

# HIV AND INJECTING DRUG USE IN SELECTED SITES OF THE TERAI, NEPAL

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## DRUG USE SITUATION AT A GLANCE

| <b><i>BIRATNAGAR</i></b>                       |
|--|
| Estimated number of drug users: 5,000 to 7,000 |
| Estimated % of IDUs: >75%                      |
| Primary drug of choice: buprenorphine          |

| <b><i>BIRGUNJ</i></b>                        |
|--|
| Estimated number of drug users: 800 to 2,000 |
| Estimated % of IDUs: 40-50%                  |
| Primary drug of choice: heroin               |

| <b><i>DAMAK</i></b>                 |
|-------------------------------------|
| Estimated number of drug users: 500 |
| Estimated % of IDUs: 40%            |
| Primary drug of choice: heroin      |

| <b><i>DHARAN</i></b>                         |
|--|
| Estimated number of drug users: 4000 to 5000 |
| Estimated of IDUs: 80%                       |
| Primary drug of choice: buprenorphine        |

| <b><i>HETAUDA</i></b>                        |
|--|
| Estimated number of drug users: 1000 to 1500 |
| Estimated % of IDUs: 10-15%                  |
| Primary drug of choice: buprenorphine        |

| <b><i>KAKARBHITTA</i></b>           |
|-------------------------------------|
| Estimated number of drug users: 200 |
| Estimated % of IDUs: 40-50%         |
| Primary drug of choice: heroin      |

| <b><i>NEPALGUNJ</i></b>               |
|---------------------------------------|
| Estimated number of drug users: 2500  |
| Estimated % of IDUs: 50%              |
| Primary drug of choice: buprenorphine |

| <b><i>POKHARA</i></b>                          |
|--|
| Estimated number of drug users: 5000 to 10,000 |
| Estimated % of IDUs: 60-70%                    |
| Primary drug of choice: buprenorphine          |

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## **ACRONYMS**

|        |   |
|--------|---|
| AMDA   | Association of Medical Doctors of Asia      |
| BPKIHS | BP Koirala Institute of Health Services     |
| CHES   | Community Health Communication Services     |
| CPR    | Cardiopulmonary resuscitation               |
| DALO   |   |
| DDA    | Department of Drug Administration           |
| DDC    | District Development Committee              |
| FPAN   | Family Association of Nepal                 |
| FSW    | Female Sex Worker                           |
| GWP    | General Welfare Pratisthan                  |
| IDU    | Injecting Drug Use/r                        |
| INF    | International Nepal Fellowship              |
| INGO   | International Non-governmental Organization |
| KYC    | Kirat Yakthung Chumlung                     |
| NA     | Narcotics Anonymous                         |
| NCASC  | National Centre for AIDS and STD Control    |
| NGO    | Non-governmental Organization               |
| N'SARC | National STD and AIDS Research Center       |
| NRCS   | Nepal Red Cross Society                     |
| PLWHA  | People Living with HIV/AIDS                 |
| SEDA   |   |
| STD    | Sexually Transmitted Disease                |
| VCT    | Voluntary Counseling and Testing            |
| UMN    | United Mission to Nepal                     |
| VDC    | Village Development Committee               |

## **EXECUTIVE SUMMARY**

### **AIMS**

The scope of work for this assessment was:

- To describe the current situation
- To describe the responses to date
- To identify the needs of IDUs
- To identify challenges for scaling-up
- To make recommendations

Eight sites were included in this assessment. They were: Biratnagar, Dharan, Birgunj, Nepalgunj, Pokhara, Damak, Kakarbhitta and Hetauda.

### **METHODS**

During the preparatory visit in December 2000 two regional specific key persons were identified in Hetauda and Damak to coordinate with six of the eight locality-specific key persons in the eastern part of Nepal. Between January 7<sup>th</sup> and 24<sup>th</sup>, 2001, field visits were carried out at which two group meetings were conducted at each site, one with current injecting drug users and the other with representatives of key stakeholder organizations (both government and non-governmental sectors). Representation in each of the groups ranged from 10 to 20 individuals and lasted approximately two to three hours. Local experts were asked to estimate the number of drug users and IDUs present in their areas.

### **RESULTS**

#### ***Biratnagar***

Biratnagar is located in Morang district. According to local IDUs and key stakeholders gathered for this assessment, there were about 5,000 to 7,000 drug users in Biratnagar municipality, the majority of whom were injectors and nearly all of whom were male. The main drug used was buprenorphine bought across the border in Jogbani at 'tea shops', shops at which drugs could be bought and injections purchased. Sharing injecting equipment, both at tea shops and elsewhere, was common. Few services existed for IDUs and one NGO only had carried out harm reduction education and some vocational training. There was little knowledge about safe sex practices. Law enforcement authorities did not actively pursue IDUs in the community, "because so many police are drug users themselves", the team was told.

