form an ever-expanding pool of infection from which HIV is spreading to the general population of Kathmandu Valley. Sexual spread from IDUs to their non-injecting sexual partners and transmission to children has been identified as a leading cause of ongoing HIV epidemics in countries such as India (Panda *et al* 2000).

Where commercial sex workers (CSWs) also inject drugs, the likelihood of a widespread sexual epidemic of HIV increases dramatically, as there are two vectors (sharing injecting equipment, and sexual transmission) for spread of the virus. In Nepal, the level of injecting drug use among CSWs, and the level of sex work (for drugs or money) by IDUs, has not been systematically studied. However, evidence that a minority of sex workers injects drugs and the majority of women IDUs does sex work show that this issue is a concern in Kathmandu Valley.

As the pool of infected IDUs and CSWs continues to grow, the spread of HIV will soon move beyond high-risk groups to the general community. The two most important factors in the spread of HIV heterosexually from these groups to others in Kathmandu Valley are the level of sexually transmitted diseases (STDs) and the level of unsafe sexual behaviour in the general community. Traditional cultures in which sexual behaviour is not usually discussed and a very low rate of usage of health facilities suggest that unsafe sexual behaviour and STDs are very common in the Valley.

All of the factors are in place in Kathmandu Valley for a massive HIV epidemic. The Nepali Government, together with the governments of Australia, UK and USA, and international organisations UNAIDS and UN Development Program, recently joined forces to develop an effective response to HIV/AIDS in Kathmandu Valley and across Nepal. The authors were part of a five-member team (including Team Leader Dr Peter Deutschmann and Dr Damien Morgan, both of the Macfarlane Burnet Centre for Medical Research) who undertook a two-week assessment of the HIV/AIDS situation in Kathmandu Valley. The authors specifically considered various aspects of addressing HIV among IDUs in the Valley.

Methods

During this assessment, existing government and research reports and other important documents were collated and studied. Interviews were carried out with policy makers, and with staff in NGOs, government departments and international organisations.

Two surveys were carried out among IDUs and female sex workers in the Kathmandu Valley during December 2000. Two national consultants (one male and one female), working with two different NGOs in the Valley, were responsible for carrying out the surveys. They were helped by the injecting drug users and sex workers themselves working as members of the survey team. Two different sets of semi-structured questionnaires were used for these surveys, each having 10 questions. The questionnaires were translated into Nepali, translated back into English, and pre-tested before administering them in the field. The respondents were asked questions on age, monthly income, drug use practice, duration of drug use, number of sharing partners, sexual practice, condom use, number of clients in a week, felt need for health care, felt need for drug treatment etc. In addition to quantitative responses, qualitative data were also recorded.

A purposive sample of injecting drug users and sex workers was chosen from different parts of the Kathmandu Valley. In view of the fact that the national consultants were from two NGOs based in the Kathmandu district, an attempt was made to reach out to as many respondents beyond the usual clientele of these organisations as possible. The IDU survey is reported here. As well, three focus group discussions were held with IDUs (two groups of men, one group of women).

2. Characteristics of injecting drug users in Kathmandu Valley

In a survey carried out for this assessment (called here the KV survey), a total of 204 IDUs were interviewed from mid-December, 2000 through early January, 2001; 169 (82%) were from Kathmandu, 14 from Bhaktapur and 21 from the Lalitpur district. Nine out of the 204 respondents were female IDUs, all of whom were in commercial sex work. Most of the IDUs were within the age range of 25 to 30 years:

Age in years	Number (%)
15-20	34 (17)
>20-25	60 (29)
>25-30	87 (43)
>30-35	17(08)
>35-40	06 (03)

Results of this survey are provided in the sections below. In addition to the survey of IDUs, three focus groups were held with:

- clients of *Lifesaving and Lifegiving Society (LALS)* from Kathmandu city (11 male IDUs)
- women clients of *Richmond Fellowship Women's Program* (three female IDUs)
- drug users in Bhaktapur city (seven male IDUs) of whom six were aged 22 to 28 and one was 37.

Interviews were also carried out with key informants working closely with IDUs, including staff of harm reduction outreach and drug treatment services, and staff and clients of the only methadone program in Kathmandu.

From the surveys, focus groups and interviews, the following information was found. The headings below relate only to male IDUs (due to the great difficulty in finding information about women IDUs). What was discovered about women IDUs has been gathered in a specific section at the end of this report.

Number of IDUs in Kathmandu Valley

One of the key questions which needs to be answered about the emerging HIV epidemic in Kathmandu Valley is: how many injecting drug users (IDUs) are there in the Valley?. It was impossible to give a definite answer to this question in two weeks, but there are many hints that the proportion of IDUs is not as large as in some other countries. The numbers of people arrested and detained for drug crimes are in the hundreds rather than thousands each year, but there may be an element of underestimation in this, as many people arrested for drug use are registered as “people causing social unrest.” The numbers of drug users reportedly seeking drug treatment at NGOs is similarly in the low hundreds. The areas we visited with outreach teams were not heavily populated with IDUs (despite visiting one major dealing area), though this may have been the result of recent police activities. Statements by IDUs in focus groups showed that they knew about 60 IDUs in Bhaktapur (with another 10 in a nearby rural district) and “several hundred” in Khatmandu. Each of these groups is likely to only know a small proportion of drug users in their area but, in many cities, drug users refer to “thousands” or “every second teenager,” etc, as IDUs.

The official government view is that there are 50,000 illicit drug users in Nepal, of whom about 20,000 are IDUs, though there are plans to try to update this figure soon (Karki 1999). Given responses in focus groups that uptake of injecting is increasing quickly among illicit drug users in Nepal, it is likely that the number of IDUs in the country is substantially higher than 20,000 in 2001.

The government’s Situation Analysis (NCASC 2000) also noted that illicit drug users could now be found “...from all family backgrounds, caste, socio-economic status or educational status,” again suggesting that drug use (and drug injecting) are not confined to the poor or the disadvantaged in Kathmandu Valley.

Also, a discussion in Biratnagar for the Situation Analysis discovered that there were around 10,000 - 15,000 drug users in the Biratnagar area alone, most of whom were drug injectors.

Given that Kathmandu Valley holds the largest urban conglomeration in Nepal, and given that most countries see a ‘big city’ effect (where the anonymity and the chance for illicit or quasi-licit activity is greater in the country’s largest urban centre, thereby drawing more illicit - and especially injecting - drug users), it can be expected that the number of IDUs in Kathmandu Valley is substantially larger than in the Biratnagar area.

For these reasons, we suggest that a tentative figure be proposed for the number of IDUs in Kathmandu Valley. This figure can be checked through future research as part of the activities to prevent HIV among IDUs in Nepal. We propose that there is a minimum of 15,000 IDUs in Kathmandu Valley.

Types of drugs injected

Among KV survey respondents, the primary drug injected was *Tidigesic* (buprenorphine) for most of the IDUs (131/204; 64%). Only *Tidigesic* injecting was reported by approximately half (73/131; 56%); switching every now and then to other injectables (diazepam, pentazocine, ‘brown sugar’ heroin cooked with vitamin C, pheniramine maleate, methadone) was reported by the rest (58/131; 44%).

Switching to other injectables was also reported by the IDUs whose primary drug of use was ‘brown sugar’ (63/204; 31%); only ‘brown sugar’ injecting was reported by as few as 10 IDUs. Reasons for switching to other injectables were of similar nature in both the groups (*Tidigesic* injectors and ‘brown sugar’ injectors):

- When I don’t get my drug I inject other things (non-availability)
- To get more high
- I could not any more bear the cost of injecting ‘brown sugar’
- Injecting *Tidigesic* causes collection of water in the lungs.

In a focus group discussion, all but one *LALS* client said they used *Tidigesic* most of the time, only using ‘brown sugar’ when they had additional money and when the drug was available and was of relatively good quality. (The one exception was the man whose brother is a ‘brown sugar’ dealer.) All started using opiates through ‘brown sugar’, mostly by smoking. They said ‘brown sugar’ was only 40 Nepali Rupees (NR) a gram five years ago. (They also mentioned that white heroin was cheaply available 10-12 years ago, costing 15 NR a gram.)

In Bhaktapur, all seven IDUs injected only *Tidigesic*. They said, if *Tidigesic* was hard to get, they used a mixture of other drugs (pills, usually not by injection).

LALS clients said the usual price of ‘brown sugar’ (heroin) was 600 NR a gram, with half a gram used in each injection. *Tidigesic* costs 60-100 NR for one ampoule (bought on the black market as *Tidigesic* is now banned from sale in Nepali pharmacies). *Tidigesic* costs 50-60 NR for one ampoule in Bhaktapur.

LALS clients also referred to the cost of going to India to buy drugs. Many drug users and small-scale dealers go to India to buy drugs, especially at Raxaul. If they do not want the risk of carrying the drugs themselves, they can pay others to carry for them (charges being 10 NR a gram from Raxaul to Birganj, 10 NR from Birganj to Hetowda, and 20 NR from Hetowda to Kathmandu). They also spoke of a coalition between police and drug dealers in Raxaul to identify Kathmandu drug users, sell them drugs, then threaten to arrest them at the border to extort bribes.

It should also be noted that a popular myth exists (repeated by staff of the harm reduction outreach and two NGO drug treatment services) that injecting ‘brown sugar’ is safer (in terms of acquiring HIV) than injecting *Tidigesic*. The theory goes that the time taken to prepare a shot of ‘brown sugar’, including heating the liquid, kills HIV whereas the breaking open of a *Tidigesic* ampoule, drawing up and injecting is so fast that HIV stays alive. We showed that these were not scientifically valid observations and suggested that an observed difference between HIV rates among *Tidigesic* and ‘brown sugar’ injectors could be caused by a variety of factors including the youth and relative poverty of *Tidigesic* injectors.

No evidence was found of injection of amphetamine-type substances. However, the rapid increase in uptake of these substances in other parts of South and South-East Asia suggests that further, ongoing research should be carried out to verify this finding.

Risk behaviours

Needle and syringe sharing remains a common risk behaviour for IDUs in Kathmandu Valley, though *LALS* clients say they rarely or never share since becoming *LALS* clients. After some probing, it emerged that sharing still occurs at least occasionally among *LALS* clients. “If I’m sick or in withdrawal, certainly I’ll take a bit from someone else’s syringe,” said one - and most nodded their heads. However, one said that even in that condition, he had run to a pharmacist to get a new needle and syringe.

Several *LALS* clients said that bleach needs to be distributed so disinfection can occur on those occasions when an IDU is “hanging out.” Needle sharing also occurred when IDUs were very stoned and “didn’t know what they were doing.”

Most *LALS* clients had shared about six to seven months previously, usually with two other IDUs. Two clients admitted they had shared with each other two weeks previously. Of the seven Bhaktapur IDUs, two had shared a needle and syringe (with each other) on the morning of the focus group discussion. The number of people with whom the Bhaktapur IDUs had shared injecting equipment in the previous week ranged from zero to six, with most sharing with two to three people. Some of the Bhaktapur IDUs talked of never “taking” a used needle and syringe but only “giving” their needle and syringe after use. The level of understanding of viral transmission among both the *LALS* clients and the Bhaktapur IDUs was quite high.

In an interview, the psychiatrist in charge of the methadone program in Lalitpur showed the results of a 1999 survey of 92 methadone clients that found that 36% shared injecting equipment. In the KV survey, 46% (93/204) of the IDUs interviewed had shared injecting equipment during the last month and almost one third of the respondents (71/204; 35%) reported shared injecting equipment and/or injecting paraphernalia on the last injecting occasion. This above focus group discussion revealed that most of the time they were sharing injecting equipment and/or paraphernalia with the same one or two friends. However, when there was a shortage of the drug of choice, they went to far-off places within Nepal (mostly to towns bordering India) to secure drugs, and shared even with unknown persons.

The reasons cited for sharing of injecting equipment and/or paraphernalia are given below:

- I share only with one friend of mine.
- I did not have new syringe and needle.
- Our group had only one syringe.
- Don't have money to buy syringe.
- I am afraid of my parents - that's why I don't carry syringe and needle.
- I don't want to carry them.
- I did not know how to inject .
- My friend borrowed my syringe.
- Ignorance.
- Used same spoon and pot.
- Took drug from the same ampoule.
- Don't have alternative.

Also in the survey, a few respondents reported collecting cottons (used for filtering cooked ‘brown sugar’) from friends and injecting the water squeezed out of those cotton balls. Used cotton balls thus collected are generally obtained free, but sometimes cost charged 10 NR each.

The very high risk of contracting blood borne infections, associated with this particular practice, needs to be addressed immediately through carefully designed intervention messages.

In the KV survey, the number of sexual partners ranged from one to eight for the male IDUs who reported having sex within one year from the day of interview (142/196; 72%). Most of them (76/132, 58% - data was not available for 10 of the respondents) had had sex with one partner whereas a high proportion (42%; 56/132) had had sex with two or more partners:

# of sex partners	IDUs
1	76
2	32
3	07
4	02
5	02
6	01
7	01

On the other hand condom, use during the last sex act was remarkably low among the respondents (24/142; 17%); the reasons were as follows:

- My wife does not like it.
- I had sex only with my wife.
- Don't know why I should.
- She was my friend.
- Pleasure would be less.
- The foreign girl I was having sex with told me not to.
- Did not have condom.
- Ignorance.
- My wife is doing other family planning methods.

Those who did use condoms did so due to “fear of pregnancy”, “fear of diseases” and “fear of HIV/AIDS.”

Six of the 11 *LALS* clients were married and said they only had sex with their wives; of these, two used condoms with their wives. Four of the seven Bhaktapur IDUs were married (two had two children each, one had one child, one had no children). Knowledge about sexually transmitted infections among the Bhaktapur IDUs was good.

Some of the *LALS* clients had been tested for HIV (we did not ask them to disclose their status), but most of these seemed to mistrust the diagnosis. One of the seven Bhaktapur IDUs had been tested. The others felt they should test but there is no HIV counselling or testing centre in Bhaktapur. There is a government laboratory where an HIV test reportedly costs 325 NR or an anonymous test can be had in a clinic for 1500 NR.

One of the Bhaktapur IDUs said he lived outside the city and said about 10 IDUs lived in the rural area in which he lived. All agreed there could be many IDUs living in rural areas in Kathmandu valley.

Risk assessment by the Bhaktapur IDUs was very uneven. About half could see that they were at 'some' risk of acquiring HIV if they did not change their needle-sharing behaviour. But the other half felt they were at very low or no risk (yet this group included those who had shared most recently and with the largest number of people). Also, when speaking of a friend who had died - possibly of AIDS - in the previous year (see below), several Bhaktapur IDUs said that the dead man had "been with many girls" and had often "gone to Kathmandu" so there may be a misconception that HIV is mostly spread sexually and/or that it is only prevalent in Kathmandu (the common perception that AIDS is a disease of 'the other').

One group that the assessment team was unable to meet with was street children who either are already injecting drugs or who may be likely to start injecting in the near future. Given the high vulnerability of this group (emphasised in the NCASC Situation Analysis), the specific risks of HIV transmission among street children need to be considered as part of ongoing research projects.

Types and numbers of needles and syringes used

Among *LALS* clients, several came to *LALS* or were visited by *LALS* outreach workers five times a week. Those who lived further away from the *LALS* office usually only visited *LALS* once a week. Most clients exchange five syringes at a time (*LALS* will only provide a maximum of five syringes a day per client, due to financial restrictions). When asked whether those who visited the NSP needed 25 syringes a week, they stated that the new syringes being distributed (a very cheap syringe compared with Terumo syringes which were distributed until 1998) were easily blunted and had to be discarded after one injection. By comparison, Terumo syringes were used four to five times without blunting.

Most *LALS* clients injected twice a day virtually every day (unless they did not have enough money for two shots), and most said they would take three shots whenever they had sufficient money to do so.

One client, who later said his brother was a dealer and he received his drugs for free, injected four times a day. (He also said his brother, 42 years old, had been using heroin for 30 years.)

When injecting 'brown sugar', *LALS* clients preferred to use a separate needle and syringe; *Tidigesic* injectors preferred to use a 1ml fixed needle-and-syringe. When buying syringes, the cheapest is a 2.5ml syringe with separate needle (5 NR), but the needle is so large it causes pain and scarring. If they have to use this type of syringe, they use the needle that comes with the syringe for drawing up (the drug into the syringe), then replace it with the needle from a 1ml syringe for injecting. No one mentioned the potential HIV transmission risk from this activity (the risk arises from the 1 ml needle which has not been purchased and is therefore presumably being re-used or shared).

Women IDUs

The number of women IDUs appears to be low. Only three *LALS* clients had ever injected with a woman. In Bhaktapur, the seven IDUs could only think of two women IDUs in the city, though they knew around 60 male IDUs. Karki (1999) stated that there were only four women among the 1108 illicit drug users interviewed in the 1998 Rapid Situation Assessment surveys.

Since mid-2000, a *Women's Program* has been run at the drop-in centre of the *Richmond Fellowship (RF)* - an NGO drug rehabilitation service - see next chapter). Interviews with the *RF Women's Program* staff discovered that they had heard (from male *RF* staff) of 20-25 sites in Kathmandu where women were injecting drugs. In these sites, the staff found around 30-40 female drug users, of whom about 25 were IDUs. Since starting the *Women's Program*, the staff have identified a further 10 sites with 10-12 more women IDUs. Of these, five have died in the eight months since the program has been operating. However, as shown below, the stigma of being a woman IDU in Kathmandu Valley is extreme, so women IDUs may be much more carefully hidden than male IDUs.

Program staff said the women at these sites are living in very depressed conditions, often without access to clean water and sanitation. Many live on the streets or in slum areas. They mostly have children, generally illegitimate (which is very problematic in Nepali society) for whom they cannot always care adequately. Some have been sexually abused either before leaving home (and often leaving home was a result of this abuse) or while living on the streets.

Many of the women have nowhere to store their clothes and other possessions. They are “treated very badly” by health services as they are so dirty, and as women IDUs are seen as morally worse than male IDUs. The staff said most women start using drugs through a male sexual partner who is using drugs. One staff member said, “The first 25 women I met were all HIV positive.”

A recent survey of 300 female sex workers in Kathmandu found that 5% of the respondents had ever injected drugs and that 11 of these 15 women were HIV-positive, representing 21% of all HIV-positive women in the sample. In the IDU surveys carried out for this assessment, nine out of the 204 respondents were female IDUs, all of whom were involved in commercial sex work. These results suggest that a link between injecting drug use and sex work among women IDUs may lead to much higher rates of HIV among this group.

In the KV survey, only one out of nine female IDUs interviewed said that she had used condoms with her client during her last sex act. The client himself carried the condom and he was using it due to “fear of diseases.” The rest who did not use condoms reported “clients refusing” (5), “clients under the influence of alcohol not wanting to” (1), “non-availability” (1), and “selling sex for ‘brown sugar’” (1). All the female IDU respondents except one were in touch with intervention programs within the last month, but this did not ensure they were able to negotiate safer sexual practices with their clients.

Focus Group Discussion (FGD) with women drug users

A focus group discussion was held in the third week of January 2001 at the Kathmandu campus of the *Richmond Fellowship's* Research Program for women using drugs. It is a drop-in centre for women, the only one of its kind in the valley. The research program is expected to run for one year.

Of the four participants, three were IDUs and one had a problem with alcohol use. Age range for the participants was from 25 to 40 years. All except one reported staying on the street and staying away from her husband. The one member of the group who had a home and a husband to stay with said that she was inducted in injecting drug use by her husband who during the present FGD was in jail for drug peddling. All the participants had children, except one who had a miscarriage following pregnancy.

The primary drug of use for this group was *Tidigesic*, although one of them reported switching from injecting white heroin to ‘brown sugar’ to *Tidigesic* (buprenorphine).

All the female IDUs reported having shared injecting equipment frequently with others. Lack of money forced two of the injectors to stop injecting drugs a number of times. A general picture emerged of a drug-free period, followed by high risk drug-taking, when they had shared injecting equipment and also sold unprotected sex for money to buy drugs. Sex was even asked from them free and under threat by the local youths under the influence of alcohol.

The female IDUs in the group reported receiving condoms from the NGOs but were mostly incapable of using them.

The group members reported seeing females from the upper socio-economic class in Maharajanj injecting drugs; one of the group members was their drug-taking partner eight years ago. The group was aware of 20 female IDUs in the Kathmandu valley, and had seen five deaths among them - three from overdose and one who coughed up blood (the respondents were not sure what happened to the other one who died).

These results suggest that there is a small number of women IDUs; that they are socially very isolated; that they may be at much greater risk of HIV infection and of transmitting HIV (through injection equipment sharing, unsafe sex and unsafe sex work), and that their need for assistance is not confined to the areas of drug use and HIV/AIDS, but includes a wide range of personal and social issues.

Conclusions

There are an estimated 15,000 IDUs in Kathmandu Valley, about 50% of whom are HIV positive. Most IDUs inject *Tidigesic* most of the time (using 'brown sugar' heroin when they have sufficient money and it is available in acceptable purity), though a large group (possibly mostly younger IDUs) inject only *Tidigesic*. Those who inject either *Tidigesic* or 'brown sugar' also inject a range of other substances. Injecting is increasing as a mode of administration of opioid drugs. No evidence was found of injection of amphetamine type substances.

Risk behaviours remain high among most IDUs in Kathmandu Valley. Needle and syringe and other equipment sharing remain common, though clients of *Lifesaving and Lifegiving Society (LALS)* appear to share equipment much less frequently than IDUs who are not clients of the service.

The major targets for immediate behaviour change interventions are:

- Needle and syringe sharing.
- Use of cottons to acquire enough drug to inject.
- Low use of condoms.

Among both the *LALS* clients and the Bhaktapur IDUs the level of understanding of viral transmission (via shared injection equipment and sexually) was quite high. However, risk behaviours in both groups appeared to be continuing at an unacceptably high level. Risk assessment is very uneven, with some IDUs at very high risk for acquiring HIV while judging themselves to be at low or no risk, and considering HIV the disease of “the other” (something which happens to someone else).

Most HIV positive IDUs do not yet appear to be suffering many illnesses, though AIDS deaths are beginning to occur. The general lack of interest in health issues related to HIV infection (including the lack of testing among IDUs) is common in many other countries (such as Indonesia, Ukraine and Russian Federation) where a large number of IDUs have become infected only recently. Education of IDUs about HIV disease and treatment, care and support of people with HIV in Kathmandu Valley will become increasingly urgent issues within three to five years.

There appears to be a small number of women IDUs (probably less than 1000). They are socially very isolated, appear to be at great risk of HIV infection and of transmitting HIV (through injection equipment sharing, unsafe sex and unsafe sex work), and their need for assistance is not confined to the areas of drug use and HIV/AIDS, but includes a wide range of personal and social issues. They also appear to have a very high death rate.