#### ***Dharan***

Dharan is one of the major municipalities in Eastern Nepal where illicit drug use was widely considered a serious social problem. Informants estimated that the area had 4,000 to 5,000 drug users, including about 3,000 who injected buprenorphine bought mostly within town. Many IDUs were said to travel outside of Dharan, such as Kakarbhitta and Jogbani, to engage in sex. Local police harassed IDUs on a daily basis

in Dharan with multiple reports of bribery and corrupt practices. Carrying needles/syringes constituted a risk for IDUs. One NGO ran a 15-bed drug treatment center with limited outreach in which bleach and condoms were distributed.

### ***Damak***

Damak, located on the main East-West Highway, had approximately 500 drug users, about 40% of these were IDUs and only a few were female. Damak was firmly a 'brown sugar' (low grade heroin) town. Although syringes were available at NRs.5 per piece, many IDUs shared and condom use was low. Damak was very focused on drug use prevention. Despite having had a short-term harm reduction program, the focus had become one in which drug users were to be put into treatment even if by force.

### ***Kakarbhitta***

Kakarbhitta is a town located on the border with India and a transit area for illicit drugs. The town itself did not have more than 200 drug users, but another 150-200 drug users and dealers transited through Kakarbhitta on a daily basis. 'Brown' sugar was the drug of choice and half of the users switched back and forth between inhaling fumes and injecting; a minority only injected. Vein damage and abscesses were common. In lieu of drug treatment, IDUs were put in jail. No organization provided services or advocated on their behalf. Kakarbhitta did not have many social service organizations.

### ***Nepalgunj***

Nepalgunj, located near the border with India, had an unknown number of IDUs. Estimates varied between 300-350 (with 100-150 IDUs) according to drug users themselves and about 2500 with about a third of these injecting, according to the social service organizations. Very few were female as they had migrated to larger cities. The primary drug of choice for injectors was buprenorphine while non-injectors preferred to inhale the fumes of 'brown sugar'. Syringes were easily available but sharing continued. The social consequences of drug use prohibition were severe, involving police harassment, bribery, arrest and imprisonment. No organization provided services or advocated on their behalf and many were jailed.

### ***Hetauda***

Hetauda is a town located in Makwanpur district along the East-West Highway. There was general agreement that there were only about 100-150 IDUs, but at least 1000 drug users. They were divided between those who publicly used drugs and those who injected in the safety of their homes. Raxaul was the main location for purchasing and/or using buprenorphine and nitrozapam. Despite easy access to needles and syringes, IDUs collected discarded ones from hospital and pharmacy sites and both re-used and re-sold them. Increasingly, health care providers were demanding HIV test results before undertaking any health care for IDUs, possibly due to increased exposure. A few NGOs had offered limited services.

### ***Birgunj***

Birgunj is a town in Parsa district. Estimates ran from 800 to 2000 drug users with 300 to 700 IDUs. 'Brown sugar' was the current drug of choice, having shifted from

buprenorphine earlier. It was currently flooding Birgunj, as police control was allegedly slack. Raxaul remained the main source for other drugs. Birgunj had a number of good services reaching out to IDUs, including limited needle exchanges both in Birgunj and Raxaul.

### ***Pokhara***

Pokhara is a town in Kaski district. The best estimate of the number of drug users was about 6000, with 60-70% injecting. Approximately 5 to 7% of the IDUs were female, many of whom were sex workers. Buprenorphine was the drug of choice. About 50% of male IDUs were thought to use new needles each time, but few women seemed to have been exposed to HIV prevention messages. A few NGOs offered services to these men and women but could not meet demand,

### **Recommendations**

This assessment demonstrated the urgent need in many areas of Nepal for IDU- related HIV prevention services. The acute lack of outreach and peer education throughout the country reflects the uncertain and often negative legal and policy environment. Effective national HIV prevention among IDUs will require a network of services able to provide easily accessible, free or inexpensive injecting equipment, skills-based education, STD and abscess treatment services, safer sex counseling and opiate dependency treatment. The tension between investing in demand reduction, drug treatment and harm reduction was evident everywhere. Without policy consensus at both the local and national levels, any efforts to reduce the spread of HIV among and from IDUs are likely to be small and short-lived as in the past. For these reasons the following activities are suggested:

- *Advocacy for Donors, INGOs, NGOs and Government of Nepal Authorities.* Drug treatment and harm reduction programs must be carried out with the full approval of the relevant authorities. Consensus must be reached as to what is allowable at the present time. As these programs will cost more than any single donor can provide, collaborative funding should be explored as well as ways to integrate some of the needed services into existing programmes.
- *National Forum on Drug Treatment Options.* A series of meetings in which all drug treatment options with proven effectiveness are reviewed; delivery modes discussed in relation to local needs; resources assessed and infrastructural, commodities, and training needs established.
- *National Estimation Training Workshop.* The current estimates of drug users and IDUs are not accurate. Efforts to provide comprehensive, sustainable programming for IDUs will need to consider issues of coverage. To ensure that optimal coverage is reached, each site needs to estimate, in a sound manner, the number of IDUs in existence.
- *Female IDUs.* Specific HIV prevention efforts, including drug treatment regimes, should be designed with and for female IDUs. In preparation, short qualitative studies are required.
- *Cross border issues* play a major role in Nepalese drug use. The possibility of sponsoring a major meeting with Indian and Nepalese HIV/AIDS and drug

authorities should be explored, with the help of appropriate UN agencies.

- *Regional Workshops to Design IDU HIV Prevention Programs.* The immediate reduction of the spread of HIV among and from IDU communities should be undertaken by those agencies ready for the challenge. These workshops should result in full proposals with budgets for submission.
- *HIV Education and Prevention for Police.* Given the great influence police have at the street-level over access to IDUs by NGOs, and their own levels of risk, much effort is warranted on police HIV education, with peer educators and curriculum development for police training programmes.

# **HIV AND INJECTING DRUG USE IN SELECTED SITES OF THE TERAI, NEPAL**

## **AIMS**

Over the past few years, valuable research on the drug- using population of Nepal has been carried out. Of the 1109 drug users included in a study conducted in 19 urban areas throughout the country in 1998, 725 (564 injectors and 161 non-injectors) consented to be tested for HIV, HBV and HCV. The prevalence rate among injectors for HCV was 60%, followed by HIV (40%) and HBV (6%). In comparison, the rates among non-injectors were lower, i.e. 28%, 8% and 4% respectively<sup>1</sup>. A rapid rise in HIV among IDUs in Kathmandu was also detected in 1999 in which HIV prevalence had reached nearly 50%<sup>2</sup>. Family Health International, Nepal, undertook to make a rapid assessment of the situation, current responses, and examine ways to participate in an effective programme to reduce the spread of HIV among and from injecting drug users (IDUs) in Nepal.

The scope of work for this assessment was:

- To describe the current situation
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## **METHODS**

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<sup>1</sup> B.B.Karki. Rapid Assessment among drug users in Nepal. **AIDS Watch. WHO South-East Asia Region on STI, HIV and TB.** May-August 2000.

<sup>2</sup> Oelrichs, R., Shrestha, I., Anderson, D., and Deacon, N. The explosive human immunodeficiency virus type 1 epidemic among injecting drug users of Kathmandu, Nepal, is caused by a subtype C virus of restricted genetic diversity. **Journal of Virology, 2000, 74: 1149-1157.**

## **Map of Sites Visited**

## **RESULTS**

## **BIRATNAGAR**

### **Background**

Biratnagar is located in Morang district. According to local IDUs and key stakeholders gathered for this assessment, there were about 5,000 to 7,000 drug users in Biratnagar municipality, the majority of whom were injectors. Very few female IDUs lived in Biratnagar, although it was said that female IDUs from neighboring towns, such as Dharan, traveled to Biratnagar and to Jogbani to buy and use injectable buprenorphine (trade name: Tidigesic). Most female drug users in Biratnagar preferred Phensedyl (codeine-based cough syrup). The majority of IDUs encountered were unmarried and between the ages of 15 to late 30s. Of the few married men, all had children.

Historically in Biratnagar heroin (usually available as low grade heroin, or 'brown sugar') was little used because pharmaceuticals were easily accessible locally, as well as from across the border. In the early 1990s, Phensedyl and Valium (diazepam) were the drugs of choice. In the mid-90s these were replaced by buprenorphine, due to the increasing cost of Phensedyl after listing as a scheduled drug. By the year 2000, buprenorphine was well established as the most common drug used, often in combination with Phenergan (promethazine hydrochloride), Calmpose (probably diazepam) and Avil (chlorpheniramine), administered as cocktails. Reportedly, an alternate to these drugs is Spasmo Proxyvon, supplied as pills dissolved for injecting. The active ingredient in Spasmo Proxyvon is dextropropoxyphene, another opioid analgesic that provides effective relief in all musculo-skeletal pains of varying intensity. The price for Phensedyl has remained high, at NRs. 60 to 65, whereas buprenorphine was NRs 25 (2 ml), Calmpose NRs 15, Phenergan and Avil, NRs 7 (2ml) at the time of this assessment.

### **Drug use patterns and risk behavior**

The daily routine for IDUs in Biratnagar involved a trip to Jogbani, just across the border in India. Jogbani was not much more than a border crossing, but it served as a center for accessing and using drugs. About ten kilometers from Biratnagar, Jogbani was very accessible by public transport.

Drugs, such as buprenorphine, were available across the border in various locations, most commonly at 'teashops'. Proprietors fronted these teashops, which were actually one-stop facilities. IDUs paid to buy and inject drugs on-site. A new syringe cost NRs. 5 and the proprietor performed the injection for an additional NRs. 5. The majority of these teashops were located in a no-man's land between Jogbani and Rani. Drugs could also be purchased in medical halls where the 'doctor' sold syringes as well as injected users for a NRs. 5 fee. On rare occasions where IDUs only purchased drugs, then returned to Biratnagar to inject. The total cost of an excursion to Jogbani was approximately NRs. 100, i.e. NRs. 25 for drugs, NRs.10 for the syringe and injection, NRs.28 for the return bus fare, and NRs.37 for snacks/tea or cigarettes. On average, IDUs injected twice a day, 2ml each time. Indian IDUs across the border accessed drugs in the same manner.