Further research is needed to discover how the social networks of IDUs operate and to assist in the expansion, and derive some meaningful variables for effectiveness studies, of HIV prevention programs. These include:

- **Qualitative data on the mixing or sharing patterns of injecting equipment use:**
 - **‘closed’ sharing with friends and sharing outside ‘closed’ circles;**
 - **meanings of sharing (rituals, etc);**
 - **whether sharing patterns and other risk behaviours differ for ‘brown sugar’-only injectors, *Tidigesic*-only injectors, and *Tidigesic*/'brown sugar' injectors;**
 - **whether sharing patterns differ between male and female injectors;**
 - **what types of injectors use what types of needles and syringes, when and why;**
 - **reasons for equipment sharing and IDUs’ ideas for strategies to prevent sharing;**
 - **sexual behaviour, including condom use and partner numbers over time;**
 - **whether IDUs (male or female) predominate in one or more ethnicities or cultures, and**

- what effects these cultural characteristics may have on effective HIV prevention.

- **Verification of the estimate of the number of IDUs in Kathmandu Valley;**
- **Number of partners with whom each piece of injecting equipment is shared and whether sharing involves giving and/or receiving;**
- **Number of injections in an average week or month;**
- **Number of injecting occasions where sharing occurs and what type of sharing;**
- **Amounts of blood and levels of HIV in HIV-positive blood remaining in syringes during sharing;**
- **Number of times each week or month a shared injecting space is used (and how many needles and syringes are left at such places);**
- **Mapping of shared injecting spaces and ‘neighbourhoods’ where IDUs tend to congregate.**

Much more intensive work is needed to discover more about the specific sub-populations of women IDUs (including the apparent high death rate) and street children, and to develop appropriate strategies for HIV prevention, care and support.

3. Immediate Environment

The ‘immediate environment’ surrounding IDUs in Kathmandu Valley includes all those services that are designed to assist drug users, as well as the general community and community attitudes towards IDUs, and the attitude and behaviour of medical and law enforcement personnel.

The NCASC Situation Assessment questions whether the right methods have been used to address HIV among IDUs in Kathmandu, and whether the right groups have been targeted - or were the same groups targeted over and over? In this section, we try to answer these questions, as well as looking at the reach and quality of services and their ability to expand, and what may be needed from local communities to assist in this expansion.

Harm reduction outreach/NSE

Background

In the KV survey, 83 IDUs (83/204; 41%) said they were in touch with a drugs or HIV/AIDS intervention program within the last month, and a larger proportion (121/204; 59%) reported not being in contact with any intervention. The Kathmandu-based NGO, Lifegiving and Lifesaving Society (*LALS*), was the most commonly cited organisation as an intervention provider (76/83).

Established in 1991, *LALS* is the only organisation in Kathmandu Valley carrying out harm reduction outreach, and needle and syringe exchange (NSE). From 1991 to 1998, *LALS* gradually increased its client base so that it was providing needles and syringes, bleach in small bottles for disinfection of injecting equipment, condoms, alcohol swabs (for disinfecting injection sites) and other first aid materials (and collecting used equipment), to IDUs in 62 ‘sites’ (locations ranging from public squares and parks to slum housing areas).

During this time, *LALS* met great political and community opposition but also achieved support from health and even some law enforcement bodies. In its early years, its work was extensively studied and it was found that Kathmandu IDUs' knowledge of HIV prevention methods had increased substantially, and HIV infection had fallen from 1.6% in 1991 to 0% in 1994 (Peak *et al* AIDS 1995). Between 1993 and 1997, the number of clients visiting or visited by *LALS* increased from 450 to 1025.

However, in the mid-1990s, the situation changed dramatically. Compulsory HIV testing at the *Assra* drug treatment service (see below) of 200 IDUs entering treatment in 1997-98 found that 45% of this sample was HIV positive (NCASC 2000). Around the same time that these results were discovered (1997-98), *LALS* underwent serious funding upheavals (apparently unrelated to the increase in HIV infection), which resulted in about a 50% cut in funding, necessitating a massive reduction in services.

The period from 1998 to 2001 has been very difficult for *LALS*. Client numbers have grown very slowly (numbering 1433 at the time of our visit) and restrictions have been placed on many services. In addition, the death in 2000 of Manisha Singh, one of the key figures in advocating for and assisting *LALS* over many years, caused enormous morale problems at the service.

LALS now provides outreach in three teams (each of two people) providing a total of 54 hours a week to 62 spots inside the Kathmandu 'ring', including parts of Lalitpur. In addition to its outreach work, *LALS* has provided a wide range of other services:

- Operating a drop-in centre, originally away from the *LALS* office (until it was closed due to community opposition), now within the *LALS* office;
- Working on community awareness-raising and advocacy for harm reduction (see 'Community' below);
- Legal assistance;
- Developing and distributing IEC materials for IDUs;
- Training organisations outside Kathmandu Valley in community assessment, peer education, outreach, care and support of people with HIV/AIDS, management;
- Developing and distributing training manuals on outreach, HIV/AIDS/STDs and home-based care for people with HIV/AIDS;
- Advocacy to chemists to sell syringes to IDUs;
- Peer education training.

Some of these activities have been stopped or reduced due to funding cuts. The most worrying of these reductions is (1) the limit of five needles and syringes to be distributed

to any one client in a day, and (2) the stopping of peer education training. These have been caused purely by funding cuts to the service.

Quality of service

Of the 1433 *LALS* clients, we were not able to ascertain how many visited the centre or were visited by outreach workers on a regular basis. However, a 1998 study of *LALS* found that 60% of the then 1025 clients were in touch with the agency at least once each month (Reynolds 2000). Even this level of regularity is unlikely to be sufficient to provide the education and harm reduction materials needed to prevent HIV from spreading among most *LALS* clients. With financial and service cutbacks since 1998, it is likely that even fewer clients are receiving appropriate levels of harm reduction supplies.

At the same time, demand for all *LALS* ‘street’ services continues to grow. In addition, as the only long-standing harm reduction outreach program in Nepal, *LALS* is increasingly being asked to train others in the methods they have pioneered. This schism - between street-based work in Kathmandu, and national training and advocacy work - is causing major problems for the organisation, and needs to be carefully addressed if *LALS* is to expand. It appears that both types of work are necessary in Nepal and there are no other organisations that can do this work at present.

Through interviews with staff and the *LALS* Director, and through accompanying outreach workers onto the streets, we found *LALS* to be a highly professional organisation, providing a very high quality of service (reflected in the Clients’ Views below). But funding cutbacks and the difficulties of carrying out two sets of very different tasks are causing problems in morale and prompting interest in trying new techniques.

One problem that we identified was the myth of the ‘safety’ of using brown heroin rather than *Tidigesic* as a HIV prevention measure. This was mentioned by staff at *LALS* and may have been discussed by staff with clients. The existence and perpetuation of this myth point to a lack of technical understanding (or insufficient technical assistance) in the organisation.

In terms of street outreach, some areas that could be improved are:

- Reach of services;
- Increase in the number of needles and syringes able to be distributed to each IDU;
- Increase in the number of outreach staff, both for street work and for training;
- More emphasis on sexual transmission;
- Increased understanding of the technical aspects of viral transmission.

The Home Ministry has demanded that all services dealing with drug users provide the names, addresses, HIV status and other details of all their clients. *LALS* has refused to do this as it would compromise their service (and would probably be impossible given the nature of the service). This is an appropriate response.

Staff training

Staff at *LALS* can be placed into three groups: management, outreach and office staff. The Director is very well qualified with a medical degree, Masters in Sociology and much training through international organisations in program management, personnel and logistics management etc. Other management and quasi-management staff (such as Canadian and Dutch volunteers) have varied backgrounds, mostly with little formal training in NGO management or managing harm reduction programs.

Outreach staff are drawn from three groups. One group is ex-users (though *LALS* management said they would be willing to employ active drug users if they were physically and mentally capable of the tasks, trusted by the organisation and acceptable to the community). This group tends not to have much formal education and is trained in-house in outreach techniques, counselling, first aid and care and support of people with HIV/AIDS. Other staff have a social work or nursing or paramedic background. Teams are normally combined from these different groups. Office staff have received some training in specific tasks such as accountancy, development of IEC materials, desktop publishing.

Further training is likely to be required after the reorganisation recommended below.

Capacity building

LALS is in the privileged and unfortunate position of being the leading harm reduction outreach organisation in Nepal. Its decade of experience is being - and must be - tapped by all agencies trying to do similar work throughout the country. Yet the HIV situation among IDUs in Kathmandu Valley is such that *LALS* needs to rapidly expand this side of its work as well.

LALS has become two organisations in one and this is causing serious problems. In our view, *LALS* has the capacity to fulfil both these functions and to expand them significantly, given adequate technical assistance and some structural changes.

First, the organisation needs to undertake a comprehensive strategic planning exercise, in which core activities are identified and prioritised. No NGO can do all the activities needed to prevent HIV among IDUs, and *LALS* has to identify where its strengths lie and how best to build on those strengths without dissipating its staff energy and time across too many activities.

In addition, the organisation needs to examine its structure and staffing. Currently, there is a Director, six outreach and 10 office staff. The reorganisation should provide a task analysis of what is needed to pursue *LALS*' core objectives and assemble a staff that has the skills to carry out the necessary tasks. Areas that will need specific attention for training are:

- Departmental and cost-centre management;
- Managing personnel in widely varying task areas;
- Complex financial management.

One of the strengths of *LALS* is that it uses a limited quality assurance process to continually upgrade and improve the street work services of the organisation. The *LALS* process is to use regular staff meetings to discuss issues arising from the streets and to develop new services to meet the needs of IDUs. A process like this should be developed for the whole organisation so that:

- All services are continuously monitored to search for problems and new issues which are not currently being addressed;
- Regular reports on this monitoring feed into management at an appropriate level for quick decision-making;
- Management decisions on ways to address problems or new issues are fed back to staff and are implemented quickly;
- Monitoring continues to check whether the new ways of working are effective or whether new issues are again emerging.

This circular process is now regarded as international best practice as it ensures an ever-growing evidence basis for each activity and an ongoing improvement in services.

Clients' views

The focus group of *LALS* clients felt very positively towards the agency and its services, and made no negative comments about the service apart from some dissatisfaction with the needles and syringes they now receive. In addition, the *LALS* clients generally felt a desire to provide other IDUs with education about drugs and HIV/AIDS and several times the focus group members demonstrated their attempts to educate and provide peer support for their drug-using friends.

Six of the seven Bhaktapur IDUs had had no contact with any harm reduction service - the remaining IDU had attended a two-day workshop in Kathmandu called 'An introduction to HIV and hepatitis C', part of a Danish research project. All stated that there was no HIV information in Bhaktapur.

The Bhaktapur IDUs were unanimous that a harm reduction service was needed in their city because, "We cannot go to Kathmandu..." as it takes too much time and costs too much. "Here there are often five or six people sharing syringes. We need a project to stop the sharing first. We need to think about the whole community of Bhaktapur. We need needle exchange first. Then detoxification." This desire to help the community of IDUs in Bhaktapur, together with fears for the safety of the larger Bhaktapur community - because of HIV spreading among IDUs - may be a sign that drug user organising and other forms of peer support could be effective in assisting HIV prevention among IDUs in that city.

Also, one Bhaktapur IDU said, "Even if we stop, no one will believe we are free from drugs. So no one gives us jobs. We are treated badly whether we use drugs or not." Similar concerns led to the support group *Beyond Appearances* for drug users and ex-users in Delhi, India. A similar group might be useful in Bhaktapur.

In the KV survey, most of the respondents said they wanted "Awareness and education." A substantial number of IDUs did not know what *could* help them, which is a significant finding. Repeated mentions of the need for a "IDU-friendly centre", "love and care" and "offices/organisations like *LALS*" also requires immediate attention.

Reach of services

In an analysis of a 1998 assessment, Reynolds (2000) found that Kathmandu IDUs were injecting on average 16 times a week or about 70 times a month, while they received only an average of five needles and syringes a month from *LALS*. This means that each needle and syringe was being used an average of 14 times (unless other needles and syringes were purchased from pharmacies). In focus group discussions with *LALS* clients, it was apparent that few clients purchased large numbers of needles and syringes in addition to those provided by *LALS*. It appears that even *LALS* clients are not receiving the level of harm reduction equipment required to prevent a HIV epidemic in this subsection of the greater KV injecting population.

If the figure of 15,000 IDUs in Kathmandu Valley is accepted, then the total number of *LALS* clients is less than 10% of the number of IDUs in the Valley. Without any other organisations to provide harm reduction materials, the total coverage of IDUs falls well

short of the 80% and 100% coverage figures sought by the government and international donors.

In addition, a substantial proportion (likely to be more than 50%) of the overall *LALS* client base is unlikely to be in regular contact with *LALS* to a level where these IDUs are equipped with sufficient sterile injecting equipment to ensure they do not share. Not only must 13,000-15,000 IDUs be reached by these services, but they must also be reached regularly with an adequate level of harm reduction equipment, and with quality education and support services, so that all or a very high percentage of this group will change behaviours that are currently transmitting HIV infection.

Such a task is beyond the capacity of *LALS* at present, given other managerial issues, and may be beyond the ability of any single organisation in Kathmandu Valley. A more comprehensive and co-ordinated approach to the provision of harm reduction materials is required (see next chapter).

Drug substitution treatment

Background

There is one drug substitution program in Kathmandu Valley: a methadone maintenance program that has operated since 1994 from the central psychiatric hospital in Lalitpur. The program has 270 registered clients, of whom about 135 attend the hospital every day for dosing. Information on this program comes from the psychiatrist in charge and founder of the program, Dr Dhruba Man Srestha.

Of the other 50% of clients who are registered but do not attend the program, the psychiatrist in charge of the program said there were many reasons for dropping out. Some are tourists who leave the country; some are expelled from the program due to nuisance; many are arrested and go to jail; some stop by themselves, trying to quit drug use by stopping methadone; some die. The program has no follow-up workers to try to discover what has happened to 'dropouts'. About 60-70% of total clients are *Tidigesic* users (remainder use heroin); 90% of new clients are *Tidigesic* users.

The program provides outpatient dosing from 8am to noon, seven days a week. There are two staff: the psychiatrist in charge and a nurse (the same woman has dosed patients every day for seven years). The program costs 20 NR for a 40mg dose. Average dose is 40-60mg, with no upper limit. The program offers individual counselling prior to entry to program, and counselling on request after that. All clients must have a HIV test on entry to the program. WHO provides the methadone tablets to the program. The nurse grinds them and clients drink this powder in solution.

Quality of service

The program was evaluated in 1999 after its first five years. At that point, there were 204 registered clients, of whom 92 were dosed each day. Of these 92, 70% were aged 26 to 35, with 13% aged 15 to 25 and 17% aged 36 to 45. Fifty were from Lalitpur district and 42 from Kathmandu. Only two clients (one from each district) were women. Evaluation results are not clear from the reports we were shown. However an indicator of success is that there has been a HIV seroconversion rate among clients of 2% each year, which is much lower than the general population of IDUs in the Valley.

The fact that an evaluation was carried out by the psychiatrist in charge of the program suggests that the need for quality assurance is understood at the hospital, though this process should be formalised (as detailed in the *LALS* section above).

During our visit, we observed the need for more emphasis on associated activities such as counselling and social services (through referral and assistance), HIV/AIDS education, pre- and post-HIV test counselling, maintaining confidentiality of client records, and follow-up of dropouts. In addition, the program's staff numbers need to be increased immediately. Relying on one psychiatrist and one nurse is unsustainable.

The methadone program complies with the Home Ministry's requirement to provide clients' names, addresses, etc: "If we didn't, we would simply be shut down."

Clients' views

We were able to speak briefly with three clients of the program: a married couple in their 40s and a young man in a popular Nepali rock band. The couple was very pleased with the methadone program, which they had attended for seven years. "We can do our work [they own a small business], we can do everything in time now. There's no trouble getting here - we come before work each day." They previously used 'brown sugar' but say they now use only methadone. They have had no physical problems while on methadone.

The other client, in his early 20s, said he wanted to use methadone as a step in stopping drug use, which he hoped to achieve within two months.

Reach of service

There is a lot of demand for methadone treatment, and the hospital wants to increase the clients being dosed daily to 200, but the government will not allow the service to expand.

The psychiatrist in charge of the program believes that a much larger group of drug substitution programs is needed in Kathmandu Valley, "It cannot all be run from a single psychiatric hospital. Other government centres or reliable NGOs should provide different types of substitution programs suitable to a wide range of clients. Government oversight would be needed to control the programs."

He also suggested that buprenorphine substitution was not appropriate at his hospital because of the need for dosing twice each day. "If you could make buprenorphine available through government pharmacies at the local level, that might work." In this way, treatment would be available to drug users in their own local areas.

Abstinence-based drug rehabilitation

Background

There are three non-government drug rehabilitation services in Kathmandu, two of long standing and one more recently opened. There is a government detoxification service, and a government service that purportedly carries out drug rehabilitation. There are no low-threshold services such as outreach and outpatient drugs counselling (except in a limited way from the three NGOs mentioned above), brief interventions, assisted home detoxification and so on. All of the services cater only to men, with the exception of the *Richmond Fellowship Women's Program* and the government detoxification service.

The oldest of the NGO rehabilitation programs is *Freedom House (FH)*, run by a Jesuit mission. It was started in the 1980s to assist people with drug problems as an extension of the mission's work with the homeless, orphan and street youth population of Kathmandu city. *FH* offers a [usually non-medicated] detoxification service assisted by acupuncture and *Valium* where necessary. It also offers a residential rehabilitation service for a minimum of three months (with most residents staying for about six months). It follows the US Daytop model for therapeutic communities (TCs), adapted to Nepali conditions. It has 25 beds and takes about 65 residents per year. There are two outreach workers with the Jesuit project, identifying homeless and poor people (including IDUs) and trying to cater for their needs within the project's activities. There are no ex-users on staff.

Youth Vision (YV) was started in 1984. It now has 30 beds for detoxification and rehabilitation (160-175 residents per year), and day care and after care for up to 500 drop-in clients a year. It provides medicated detoxification for about seven days, individually assessed and prescribed by a visiting doctor, followed by residential rehabilitation for a minimum of three months in a TC that uses group therapy, encounter groups, and *Narcotics Anonymous (NA)* steps. It has a wide range of other programs including a drop-in centre, support group for ex-residents (using NA steps), halfway house, training and work as volunteers within the residential service, limited vocational training program (making envelopes and candles), outreach both for after care to ex-residents and to encourage drug users to come into treatment. All staff - except the Coordinator - are ex-users.

Richmond Fellowship (RF) runs two services, a rehabilitation service for male drug users, and a drop-in centre and *Women's Program*. The rehabilitation service provides non-medicated detoxification, encouraging its new residents to minimise their drug use as much as possible prior to entry.

Assistance with withdrawal symptoms is provided through massage and yoga. It has a capacity of 20 beds, with 103 residents during the past year. The program runs for a minimum of three months up to nine months and is based on a UK model. There are classes each day in yoga, meditation, *NA* steps as well as group therapy, counselling, work therapy (mainly cleaning and gardening), and discussions, including HIV/AIDS education. *RF* also provides day care (compulsory for ex-residents for the first month after leaving the program), and drug education and HIV advocacy in schools. All staff are ex-users.

RF Women's Program, which operates from the service's drop-in centre, was established only eight months ago as a research project to investigate (1) why women begin to take drugs, and (2) discrimination against women drug users. It has three women workers who all do outreach work, seeking to find and interview women drug users. So far, they have contacted about 30 women IDUs, of whom five have died during the project period. In addition to research, the *Program* is attempting to provide assistance to women drug users, including provision of meals, bathing, laundry and storage facilities at the *RF* drop-in centre and assistance with detoxification. Assisted detoxification (carried out at the government detoxification centre) is expensive and logistically difficult (see below). The *Program* wants to refer the women for further assistance but there are no services that can or will take them, "We want to do social work but we can't; we end up providing all the services we can." Safe injecting and safe sex information and condoms are provided to clients (though the *RF Program* is more geared towards women wanting to stop drug use), as well as milk for babies, "We do babysitting and a lot of first aid." None of the staff is an ex-user.

The *government detoxification centre* at one of Kathmandu's teaching hospitals provides medicated detoxification for 15-20 days. Clients must pay for all medications and medical interventions, as well as bringing a family member who must stay with the client, cook their meals, provide support etc. The NGO rehabilitation services said that staff at the service were not friendly towards IDUs, and that poverty and lack of close relationships (or the fear of disclosing drug use to family members) meant that the detoxification service was not popular with IDUs. The *RF Women's Program* said the government service was the only place where women could be detoxified in Kathmandu Valley. But the *RF Program* clients' lack of social support meant that Program staff had to go to the centre to cook meals and be with the detoxifying women all night, every night, for 15-20 days. Staff members are also expected to carry on their usual duties during the day.

Assra is a drug treatment service run by the police. At the time of our visit, there were 30 clients, of whom around half were IDUs. Its capacity is 40 beds. Parents or police bring IDUs to the centre. There are four civil and 16 police staff. The program uses exercise, yoga and meditation to assist clients through withdrawal. Treatment usually lasts for three months.

Quality of service

The quality of drug rehabilitation services is difficult to judge from brief visits but there were several indicators that the NGO drug rehabilitation services in Kathmandu are providing high-quality drug treatment. One indicator is the general lack of locked doors, barbed wire, guards and so on, which often characterise compulsory treatment centres (though *FH* has a locked gate so that a short fence needs to be scaled). All of the Kathmandu NGO services allow drug users to leave if they wish and they all accept IDUs back for repeat treatment (though there may be conditions placed on repeat treatment).

Assra, by comparison, has a staff of four treatment workers and 16 police, and appears to be heavily guarded. Whether *Assra* is in fact a compulsory treatment service was difficult to determine: some IDUs said that it was but some said they were allowed to leave when they expressed this desire. Some IDUs said that they saw inmates encouraged to leave because they had received a positive result to their HIV test.

Another feature is the lack of compulsory HIV testing at most NGO services. Each of the NGOs offers pre-test counselling, and mostly the staff will accompany the resident to the clinic or hospital for both the test and to pick up the result, and provide post-test counselling. *RF* tests all residents for HIV, provides pre- and post-test counselling, and keeps their status confidential. If desired by the resident, staff call the parents of HIV positive residents and counsel them. *Assra* compulsorily tests all inmates for HIV on entry; ex-clients said that no counselling was provided.

A third key indicator is how the NGOs deal with HIV education. In many abstinence-based services worldwide, explicit HIV prevention among IDUs is not carried out for fear of upsetting residents, causing them to think about drug use or lessening their confidence to the point where they may return to using. Unfortunately, most residential rehabilitation services see very high levels of relapse (up to 90%) among their clients, so the refusal to address explicit HIV prevention is a very dangerous failure of many rehabilitation services.