Due to relatively easy access to drugs, Biratnagar has become a focus of IDU in-

migration from as far as Pokhara and Kathmandu. Due to increasing police surveillance in other areas of Nepal, few bought with the intent to sell elsewhere. Occasionally, IDUs sought ways of obtaining pethidine from the hospital.

Sharing injecting equipment, both at teashops and elsewhere, was said to be common. Often, IDUs helped others inject, and sometimes introduced new injectors to the practice. Hot water, saliva, and urine were common means of cleaning needles/syringes. However, the education provided by HELP seemed to have raised awareness of the need to sterilize injecting equipment and to decrease sharing of needles/syringes. The assessment team was informed that, “after the HELP training, we try to buy new needles”.

IDUs were also at risk of infection through the practice of cleaning needles/syringes, re-packaging, and re-selling. The assessment team was also informed that sometimes, the drug ampoules themselves were re-labeled.

While most IDUs said that their sex drive decreased due to drug use, no one denied they were sexually active. One IDU reported undergoing STD treatment recently. Condoms were available at various health posts, but it does not seem that IDUs accessed these on a regular basis. There was little knowledge about safe sex practices.

While IDUs were generally unable to find employment, family support continued. Although many IDUs spoke of family threats to evict them, over 90% in the discussion group still lived in a joint family setting. Law enforcement authorities did not actively pursue IDUs in the community, “because so many police are drug users themselves”, the team was told. Less than 1% of the men in the IDU discussion group had even been to jail once.

Vein damage, including collapse and abscess, appeared to be more common with the use of dextropropoxyphene than with buprenorphine. IDUs were unable to articulate any specific negative health consequences related to buprenorphine. Very few had even heard of hepatitis and less than 1% suffered from TB. Over the last year, about 10 IDUs among those reached by HELP have died, including four or five from AIDS and one overdose death.

### **Service provision**

Services for IDUs were severely limited. Hospitals and clinics were unwilling to treat IDU patients once they became aware of their drug use. On the few occasions they were treated well, referrals had been made by an NGO, such as HELP. IDUs preferred to self-medicate rather than to approach a health institution. No specific program existed to educate IDUs about the health consequences of injecting. Although there were numerous NGOs and INGOs working on HIV/AIDS prevention, not one had considered HIV prevention programming with IDUs. There appeared to be a general lack of awareness about the link between HIV and injecting drug use.

No drug treatment center existed in Biratnagar and many men seeking drug treatment

traveled to Pokhara or Kathmandu. The Zonal hospital had a psychiatric ward with a consultant psychiatrist but had not admitted any drug users for treatment.

Some IDUs had been involved in the National Center for AIDS and STD Control's (NCASC) Rapid Assessment conducted in 1998. As part of the assessment, blood samples were taken to test for HIV, syphilis and hepatitis B and C. Many never received their test results and others waited several months. No free HIV counseling and testing facility was in place. The Nepal Red Cross Society ran a blood bank that charged NRs. 500 per HIV test, as did the Zonal hospital. It was not clear if pre- and post-test counseling services were provided at either locale. TB testing was available at the zonal hospital, but a trained counselor was available only to TB patients.

The vocational training program conducted by HELP was well received by IDUs. Vocational training has been provided in subjects such as electrical wiring, bicycle repair and other skills.

### **Identified programming/service gaps**

One of the greatest service gaps identified by IDUs was the lack of drug treatment facilities. Many IDUs tried to detoxify themselves with limited success.

As a result of the NCASC assessment, IDUs were very keen to have rapid HIV testing facilities, although they demonstrated little understanding of risk behaviour in relation to testing procedures. Many wanted to test "to feel safe" without understanding the window period or other aspects of the HIV testing process.

Many IDUs appreciated the HELP vocational training program and wanted the system to help them start their own businesses. The techniques of outreach were little understood and no services were provided in locations where IDUs met, injected or lived. HELP trained 200 out of the estimated 5,000-7,000 IDUs in the Biratnagar area, but had no educational materials for IDUs.

### **Scaling-up**

The magnitude of drug injecting in the Biratnagar area justifies providing targeted educational interventions for IDUs in HIV/AIDS prevention. Given the lack of existing services, much preparation is needed in order to introduce new programs, including policy harmonization among appropriate agencies, training with regard to effective drug treatment modalities, and the improvement or development of important ancillary services, such as health services, vocational training, and small business development.

According to IDUs, the following services need to be put in place:

- Drug treatment facilities
- Scaling-up of vocational training opportunities
- Two to three fixed service sites near Jogbani and in Biratnagar to provide education, training and counseling.
- HIV testing facilities that would provide results quickly

Many IDUs felt that a needle exchange was not a high priority because needles were easily and cheaply available. Some persons felt that a needle exchange might jeopardize other services for IDUs as law enforcement authorities would take a negative view of such a service.