In Kathmandu Valley, the staff of all NGO services spoke at length about their HIV education and made it clear that they understood that the relapse rate was very high, so such education was very necessary. Education included discussions of HIV transmission, the role of needle and syringe sharing and unsafe sex in transmission, and methods of prevention.

RF even provides the *LALS* phone number to be used if the ex-resident believes they might relapse. *YV* describes itself as a harm minimisation service: “If drug users can come off the streets, improve their health a little, improve their social and economic conditions, then that’s a success; if they relapse, that’s less important as an indicator of success. Our target is to improve their quality of life.” These are elements of international best practice and excellent examples of the ways that harm reduction and drug treatment philosophies can work together. At *Assra*, there is HIV education twice a month but there seems to be little explicit information provided.

Another indicator is whether services involve the families of drug users. This has been shown to be essential in other countries and is widely practised among the NGO treatment agencies in Kathmandu Valley, with some inviting family members to specific regular meetings and others providing outreach to families. It was not able to be determined whether *Assra* involved families of drug users in its program.

The NGO services saw their greatest strengths as:

- Counselling;
- The ability to assist drug users towards a drug-free life;
- Flexibility: decision-making is very quick;
- Peer support and peer counselling.

The NGO services saw their greatest weaknesses as:

- Relapse by ex-residents into drug use;
- Staff training;
- Teambuilding;
- Funding;
- Documentation/evaluation of service;
- Emotional attachment to drug users (“You start relationships that go forever.”);
- Lack of emphasis on families (by some programs);
- Lack of skills training, job creation, after care facilities (in some programs).

Additional problems were observed at the *RF Women's Program* which faces a similar crisis to *LALS*: overwhelming demand for services coupled with the need to carry out another complex set of tasks (researching women's drug use). Substantial assistance is required to ensure that this program can carry out its service tasks more effectively, either through strengthening management and expansion to cover both sets of tasks, or through choosing one role and set of tasks and working with other institutions to carry out the remaining tasks.

Staff training

For all the drug treatment services (NGO and government), staff training is a major issue. At *FH*, the Manager has received specialist training in the USA in the use of acupuncture for assisting in detoxification, as well as other training courses in the USA, NZ and UK, and his assistant visited a teaching hospital in India for three months. However, neither he nor his assistant have received training in other areas that would be useful in their current activities - and essential if an expansion of their service is to occur. Also, current training activities have been concentrated in one person and there is little spreading of training throughout the organisation.

According to *FH* staff, a major problem in staff training in rehabilitation programs is the low level of English literacy among most staff. Most training materials, books, scientific papers, etc are available only in English. They spoke of the need for translations of key works on drug dependence and counselling into Nepali. There should also be very simple Nepali documents (summaries of other information or short 'how-to' guides), with little text and many illustrations, as many ex-IDUs who become (or may want to become) staff members may have low literacy in Nepali as well.

At *RF*, the rehabilitation centre's Co-ordinator has attended 10 short training courses, two of his staff attended a few courses and three other staff attended none. *RF* staff identified the following areas where additional training is needed:

- Behaviour change interventions;
- Relapse prevention;
- Development of self-help groups.

Staff at the *RF Women's Program* are trained social workers, but identified their lack of specific training in drugs counselling as a major issue. Also, due to the level of first aid they provide, basic nursing skills would be an advantage. At *YV*, the full-time volunteer co-ordinator is highly trained (including an MBA and certification in substance abuse counselling from the World Federation of TCS, as well as training in Italian and US TCS), but the six full-time staff have a varied background: two have university degrees and two are ex-drug users, some have been to other TCS in Italy and India.

At *Assra*, the police staff appeared to have little training in drug rehabilitation. The service needs substantial redesign to become as effective as its NGO counterparts (see below), after which appropriate staff can be provided with the training they need.

The myth of the safety of using ‘brown sugar’ was prevalent at *RF*, *LALS* and *YV*. This also suggests that staff training is deficient, as such ideas should be rigorously investigated before they are spread among treatment workers and their clients. Both as a quality assurance measure (see below) and as a way to decrease dependence on international donors for training and information, staff training should include ways to access and assess information via the Internet and other electronic sources.

From our observations, further training is needed in:

- theoretical background and standardisation of counselling knowledge, as well as specific skills in counselling on drug use and living with HIV/AIDS;
- the range of drug treatments available and how residential treatment should fit into this range of services;
- advocacy for drug treatment services;
- drug education (at schools and in the community);
- program management for all current staff below co-ordinator/director level (to allow rapid expansion of services);
- general management for all current co-ordinators/directors (emphasising change management, use of quality assurance processes, managing diverse organisations, personnel management and human resource development, financial management and reporting to diverse funding sources, networking).

Capacity building is needed to create many more trainers and institutional backing for ongoing learning by trainers. Rather than create a single training centre, training capacity should be enhanced at appropriate organisations (especially NGOs). A training assessment is needed to identify the most appropriate training sites and the needs for training, to develop initial training programs (together with local trainers) and structures/processes for ongoing learning by trainers.

Consideration should be given to expanding training at services not specifically related to HIV/AIDS and drug use: for example, *United Missions Nepal (UMN)* has a good track record in developing and delivering a range of counselling training programs. Technical assistance could be provided to *UMN* to provide training in drugs counselling (including outreach counselling) and counselling of HIV positive IDUs.

UMN has also taken the initiative in getting materials published in Nepali; the experience gained by them in the process should be utilised for future endeavours.

In addition, NGOs working with sex workers should be assisted to widen their training to include issues related to drug use for those sex workers who inject drugs, and should work with groups such as *LALS* and *RF Women's Program* on combined training of harm reduction, drug treatment and sex worker outreach staff.

Capacity building

For the NGOs, capacity building for management (especially change management) is needed to ensure that services can be quickly expanded. NGO drug rehabilitation services worldwide tend to have major difficulties in managing expansion. Often a charismatic individual or a small group of friends has started the organisation and they are able to manage a small program in a single residence. For the same organisation to manage multiple residences or services without losing control over the quality of services is extremely difficult.

Expansion of drug rehabilitation in Kathmandu Valley requires sustained, intensive technical assistance to the current group of NGOs in the field to assist them to undertake new services from within existing programs and, if necessary, start further residential rehabilitation services.

The most urgent new services that need to be started at these NGOs are *outpatient* and *outreach drug counselling*. This would require expansion of outreach and drop-in centre staff, training in specific counselling techniques, working with families, and other content areas. These counsellors would also assist in expanding networks of *NA* meetings. All NGO services have (usually limited) skills development, job training programs and recognise unemployment as a strong factor in relapse. Work skills development, job training and income generation projects should be gradually increased to both reduce relapse and aid sustainability of the services. To expand current services and start new activities may require an increase in financial management skills among program co-ordinators/directors. A funding bodies' database, providing details of available funding, application forms, deadlines, etc, would also be useful.

One of the most important deficiencies among drug treatment services is the lack of a quality assurance process. The basic elements needed for quality assurance are the same as those described for *LALS* (above). *RF* attempts to follow its ex-residents for two years, which is an excellent starting point for a quality assurance program.

Other agencies should be encouraged to follow suit. (Despite problems with the RF service, it must be retained, as it provides the only opportunity for women to be detoxified in Kathmandu Valley.)

At the government services, more structural interventions are required. The government detoxification service needs an upgrading of skills among its doctors and nurses (see ‘Other health services’ below) and the government needs to clarify the role and objectives of the service. The current requirements that make detoxification expensive and logistically difficult need to be removed. Quality assurance processes are needed to ensure that treatment protocols are evidence-based and appropriate, and that the quality of the service continually improves.

Assra, on the other hand, needs to be completely reconceptualised. Its reliance on compulsory testing, seemingly forced detention, lack of clear treatment activities, emphasis on police staff (apparently with little training in drug treatment), should all be re-thought. Consideration should be given to closing the service down completely and either working with the treatment NGOs to expand their capacity, or rebuilding *Assra* as a government service that has the best elements of the NGO services.

Police involvement in drug treatment of this sort has not proven successful in any other country, so removing their involvement from *Assra* would also be likely to improve the service.

Clients’ views

All of the NGO drug rehabilitation services received positive comments in focus group discussions. This is very unusual (especially in the absence of any negative comments) in our experience of talking with IDUs in many countries. Again, this suggests that the quality of the NGO rehabilitation services in Kathmandu Valley is high. Client views also supported the finding that *Assra* is not an effective drug rehabilitation or HIV prevention program.

Four of the 11 *LALS* clients had ever entered drug rehabilitation. The general feeling of the group was that *FH* and *YV* were very good treatment centres because of the atmosphere, the assistance with withdrawals (medications at *YV*, acupuncture at *FH*), the food and counselling. The other seven *LALS* clients were generally aware of drug treatment programs in Kathmandu.

One of the seven Bhaktapur IDUs had been to a drug rehabilitation service (*RF*). The others said they had never been in touch with drug treatment though it later turned out that five had been in *Assra* (see below). The IDU who had been to *RF* found it very useful - “They even give medical help to active drug users at their drop-in centre.”

Assra was generally felt by *LALS* clients to provide little assistance. “Like jail,” “No medicines,” and “They torture you mentally...” were some of the comments. Of the seven Bhaktapur IDUs, four had been brought to Kathmandu by police, told about ‘special treatment’ being offered to Bhaktapur IDUs, and placed in *Assra*. Three had stayed for two months, the other left after 11 days. All five were compulsorily tested for HIV with no pre-test or post-test counselling.

The biggest issue identified with drug treatment was the cost. A three-month course at *YV* was said to cost 3500 NR. *FH* cost 750 NR per month. Most said they could not afford this. Asked if they would seek drug treatment if it were free, nine *LALS* clients agreed. When asked if a detoxification camp were set up with free assistance to stop using drugs, whether IDUs would be able to pay either some money to cover food costs or bring their own food, eight of the 11 *LALS* clients agreed they would.

All the Bhaktapur IDUs wanted access to free, local detoxification and rehabilitation services.

One problem with costs of drug treatment was that such costs were often borne by family members. But several *LALS* clients said their family did not know they were using drugs; one said he had been using for 15 years but his family did not know. Others said their family was “sick and tired” of paying for their treatment and had refused to pay for any further treatment.

One *LALS* client had successfully stopped using drugs through *FH*. He remained drug-free for six to seven months but then met some friends and had no employment, so he relapsed to drug use. Both *LALS* clients and the NGO treatment services clearly understood that many attempts may be needed at drug treatment, with relapse into drug use likely several times before abstinence is achieved.

Some IDUs and treatment staff seemed to understand that abstinence was unlikely to be achieved by some drug users.

One Bhaktapur IDU had stopped using drugs for periods of up to six or seven months through home detoxification. He used wine, stayed at home by himself watching TV

until the worst withdrawal symptoms passed and, after about two weeks, rejoined his drug-using friends on the streets but no longer used. But he “always” relapsed, he said. Most Bhaktapur IDUs see employment as the key issue in staying off drugs. One said, “When I’m on drugs, I can’t do my work properly.” Another said, “When I’m on drugs I spend all my money on drugs so there’s no use having a job. Anything I earn I spend on drugs.” (This may be referring to a controlling mechanism used by some drug users in other countries: by earning less, drug use is reduced or maintained at a relatively low level. If more money is earned, drug use is simply increased and health problems ensue.) One, however, disagreed and said he was able to work well on drugs: “I had a job in a government textile factory. I knew if I didn’t get paid, I couldn’t get any drugs. So I was there on time every single day.”