According to key stakeholder organization discussions, the following were needed:

- Drug treatment facilities, emphasizing relapse prevention.
- School-based drug use prevention education
- Training of peer educators among IDUs
- A means to coordinate information between the health and education sectors
- Skills training and employment opportunities

## **DHARAN**

### **Background**

Dharan is one of the major municipalities in Eastern Nepal with a population of about 68,000 people. Illicit drug use was widely considered a serious social problem. At the time of the assessment, there were 4,000 to 5,000 drug users, including about 3,000 who injected buprenorphine. Law enforcement officials estimated a lower number of IDUs based on their seizure data, which indicated only 20% of drugs confiscated were injectables. Anecdotal evidence pointed to a slight increase in the availability of 'brown sugar', although heroin had not been popular earlier. The cost for buprenorphine was NRs. 60 to 100. Other drugs used in Dharan, in combination with buprenorphine, were Avil (chlorpheniramine), Calmpose and nitrozapam.

### **Drug use patterns and risk behavior**

Dharan did not seem to be a transit point for drug trafficking. 'Brown sugar' was normally transited through Bhandabari and Kakarbhitta, while pharmaceuticals such as buprenorphine, were available through Jogbani. Few drug users or dealers traveled to Jogbani to purchase buprenorphine. Most of the drugs available in town were obtained for sale and consumption in Dharan itself. Chemists and medical facilities did not carry buprenorphine, with the exception of B P Memorial Hospital where it was obtainable by prescription. There were, however, two main fixed locations where dealers sold buprenorphine within Dharan town. Syringes were easily accessible and cost NRs.10 for Indian brands and NRs.15 for imported brands. The cost of syringes was the main barrier to access. Drug users ran the risk of police harassment while carrying injecting paraphernalia such as needles/syringes.

Buprenorphine was injected two to four times per day, with doses ranging from 1ml to 2 ml. Because buprenorphine was packaged in 2 ml ampoules, sharing was common. Among the drug users who accessed an NGO known as Punar Jiwan Kendra, 25% attempted to sterilize syringes with bleach before sharing and 75% used hot water. IDUs felt that it was not always easy to carry bleach as it is bulky and stains clothes. One IDU mentioned that it was not always practical as drug injection might take place "in the woods" and bleach was usually kept at home. NGOs mentioned that injecting

commonly took place on school grounds either after-hours or during the vacation period, and in isolated locations, such as bushes and jungles.

More extensive mobility was associated with sexual behavior. Many IDUs were said to travel outside of Dharan, such as Kakarbhitta and Jogbani, to engage in sex. Most indicated a decrease in sexual drive when taking buprenorphine. Once drug use was discontinued, sexual appetites increased. Condoms were also used to lubricate syringes. The plunger was rubbed against the condom lubricant and then the syringe was cleaned.

Health complications due to injecting were more prevalent when mixing different drugs and when the same syringes were used repeatedly. IDUs spoke of the generally negative treatment they received at institutions such as the BP Koirala Institute of Health Services (BPKIHS). One NGO referred IDUs to the psychiatric unit of BPKIHS. IDUs also mentioned two private doctors in Dharan with whom they felt comfortable. These doctors treated IDUs with respect and were willing to forego full payment of fees.

Local police harassed IDUs on a daily basis in Dharan. Instances of abuse and bribery were reportedly commonplace. Carrying needles/syringes constituted a risk for IDUs as they could be arrested or otherwise harassed for money if caught. Quite a few of the IDUs interviewed had been in prison. They spoke of drugs being planted on them, jewelry being taken from them, and bribing their way out of prison. While no services were provided in prison settings, IDUs were able to obtain drugs from guards and police.

### **Service provision**

In the field of HIV prevention for IDUs, Kirat Yakthung Chumlung (KYC) was the most active NGO in Dharan municipality. KYC ran a 15-bed drug rehabilitation center called Punar Jivan Kendra (PJK) and conducted outreach services to IDUs. PJK was the only drug treatment center in Dharan. Recently, the municipality had donated land for the construction of a larger rehabilitation center, to be constructed with funds from the British Gurkha Welfare Trust.

PJK had only two part-time outreach workers who provided bleach, condoms and primary health care to IDUs. No other NGO or GO provided outreach services. KYC had received funds in the past from SCF-US as well as UNDP/DDC/NCASC to run their harm reduction program. PJK also had informal links with the BPK Hospital Psychiatric Unit. Currently there were no vocational training programs for IDUs in Dharan.

BPK Hospital had numerous health services available that did not directly target IDUs, but could conceivably be accessed by IDUs in the future. BPK ran a monthly health awareness camp in Dharan that includes HIV and hepatitis education. BPK had recently initiated 7-8 DOTS sites for TB prevention and control. All drugs were provided free, with only a nominal registration fee. BPK charged NRs. 275 for an HIV test consisting of two different ELISA tests and results were provided the same day. The Nepal Red Cross Society provided HIV testing, but few persons accessed this service. The district

hospital in Inaruwa, Sunsari district headquarters, had a new counseling unit manned by one trained counselor. DDC/UNDP and NRCS supported this program.