Reach of services

In the KV survey, the majority of IDUs said that they sought help from hospitals, free clinics and/or rehabilitation centres/programs offering harm reduction materials and messages during illnesses, but the cost of drug treatment through detoxification/rehabilitation centres seemed prohibitive. When asked what they needed most, 54 of 204 IDUs replied, “Rehabilitation and drug treatment.” If this figure was true across the Valley, then up to 4000 IDUs may be wanting drug treatment at any time.

The current reach of all NGO residential drug rehabilitation services for male IDUs in Kathmandu Valley is fewer than 350 in the past 12 months. Of these, some are ex-residents returning for a second or further attempt at becoming abstinent from drugs. If there are 15,000 IDUs in Kathmandu Valley, these services are assisting fewer than three per cent of this population. While residential rehabilitation is not appropriate for all IDUs, such treatment should be more widely available and affordable so that those who wish to use this method to work towards abstinence can do so.

Government services may reach a further five to ten per cent but these are of such short duration and difficulty of access (detoxification ward), or of such low quality (*Assra*), that they are unlikely to be of great benefit.

RF and its *Women’s Programme*, and *YV*, reach several hundred more IDUs with drop-in programs, and their outreach workers reach several hundred more again. However, the finding that almost 60% of the IDUs interviewed in surveys for this assessment had not been contacted by any agency in the past month suggests that there is a need for large and rapid expansion of services.

Pharmacies

When they are unable to get needles and syringes from *LALS*, most clients have tried to buy them at pharmacies. They identified several problems with pharmacy purchase including:

- Refusal to sell: if chemists think the purchaser is a drug user, they refuse to sell needles and syringes;
- Judgmental attitude: chemists tend to treat the clients badly, serve them last and in other ways discourage them from purchasing needles and syringes;
- Raising prices: If chemists do sell to drug users, they tend to raise prices so that a 3 NR needle costs 10 NR and a 10 NR syringe and needle costs 17 NR.

In Bhaktapur, there is no needle exchange or distribution program. The Bhaktapur IDUs usually buy equipment from pharmacies. “There’s usually no problem,” they said. “You can’t go to every store. In some, you’ll be arrested, but in others they treat us okay.” In the previous week, the number of needles and syringes bought ranged from six to 20, with about 10 being the mean. Normally they use 3ml and 2.5 ml needles and syringes (which cost 5-6 NR each). The Bhaktapur IDUs generally used 2ml of *Tidigesic* a day in one or two injections, though they would have a third injection if they had money for more *Tidigesic*.

LALS has started discussions with chemists about playing a role in needle exchange programs. This has been a prominent part of responses to HIV among IDUs in countries such as Australia and the UK. Further work is needed to ascertain whether chemists would be interested in such a role, what incentives they might need, and what logistical arrangements, training and safeguards might be required.

Other health services

Due to time restrictions, not much information was gathered in focus groups on experiences with health services, though it also seems clear that IDUs rarely access mainstream health services.

Of the 11 *LALS* clients, four had accessed medical care in the previous year. Of these, two had had abscesses (and the others said this was the most common problem for IDUs), which were treated by *LALS* staff. The others needed a chest X-ray and typhoid treatment, for which *LALS* paid.

Of the seven Bhaktapur IDUs, three had received treatment for abscesses at the local clinic (ranging from three months to 18 months previously). One had been in a fight using beer bottles and needed 22 pieces of glass removed from his face and eyes. Interestingly, none of the Bhaktapur IDUs has ever overdosed (probably because they usually only used *Tidigesic*).

In the KV survey, female IDUs talked about the need for facilities for STD treatment.

The Bhaktapur IDUs also referred to two friends with conditions that sounded like AIDS. One had died a few months previously of bone cancer (though after probing, several suggested he might have died from AIDS) and a second had been bed-ridden for more than two years due to hepatitis.

For both men and women, there are few options when HIV positive active drug users become ill. *YV* staff said that their residents experienced a great deal of discrimination by medical services, especially if they were HIV positive: “You see it a lot: rejection by doctors, forced to leave medical treatment.” *RF Women’s Program* staff said: “Doctors treat them very badly. If it’s winter they give them one blanket and tell them to bring more blankets from home. But these women have no homes. There is no hot water so the blanket can’t be washed and they end up stinking. Everyone hates them.”

If the drug user is still connected with his or her family and can undertake all the difficulties of hospital (including a relative to stay and provide meals, payment for all medications and equipment used, etc), then medical care is available for them. However, even these fortunate IDUs, according to the NCASC Situation Assessment, often receive a lower standard of health care than other members of society, and doctors are not appropriately trained to provide counselling, treatment, care and support for HIV-positive IDUs.

Those who are less connected with their families or are poor have virtually no access to assistance. *LALS* continues to provide first aid and tries to provide medical assistance (for example, by paying for clients’ X-rays and medications) but this will become increasingly difficult as the number of sick HIV-positive clients continues to grow.

(*Prerana*, which was established as a HIV support service by and for people with HIV/AIDS including IDUs, has virtually ceased to function, according to interviewees at all of the other services in Kathmandu. *Prerana* has recently received increased funding but an attempt to interview its President about present and future activities was not successful.)

For IDUs with AIDS, the situation is worse still. For women, there are centres primarily set up to assist HIV-positive sex workers returning from India, but these will not take active IDUs (according to *RF Women's Program*). For men, the only option appears to be *Nagipot Farm*, a generic sheltered accommodation centre for very ill, homeless people in Kathmandu (run in conjunction with *FH*). *Nagipot* has acted as a hospice for two IDUs who died from AIDS.

There are two issues that need to be addressed urgently:

- *First is the issue of general health and medical care (including STD treatment) for IDUs.* Services are available which can provide appropriate treatment but they are expensive and are staffed by medical and nursing staff with antipathetic attitudes towards IDUs, meaning that these services are generally neither accessible nor attractive to IDUs. In the first instance, a training program about drugs, drug use, drug dependence, methods and effectiveness of drug treatment, HIV related to drug use, HIV prevention and care and treatment of IDUs with HIV/AIDS, is needed for general medical and nursing staff. This training should also be provided to staff of the government detoxification service.

To address the costs of treatment, NGOs should be funded to assist indigent IDUs to access necessary treatments, and basic first aid and nursing skills should be upgraded at NGOs to allow IDUs to be treated outside the mainstream treatment system where possible.

- *The second area of work is on treatment, care and support for HIV-positive IDUs.* Highly Active Anti-Retroviral Treatment (HAART) is extremely expensive if full prices are paid for the medication regime required to effectively treat HIV/AIDS. It does not make sense that overseas funds be used to pay for these medications. Rather, the Nepali government should be encouraged to follow the example of Brazil and Thailand and to find ways to access these medications at a much lower cost; this must be done at the government level but NGOs can be assisted to advocate for these steps.

There is a wide range of other activities that needs to be taken in addressing HIV treatment, care and support among IDUs (described in some detail in Burrows 2000a), of which the immediate steps should include:

- Training for NGOs (especially drug treatment staff) and other non-medical staff (including psychologists and social workers) in care and support of HIV-positive IDUs;
- Development of IEC materials for HIV positive IDUs on HIV/AIDS, course of the disease, symptoms, treatments (including complementary therapies), ongoing drug use and drug treatment, psychological and social aspects of being a HIV positive IDU, and dealing with discrimination (especially by healthcare institutions and staff). The information needs to be written by or with HIV positive IDUs to ensure that the language is appropriate to the target group;
- Training for HIV positive IDUs both on self care and on peer HIV/AIDS counselling for both treatments and psychosocial aspects of the disease, and on ways to work with treatment providers (including HIV and drug treatment) to stay as healthy as possible;
- Development of a carers' manual on home-based care of HIV positive IDUs for their families and friends.

Law enforcement

The role of law enforcement officers in HIV prevention among IDUs is a complex one, dealt with in more detail in the next chapter. Here, we look only at the effects of local law enforcement on HIV prevention activities.

LALS clients universally felt that their treatment by police was “very bad.” Policemen took their money, drugs, and possessions (such as jewellery). If the IDU protested, he was arrested. “If they think you’re a drug user, they stop you - it doesn’t matter if your family is with you. They start searching you. If they find anything - drugs, watch, chain [around the neck] - they take it. They’re supposed to have a warrant but they do it anyway,” said one. Another said, “Even when they find you have no drugs, no money, no syringes - they can still take you in because of vein damage.”

When arrested and enduring withdrawal in a police lock-up, police would sometimes offer to sell the IDU *Tidigesic* in a syringe for 400-500 NR. Serious beatings sometimes occurred in these lock-ups: one *LALS* client had a leg broken, another was tortured by having his feet beaten with batons and further beating all over his legs and torso. (The latter case needed a chest X-ray, which *LALS* paid for.)

The psychiatrist in charge of the methadone program at Lalitpur said that methadone clients were very often caught by the police and put in jail, “Sometimes with reason, sometimes without reason.”

Given these problems, and the general lack of training in drugs counselling and HIV prevention among IDUs in the police force, the suggestion in the Situation Analysis (NCASC 2000) that police are involved in HIV education of IDUs is not supported. Police at the local level need to be encouraged and assisted to understand the roles of harm reduction outreach, methadone programs, drug treatment programs, etc. They should be included in the community sensitisation activities (see below) and should be kept informed of HIV prevention activities so that they can ensure that police activities do not impact negatively on prevention activities. Regular communication is needed between harm reduction services and police for mutual problem-solving, and consideration should be given to the use of registration cards for needle exchange to assist IDUs in safely accessing needle & syringe services.

General community

Several respondents mentioned that the general community reaction to harm reduction services (in particular) had been very negative over the past decade. This is common in many parts of the world due to misunderstandings of the nature and rationale of harm reduction activities, and because of widespread ignorance about drugs and drug use.

One positive aspect of the situation in Kathmandu Valley is the generally acknowledged success of community sensitisation workshops carried out by *Youth Power (YP)* (an NGO which advocates for harm reduction), together with many other local groups including *LALS*. These workshops, held in mid-2000, brought together politicians and community leaders from five municipalities in the Valley to learn about HIV prevention among IDUs, and harm reduction generally.

Positive outcomes from the workshops included invitations for *LALS* to set up their services (in premises supplied by the municipalities) in several areas. No funding has been available to enable this step to be taken, but this result shows an understanding and willingness at the municipal level to take politically difficult steps to address HIV and drug use.

YP evaluated the workshop process and included the following among the lessons learned:

- There is inadequate information about drugs and HIV in the general community;
- There need to be combined public awareness programs on HIV/AIDS and drug addiction;
- The biggest obstacles to promoting harm reduction are social norms (including State policies on drugs and HIV/AIDS) and cultural taboos.

The above advocacy activities should be extended across Kathmandu Valley to assist local communities and community leaders, police, private industry, government services and politicians at the ward/district level to increase their understanding of drugs, drug use, drug dependence, effective approaches to reducing drug use and drug dependence, and effective HIV prevention among IDUs. Technical assistance may be needed to maximise the effectiveness of these activities and to implement a quality assurance process for ongoing improvement to the advocacy process.

In addition, ward/district Drugs and HIV/AIDS committees need to be established. With assistance from current NGOs and technical assistance, these committees could carry out drug education in the community and among youth, assess the need for drug treatment, and supervise the establishment of local outreach teams to provide effective HIV prevention services.