### **Identified programming/service gaps**

The most significant gap identified by IDUs was the lack of access to clean, new needles/syringes. Many IDUs felt that while bleach was helpful, the greater need was for clean needles/syringes through a needle exchange program. IDUs felt that if organizations such as PJK provided a needle exchange program, the police would be less likely to harass them. Key stakeholder organizations also felt that a needle exchange was worth considering seriously, especially as part of a holistic program. The feeling was that legal and practical issues (needle/syringe disposal) would need to be thoroughly discussed before implementation.

Drug treatment facilities were inadequate to fulfill demand; only one organization ran such a facility. Some IDUs were also interested in drug substitution programs that would allow them to substitute opioids, with decreasing doses over time, leading to total abstinence.

The general community, as well as families of IDUs, lacked information on drug use issues. IDUs felt they were regarded with distrust even when not using drugs and that stigma was a barrier to behavior modification. Key stakeholder organizations also perceived this gap and were interested in counseling and advocacy programs for families of drug users as well as community members.

The level of programming in Dharan did not respond to the needs of IDUs. KYC/PJK's outreach program only reached about 5-10% of IDUs in Dharan. Despite having trained personnel, KYC was not able to maintain an adequate program due to lack of funds. Only 25 peer educators had been trained and there were no plans to expand or to upgrade the knowledge of these peer educators.

### **Scaling-up**

Dharan's experience with IDUs was unique in the eastern region. The KYC worked in collaboration with 25 organizations, including other NGOs and key government agencies. The main need in Dharan, as of the time of this assessment, was to scale-up activities for greater coverage. The presence of a large reputable hospital such as BPK allows opportunities for linkages. Potential collaboration with BPK could involve easier access to health services to IDUs and the incorporation of IDU/HIV prevention initiatives into on-going health programs.

The current drug treatment program offered a restricted treatment regime, as knowledge was limited of alternatives, e.g. therapeutic communities, half-way houses, drug substitution programs, and self-help support groups for IDUs, other drug users and individuals/families affected by drug use. Training on various topics, covering addiction, behavior modification, and support through recovery and sustaining a drug-free lifestyle are needed.

While all agreed that family and community advocacy for better understanding of drug

dependence issues is needed, IDUs themselves felt a pressing need for police advocacy. The level of reported corruption among the police must be addressed, because it is a barrier to HIV prevention. The key stakeholder organizations did not perceive IDU-police relations in the same way. Some even felt that law enforcement activities needed to be intensified. One concern of the local law enforcement agency was a recent change in the law, shifting responsibility for the control of pharmaceuticals, such as buprenorphine, to the Department of Drug Administration. Doubts were expressed regarding the likelihood of success in controlling the supply of these substances. There is clearly a great need to harmonize policies before scaling-up improved HIV prevention services for IDUs.

According to the IDUs, the following services need to be put in place:

- More options for drug treatment.
- More education on drugs for IDUs, families and the community.
- Increased peer education outreach
- Provision of needles and syringes
- Increased scope and coverage of current harm reduction activities.

According to the key stakeholders, the following services need to be put in place:

- School-based education
- Increased drug treatment options.
- A review of all effective drug treatment modalities and a trial of a model for Dharan.

## **DAMAK**

### **Background**

Damak is a town of 50,000 located on the main East-West Highway. According to IDUs, about 500 drug users lived in the Damak municipality. About 40% of these were current injectors and only a few were female. Damak was firmly a 'brown sugar' town, in that all IDUs favored brown or low-grade heroin as their drug of choice. Nitrosun (nitrozapam) was the only other drug used on a regular basis.

'Brown sugar' was obtained from Panitanki and then sold at twice the price in Damak. The Damak street price was NRs. 600 per gram, rising to NRs. 1000 at times of shortage. 'Brown sugar' was usually injected 3 times a day. As 'brown sugar' does not dissolve without the addition of heat and citric acid, risks of infection are enhanced by the extensive cooking and handling required

### **Drug use patterns and risk behavior:**

Although syringes were available at NRs.5 per piece, many IDUs shared and attempted to clean with saliva or water. Most injected in small groups or individually in hidden settings, e.g. homes, jungles, or public toilets.

Very few overdose-related deaths were reported, perhaps because several IDUs usually injected together. Allergic reactions and 'cotton fever' were reported to occur

immediately following injection, and were attributed to unclean water or impure drugs. IDUs indicated infections could result from missing veins when injecting while suffering withdrawal symptoms.

Sexual behavior of IDUs in Damak was reported as low due to the use of heroin. All agreed that if a person had money, there would be no problem engaging in commercial sex. Condom use was very low. Many said that if infected with a STD they would go to a private doctor rather than or to the government doctor.

### **Service provision**

Limited services were available to IDUs in Damak. One NGO, Punarjivan Sarokar Kendra, had conducted a five-month harm reduction program in 1999-2000. This program provided two part-time outreach workers, condoms, vocational skills training, and peer education as well as a drop-in center. However, this program was discontinued due to lack of funds.

Since December 2000, Dhruva Tara Sporting Club had opened a 25-30 bed in-patient drug treatment facility in Damak ward 13, apparently without trained staff. With support from the police and community, drug users were rounded up and forced into treatment. A doctor visited the center once a week to treat the clients.

Damak falls within the working area of the Association of Medical Doctors of Asia (AMDA)-Hospital, which was implementing a behavior change intervention with female sex workers (FSWs) and truck drivers.

### **Identified programming/service gaps**

IDUs felt that having more extensive and less coercive drug treatment facilities represented their greatest need. They also wanted some kind of counseling program for their families.

Key stakeholders pointed out that many began using drugs after failing their School Leaving Certificate exams and that tuition to help them pass these exams as well as vocational training programs would be valuable. A need to develop marketing skills was mentioned as well.

School-based prevention programs were also identified as a need. Many persons expressed concern about teachers' unwillingness to discuss sex, drugs and HIV with students. As a result, students were left to read the related school text chapters alone, rather than participate in a facilitated discussion.

### **Scaling-up**

Damak was very focused on drug use prevention. Despite having had a short-term harm reduction program, the focus had become one in which drug users were to be put into treatment even if by force. This seems to have galvanized the community into thinking that the current treatment program was the only option for drug use and HIV prevention. Following the stakeholder meeting, it was recognized that HIV-focused

programming for drug users could have a positive impact. One organization, Punajivan Sarokar Kendra, seemed willing to move forward on this initiative. The capacity of this organization as well as other organizations will need to be developed intensively. Any comprehensive programming for IDUs must be done at the ward level. Well-conducted advocacy might help to overcome the negative attitudes of community members and begin discussions about effective methods of reducing drug use and its harms.

According to IDUs, the following services need to be put in place:

- More drug treatment facilities
- More comprehensive counseling/outreach to community and family (on drug prevention)

According to the key stakeholder organizations, the following services need to be put in place:

- Introduction of needle exchange and other harm reduction measures
- Increased number of trained personnel
- Improved school-based education on drugs and HIV issues
- Comprehensive training/outreach to community members
- Coordinated planning and implementing activities by the municipality

## **KAKARBHITTA**

### **Background**

Kakarbhitia is a town of approximately 30,000 located on the border with India. At the time of this assessment, it was a thriving commercial center and a transit area for illicit drugs. The estimated number of drug users in the Kakarbhitia area, actually in the area between Birtamod and Kakarbhitia, was 200. Kakarbhitia itself did not have many drug users. However, many drug users and dealers transited through Kakarbhitia on a daily basis. The assessment team was informed that about 150-200 drug users passed through Kakarbhitia every day on the way to Panitanki in India where heroin could be purchased.

Drug use patterns were fluid. While about 50% of drug users switched between injecting and 'pulling' [inhaling fumes], a small number solely injected. Only very few women drug users were known. However, female drug users from as far away as Siliguri, Darjeeling and Damak frequently traveled to Panitanki to purchase and consume drugs.

As in Damak, the primary drug of choice for injectors and non-injectors was low-grade heroin ('brown sugar'). 'Brown sugar' was defined as "number 3 quality" and said to be often impure and mixed with other substances such as nitrozapam and dextropropoxyphene. 'Brown sugar' was obtained very easily in Panitanki at shops whose sole purpose was to sell drugs, i.e. no façade of another business. Dealers also had on-site facilities for injecting. These dealers lived in normal houses and the main areas of town. 'Brown sugar' was available in two forms, as 'dust' or in pieces. One gram of 'brown sugar' cost NRs. 200. A few medicine shops in Panitanki supplied

Phensedyl, some of which was fake, according to the IDUs. Buprenorphine, when available, was priced high at NRs. 48 (compared to NRs. 25 in Jogbani).

### **Drug use patterns and risk behavior**

Syringes were cheaply and easily available at a cost of NRs 5. However, sharing was extremely common and nothing was done to sterilize the equipment between users. IDUs simply flushed the syringe with available water. Injecting took place three to four times a day, due to the poor quality of heroin. A vitamin C tablet was ground up with 'brown sugar' and cooked on a spoon before being filtered through a cigarette tip filter, and then injected. Lemon juice was often substituted for vitamin C. When 'brown sugar' was not available, the common replacement drugs were dextropropoxyphene and buprenorphine.

The health consequences of injecting were serious for IDUs in Kakarbhitta. Overdoses and allergic reactions were reported. IDUs commonly believed that the risk of death from overdose was much greater when injecting alone. Two IDUs related a recent incident when they saved a friend from dying following an overdose. Risk of overdose was considered much greater if a drug user took tablets or drank alcohol prior to injecting 'brown sugar'. Vein damage or collapse led to injecting in the groin area. Many IDUs were unable to afford formal health care, and instead, treated themselves or did not seek any treatment. A lucky few had families who paid their medical bills.

Community attitudes towards drug users were very negative. The police made full use of their powers by periodically confronting drug users. In such situations, drug users with money were usually released, while others were jailed for a few days. In jail, no services were provided and drugs were not available. A few drug users said that police commonly rounded up drug users when free labor was required for construction.

The men did not discuss sexual risk behaviors other than to state that opioid users had low sex drive. No mention was made of condoms and no STDs were reported.