Prisoners

While IDUs in prison were not specifically sought for focus groups and interviews, we had the opportunity to speak with *WICOM*, an NGO carrying out prison peer education work (as well as peer education with police and military forces). The organisation has a trained group of more than 90 peer educators in one female and three male prisons. The prisons project meets international best practice standards by including:

- Workshops for Ministers and senior bureaucrats on the need for HIV peer education in prisons;
- Workshops for prison authorities on the need for HIV peer education;
- Workshops for prison custodial staff on the need for and methods of HIV peer education;
- Peer education training workshops and payment of peer educators of a stipend to encourage them to educate new prisoners;
- Condom distribution in prisons;

- Liaison with and training of prison medical and nursing staff in condom distribution and HIV prevention.

However, thus far, all the education in prisons has focused on sexual transmission of HIV. For effective HIV prevention among IDUs in prison, the above system needs to be re-oriented towards provision of safer injecting information. Also, the HIV prevention efforts within and outside prison need to be co-ordinated so that IDUs receive similar information in both contexts and are referred appropriately: to peer educators on entry to prison, and to agencies such as *LALS* and treatment services on exit from prison.

Networking

While the quality of HIV and drugs services is generally high in Kathmandu Valley, there appears to be little regular networking between services. We believe that increasing this networking function will be vital as the expansion of services occurs.

The first way to increase networking opportunities is to ensure that all the NGOs mentioned above are involved in the planning and, at least occasionally, in the delivery of advocacy activities at the political and community level. Working together in this way increases mutual respect and understanding of each other's programs.

Second, training, supervision, monitoring and ongoing assistance from the current NGOs will be required for the development of local outreach teams throughout the Valley for both harm reduction service provision and for encouraging drug users into treatment.

It is recommended that outreach teams at *LALS*, *YV*, *FH*, *RF* and *RF Women's Programs* be immediately doubled and that at least two outreach workers from each agency work with the other services on the development of new outreach teams. Technical assistance would help the organisations to manage this expansion and these new ways of working.

A range of IEC and training materials on a wide range of topics needs to be developed in Nepali or adapted/translated into Nepali, and a library and resource centre is needed for storage and distribution of these publications and other materials to appropriate services. Among the immediate adaptation/translation tasks are Nepali versions of:

- This report;
- Asian Harm Reduction Manual;
- Starting and Managing Needle Exchange Programs;
- Overview/review scientific papers on the effectiveness of harm reduction and drug treatment methods;

- General community information about drugs, drug use and harm reduction;
- Specific information for police about drugs, drug use and harm reduction;
- Care and support of HIV positive IDUs.

Local NGOs with outside technical assistance should undertake development of these publications, and storage and distribution should be centralised to enhance efficiency. Consideration should be given to assisting *RECPHEC* to expand its database, library and resource centre functions to include these harm reduction publications.

Conclusions

Any existing drugs or HIV/AIDS service is not reaching an overwhelming majority of IDUs in Kathmandu Valley. Harm reduction outreach services are reaching fewer than 10% of IDUs; about the same percentage is, perhaps, being reached through treatment programs' outreach and drop-in services, and fewer than three per cent are being provided with drug treatment and rehabilitation.

In addition, there is little evidence-based drug education of the general community, and there is community and police misunderstanding of - and opposition to - many drugs and HIV/AIDS services. To address these issues, an integrated approach to the issues of HIV/AIDS and drug use in Kathmandu Valley is required (see final chapter).

KV IDUs appear to generally inject two to three times a day, seven days a week. A coverage with harm reduction materials of 100% of injections would mean the distribution of about 14-21 needles and syringes to each IDU, each week (728–1092 per year). If there are 15,000 IDUs in the Valley, this would require the distribution of 10.92 - 16.38 million needles and syringes per year. (Encouraging re-use of the drug user's own equipment may reduce this number. According to respondents, Terumo needles and syringes may be re-used four to five times, which could cut the number of needles and syringes distributed to around 2.25 – 3.45 million per year. This figure is closer to the actual amount of equipment provided in high-coverage cities such as Sydney, which provides around 200 needles and syringes per IDU per year.) (Burrows 2000.)

The quality of HIV prevention activities among IDUs by street outreach workers is very high, as are the reported HIV education activities of drug treatment NGOs. This is not the case with the government drug treatment service visited.

The level of understanding of effective HIV prevention approaches among IDUs is very high at all the NGOs (apart from the prisons' peer education group, which has so far

concentrated on sexual transmission). This is not the case with the government drug treatment service visited.

Sufficient capacity exists in the Valley, especially among NGOs and some government services, on which an integrated response can be built. Substantial technical assistance is required to assist the NGOs to maximise the effectiveness of their current activities and allow them to both expand existing activities and start new activities to address the needs of IDUs, including expanded peer education and drug user organising, low-threshold services such as outreach and outpatient drugs counselling, brief interventions, assisted home detoxification, and work skills development, job training and income generation projects

The ability of the current IDUs to reach out to the wider mass of injectors should also be considered by all agencies. Drug users show a willingness to educate and support their friends. This willingness must be harnessed if effective HIV prevention is to occur on a large scale. Peer education programs should be promoted by all organisations working with IDUs, including within the prison system.

Technical assistance is also required for government services such as the detoxification service and methadone program to increase their accessibility and attractiveness to IDUs. Methadone places should increase from the current level of 135 clients, to 500 clients in the next two years. A large-scale study is needed on the efficacy of other drug substitution therapies (including provision of buprenorphine at government pharmacies). The government *Assra* program should be completely re-conceptualised to incorporate the best elements of the NGO services.

NGOs should be funded to assist indigent IDUs to access necessary medical treatments and drug treatment, and basic first aid and nursing skills should be upgraded at NGOs.

Capacity building is needed to create many more trainers, and institutional backing is required to support ongoing learning by trainers. Rather than create a single training centre, training capacity should be enhanced at appropriate organisations (especially NGOs). A training assessment is needed to identify the most appropriate training sites and the needs for training, to develop initial training programs (together with local trainers) and structures/processes for ongoing learning by trainers.

In the longer term, evidence-based harm reduction and drug treatment education should be included in a wide range of professional development processes, such as university and ongoing education for doctors, psychiatrists, nurses, social workers and psychologists.

In addition, formalisation of outreach work and drug treatment skills' development into an appropriately certified course should be considered to aid in the professionalisation of these workers.

From our observations, further training is needed quickly in:

- Theoretical background and standardisation of counselling knowledge, as well as specific skills in counselling on drug use and living with HIV/AIDS;
- The range of drug treatments available and how residential treatment should fit into this range of services;
- Advocacy for harm reduction and drug treatment services;
- Drug education (at schools and in the community);
- Ways to access and assess information via the Internet and other electronic sources;
- Program management for most current NGO drugs and harm reduction staff below co-ordinator/director level (to allow rapid expansion of services);
- General management for all current co-ordinators/directors (emphasising change management, use of quality assurance processes, managing diverse organisations, personnel management and human resource development, financial management and reporting to diverse funding sources, networking);
- Departmental and cost-centre management;
- Managing personnel in widely varying task areas;
- Complex financial management.

All organisations should develop and maintain quality assurance processes in which:

- All activities are continuously monitored to search for problems and new issues which are not currently being addressed;
- Regular reports on this monitoring are fed into management at an appropriate level for quick decision-making;
- Management decisions on ways to address problems or new issues are fed back to staff and are implemented quickly;
- Monitoring continues to check whether the new ways of working are effective, and whether new issues are again emerging.

A range of IEC and training materials on a wide range of topics needs to be developed in Nepali or adapted/translated into Nepali. Among the immediate adaptation/ translation tasks are Nepali versions of:

- This report;
- Asian harm reduction manual;
- Starting and managing needle exchange programs;
- Overview/review scientific papers on the effectiveness of harm reduction and drug treatment methods;
- General community information about drugs, drug use and harm reduction;
- Specific information for police about drugs, drug use and harm reduction;
- Care and support of HIV positive IDUs.

There should also be very simple Nepali documents (summaries of other information or short ‘how-to’ guides) with little text and many illustrations, as many ex-IDUs who become (or want to become) staff members may have low literacy in Nepali.

Local NGOs with outside technical assistance should undertake development of these publications and storage and distribution should be centralised to enhance efficiency, possibly through *RECPHEC*.

An investigation is needed to discover whether chemists would be interested in being part of a needle exchange program for HIV prevention among IDUs, what incentives they might need, and what logistical arrangements, training and safeguards might be required.

A training program is needed on drug use, effectiveness of drug treatment, HIV related to drug use, HIV prevention and care and treatment of IDUs with HIV/AIDS for general medical and nursing staff. Other immediate steps to assist HIV-positive IDUs should include:

- Training for NGOs (especially drug treatment staff) and other non-medical staff (including psychologists and social workers) in care and support of HIV-positive IDUs;
- Development of IEC materials for HIV positive IDUs on a wide range of topics related to HIV/AIDS and drug use;
- Training for HIV positive IDUs on self care and on peer HIV/AIDS counselling on both treatments and psychosocial aspects of the disease, and on ways to work

with treatment providers (including both HIV and drug treatment) to stay as healthy as possible;

- Development of a carers' manual on home-based care of HIV positive IDUs for their families and friends.

The Nepali government should be encouraged to find ways to access HAART medications at a much lower cost than at present: NGOs should be assisted to advocate for these steps.

Police at the local level need to be encouraged and assisted to understand the roles of harm reduction outreach, methadone programs, drug treatment programs etc. They should be included in community sensitisation activities and should be kept informed of HIV prevention activities so that they can ensure that police activities do not impact negatively on prevention activities. Regular communication is needed between harm reduction services and police for mutual problem-solving, and consideration should be given to the use of registration cards for needle exchange to assist IDUs to safely access needle exchange services.

Current advocacy activities should be extended across Kathmandu Valley to assist local communities and community leaders, police, private industry, government services and politicians at the ward/district level to increase their understanding of drugs, drug use, drug dependence, effective approaches to reducing drug use and drug dependence and effective HIV prevention among IDUs. Technical assistance may be needed to maximise the effectiveness of these activities and to institute a quality assurance process for ongoing improvement to the advocacy process.

In addition, ward/district Drugs and HIV/AIDS Committees need to be established. With assistance from current NGOs and technical assistance, these Committees would carry out drug education in the community and among youth, assess the need for drug treatment, and supervise the establishment of local outreach teams to provide effective HIV prevention services.

The current prisons' peer education system needs to be re-oriented towards provision of safer injecting information. Also, HIV prevention efforts within and outside prison need to be co-ordinated so that IDUs receive similar information in both contexts and are referred appropriately: to peer educators on entry to prison, and to agencies such as *LALS* and treatment services on exit from prison.

Increased networking should be achieved by all the NGOs mentioned above being involved in the planning and (at least occasionally) in the delivery of advocacy activities at the political and community level.

It is also recommended that outreach teams at the harm reduction outreach and drug treatment NGOs be immediately doubled and that at least two outreach workers from each agency work with the other services on the development of new outreach teams. Technical assistance will help the organisations to manage this expansion and these new ways of working.

4. Policy Environment

“Drug use is a matter for the health authorities; drug trafficking is a matter for the police.”

Senior Nepalese Police official, January 2001

Transmission of HIV among injecting drug users occurs against a policy and legal background that it is vitally important to examine in determining rates of spread and opportunities for effective prevention. Without sensible policy, expressed in effective laws - which in turn are expressed in effective practice - efforts to prevent HIV transmission among IDUs will be doomed to failure.

The development of effective policy in this area can be problematic, because it must cut across several areas, each with their own vested interests, constituencies and traditions. In particular, HIV among IDUs is both a health and a legal issue, because the population at risk of AIDS is defined by its participation in an illegal activity. Therefore, every important and relevant player must be brought together in the policy debate and development process, and every legitimate point of view must be accorded that legitimacy in the search for the right balance.

Effective policy in this area will be that which most closely allows and promotes achievement of the dual goals of minimising illicit drug use and minimising the transmission of HIV among and from injecting drug users, while having the fewest untoward effects on society in general.

Each policy setting and relevant law must be examined carefully from two points of view:

- **Does it achieve its stated aim?**
- **Does it assist or hamper efforts to prevent the spread of HIV among IDUs?**

At present in Nepal, the processes of policy development and implementation for *control of illicit drug use* and *for control of AIDS* are entirely separate; neither is happening in collaboration with the other. A process of education and advocacy with the Home Ministry is necessary to raise the profile of HIV/AIDS and illustrate the role of the Home Ministry and the police in HIV control.

It is proposed that there be a review of *current policies* and of *current law* in relation to illicit and licit drugs and their impact on HIV prevention. A first major function of these reviews will simply be to elucidate the *status quo* - what are the current policies and laws, and what do they mean? There is much confusion, even at the top reaches of bureaucracy and government, about many actual details of current law - for instance, whether simple possession of a needle and syringe is legal.

These reviews can then be used as a basis for open debate and discussion about what appropriate policy settings are and how they can be achieved. Policy is not useful if the community does not have a stake in its effective implementation; this stake will not be there if the community is not educated and involved in the policy process (at least through some peak community bodies).

Many (if not most) current policies, laws and practices have never been evaluated for their effectiveness in achieving their stated aims. For instance, the arrest and incarceration of illicit drug users simply for possession or use of a proscribed drug is an expensive stratagem, and one which is unlikely on examination to be effective in decreasing illicit drug use for either the individual or the community in general. However, this approach *can* be shown to have untoward and deleterious effects, through the experience of imprisonment and in driving illicit drug use even further underground, increasing the risk of unsafe injecting and making HIV prevention efforts more difficult.

There has been a review of current policy related to illicit drugs in Nepal, carried out on behalf of UNAIDS and UNDCP. The results of this review have not however been adequately disseminated within Nepal.

With the results of such reviews to hand, it is suggested that a dissemination process be undertaken, involving forums with relevant key politicians and public servants: within line Ministries and across several Ministries; face-to-face meetings with Ministers and Secretaries of Departments; community forums; and even consideration by Cabinet. This dissemination process should be supported by the production of a number of Policy Discussion papers in different versions, ranging from the extremely simple for the less literate members of the community, to sophisticated versions for the most literate.

As well, efforts must be made to educate the police in their role in the prevention of HIV transmission. This education should include peer education, with police consultants from other countries with more experience of harm reduction visiting their colleagues in Nepal, and study tours for senior officials in the Home Ministry and local police to such other countries. These study tours should examine every aspect of the policy making and implementation process.

5. An integrated approach to HIV/AIDS among IDUs in Kathmandu Valley

*“The determinants of drug use and drug-related harm are complex and multifaceted and involve factors other than those related only to the individual, for example, factors related to the drug itself and to the environment. It would seem logical that **more effective responses should echo this complexity and be delivered to scale, in a manner that reflects evidence-based problem solving, adequate attention to implementation fidelity and a commitment to sustained action.**”*

Reynolds, 2000 (Report Authors' emphasis)

Addressing the transmission of HIV among IDUs in Kathmandu Valley will require a rapid expansion of current services and a set of new activities that must all be implemented simultaneously. Effective HIV prevention among IDUs will only occur if many separate groups, organisations and individuals can be encouraged to work together on an integrated approach to the problem.

It is recommended that the following activities are undertaken jointly to constitute this integrated approach (see accompanying chart):

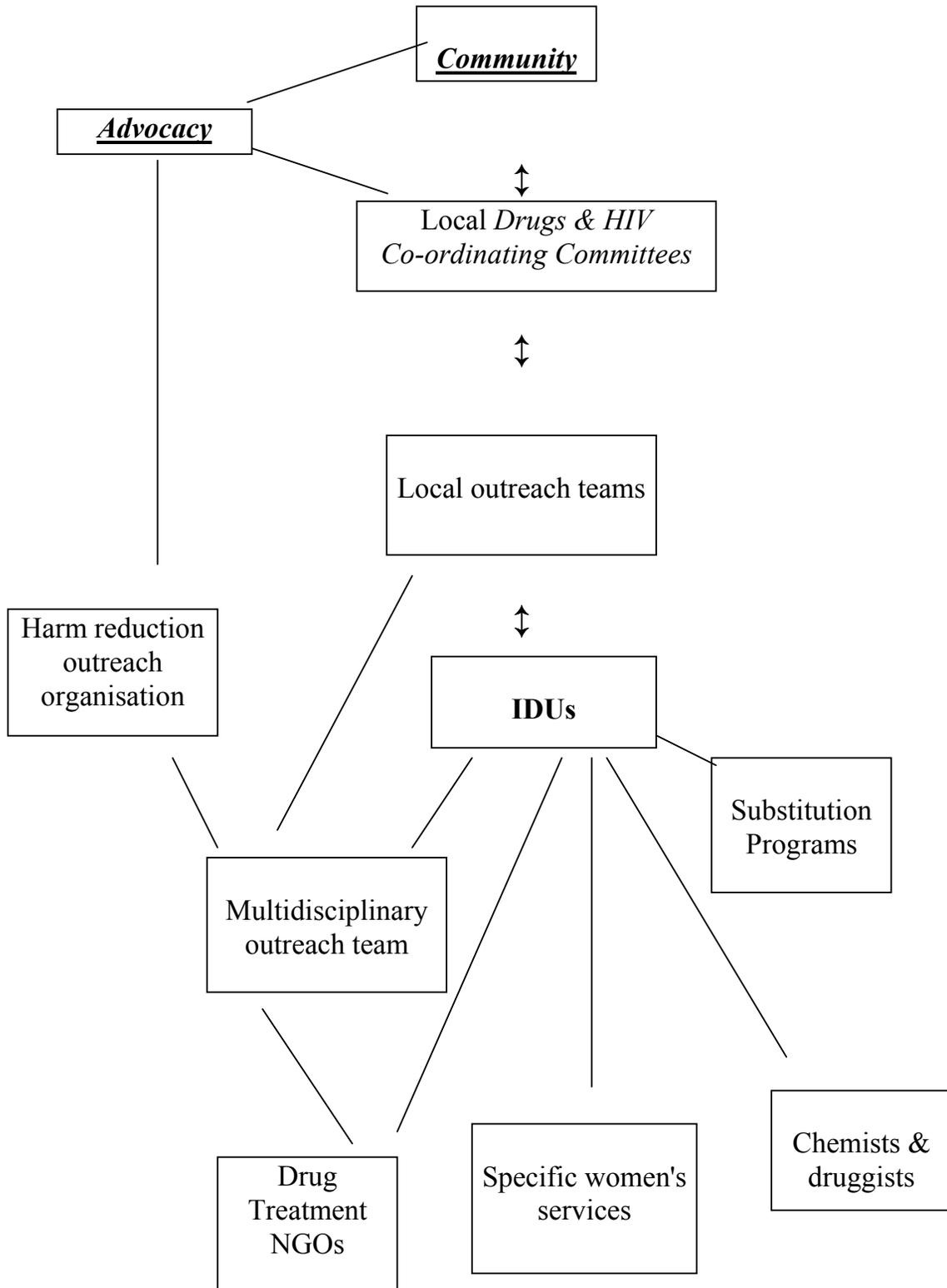
- **Advocacy activities will assist local communities and community leaders, police, private industry, government services and politicians at the ward/district level to increase their understanding of drugs, drug use, drug dependence, effective approaches to reducing drug use and drug dependence and effective HIV prevention among IDUs;**

- After the above activities, ward/district Drugs and HIV/AIDS Committees will be established in selected locations (with initial selection based on prevalence of injecting drug use and HIV/AIDS and local willingness to start programming).;With assistance from current NGOs and consultants, these committees will carry out drug education in the community and among youth, assess the need for drug treatment, and supervise the establishment of local outreach teams to provide effective HIV prevention services;
- While the above two activities are starting, current harm reduction and drug treatment NGOs (including a women-specific service) will have their outreach staffs doubled to increase their capacity to do their current work and, with help from consultants, take on a new role of providing initial and ongoing training, supervision and monitoring of ward/district outreach teams. These outreach workers will also carry out identification of key individuals to assist in starting outreach teams. Also, the HIV prevention efforts within and outside prison will be co-ordinated so that IDUs receive similar information in both contexts and are referred appropriately;
- Also at the same time, the government restriction on methadone places will need to be addressed to allow rapid expansion of the number of IDUs accessing substitution therapy and a large-scale study planned and implemented on the efficacy of other drug substitution therapies (including provision of buprenorphine at government pharmacies);
- Also at the same time, the Nepal Chemists' & Druggists' Association will be approached to determine whether its members can play a role in needle and syringe exchange;
- Also at the same time, a review of drug policies and laws and their effects on HIV prevention among IDUs will be carried out;
- More than two million needles and syringes will need to be purchased for distribution in the initial project period (12-18 months). Syringes and needles should be of a quality and type (brand, separate or fixed, needle gauge, syringe capacity) acceptable to IDUs;

- **Current harm reduction outreach and drug treatment NGOs will be encouraged and assisted to expand their existing activities and start new activities to address the needs of IDUs, including expanded peer education and drug user organising, low-threshold services such as outreach and outpatient drugs counselling, brief interventions, assisted home detoxification, and work skills development, job training and income generation projects. This will require additional funding. NGOs will also be funded to assist indigent IDUs to access necessary medical treatments and drug treatment, and basic first aid and nursing skills will be upgraded at NGOs;**
- **Active IDUs will be included in activities best suited to their skills and work abilities. Tasks may include peer education and support, drug user organising, and needle and syringe exchange;**
- **The government's *Assra* program needs to be completely re-conceptualised to incorporate the best elements of the NGO services;**
- **A training assessment will identify the most appropriate training sites and the needs for training, to develop initial training programs (together with local trainers) and structures/processes for ongoing learning by trainers;**
- **All organisations working with IDUs will develop and maintain quality assurance processes;**
- **A range of IEC and training materials on a wide range of topics will be developed in Nepali or adapted/translated into Nepali. Among the immediate adaptation/ translation tasks are Nepali versions of:**
 - **Centre for Harm Reduction Report on HIV prevention among IDUs in Kathmandu Valley;**
 - **Asian Harm Reduction Manual;**
 - **Starting and Managing Needle Exchange Programs;**
 - **Overview/review scientific papers on the effectiveness of harm reduction and drug treatment methods;**
 - **General community information about drugs, drug use and harm reduction;**
 - **Specific information for police about drugs, drug use and harm reduction;**
 - **Care and support of HIV positive IDUs;**

- **Simple Nepali summaries of relevant information and short how-to guides;**
- **The current prisons peer education system will be re-oriented towards provision of safer injecting information;**
- **Police will receive training (following a training needs assessment) to ensure they understand their role in HIV prevention among IDUs;**
- **On completion of the policy and legal review, a dissemination process of workshops and other methods will be used to increase public discussion of changes needed to laws and policies to enhance the effectiveness of attempts to prevent HIV transmission among drug users.**

Technical assistance for the above tasks will include a range of methods from visits by international consultants (for further assessments, technical advice and training), networking of local organisations in the Valley, study tours and training courses in other countries, attendance at appropriate international conferences, etc.



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