### **Service provision**

IDUs were unanimous in saying that there were no services available to them in Kakarbhitta. In lieu of drug treatment, IDUs were put in jail. No organization provided services or advocated on their behalf. Kakarbhitta did not have many social service organizations.

Despite limited organizational capacity for programming some very small steps have been taken by one organization. The Knight Chess Club, focusing on youth, has conducted a community awareness session on HIV/AIDS and drug use, with technical assistance from AMDA. The Knight Chess Club would need additional training at all levels before making a commitment to provide further assistance to the IDU community.

### **Identified programming/service gaps**

The lack of a drug treatment facility was the greatest service gap identified. An ideal treatment facility would provide medication, recreational activities, nutritionally balanced

food, and vocational training. The general consensus was that if a good facility were in place, IDUs would voluntarily undertake treatment.

### **Scaling-up**

The police and other community organizations are in need of greater understanding of how to handle the small number of IDUs in their midst. The IDUs themselves are not well informed about the risks of HIV and other health consequences of injecting. Investment in extensive drug treatment facilities at this site does not seem plausible, but considerable improvement could be brought about through education and advocacy.

## **NEPALGUNJ**

### **Background**

Nepalgunj is a city of approximately 100,000 located near the border with India. Estimates of the number of drug users varied greatly. Drug users stated there were 300-350 including about 100-150 IDUs, whereas key stakeholder organizations reported about 2500 drug users, with about a third of those injecting. Only a few female drug users were known. The men said that previously there were more female drug users, but many have migrated to Kathmandu and Pokhara. There is clearly a need for better assessment of the extent of the drug-using population in Nepalgunj.

The Nepalgunj Medical College sampled 441 people from the general population and 9 were HIV positive (2%), 29 had hepatitis B and 7 were VDRL positive. According to the Nepal Red Cross Blood Bank, 3000 sera-samples were collected and tested during the period of April 2000-January 2001, of which 7 were HIV infected (0.25%), 28 had hepatitis B and 2 were positive for VDRL.

The primary drug of choice for injectors was buprenorphine while non-injectors preferred to inhale the fumes of 'brown sugar'. Buprenorphine was usually injected in a cocktail with diazepam, available for IRs.1 for a 2 ml ampoule. IDUs reported that buprenorphine by itself was rarely injected. A non-injectable alternative to buprenorphine is Corex (codeine-based cough syrup). While not a preferred substitute, it does ease withdrawal symptoms. Dextropropoxyphene is another drug that helps alleviate withdrawal.

, tablets, and 'brown sugar' were easily available in Rupedhiya (India), only 5 km from Nepalgunj, but IDUs traveled as far as Nanpara and Babagunj (a further 6-14 km into India) to purchase buprenorphine at a lower price. The cost of buprenorphine was as low as IRs. 20 (NRs.32). In Nepalgunj, the cost went up to NRs. 60-100. Another source of 'brown sugar' was Tikara in Barabankhi district of Uttar Pradesh. All agreed that this district had many fields of opium that were processed into heroin. Barabankhi district is one of the areas in India where opium is legally grown. 'Brown sugar' costs IRs. 600 per gram.

Nepalgunj has the unique history of many IDUs having been initiated into injecting by a

single individual. IDUs reported that Dr. Dixit in Rupedhiya started by offering buprenorphine injections for NRs. 5 to 10 about 5 years ago. Once he saw the profit to be made, he started selling buprenorphine. Community and police action eventually stopped Dr. Dixit from offering injections; he now only sells tablets.

### **Drug use patterns and risk behavior**

Syringes were easily available on both sides of the border. For example, 2 ml and 3 ml syringes were available for NRs.5 each, while 1ml and 5 ml syringes cost NRs. 8. Needles alone were also available in India for IRs. 1 (NRs 1.60). These were re-sold in Nepal for NRs. 5. Drug users said 26 gauge needles (insulin size) were best for those with exhausted veins. In general, there were few reported cases of injection at groin and neck sites.

Buprenorphine was invariably mixed with diazepam before injection, with diazepam serving to clean the syringe. IDUs believed that any water left in the syringe could cause infections, so syringes were commonly flushed with diazepam to kill germs. Other common cleaning agents were saliva, water and urine. Sharing was common, especially when short of money. IDUs required a minimum of two injections per day, but some reported they would inject as much as they could afford.

Few men would discuss sexual behaviors, condoms or STDs. Little was known about STDs among IDUs in this area. No overdose deaths were reported and known health consequences among drug users were restricted to abscesses. Access to medical care was not a particular issue.

Community attitudes towards drug users were very negative. The social consequences of drug use prohibition were severe, involving police harassment, bribery, arrest and imprisonment. IDUs alleged that police threatened imprisonment unless they cooperated in setting up friends for arrest.

The law was very strict on heroin users and dealers. Both IDUs and key stakeholder organizations said that the minimum punishment for heroin was five years, whereas they believed the law was ambiguous on use and dealing of pharmaceuticals. Once in prison, drugs were not accessible even by bribery, although relatives were known to slip in drugs with gifts of food.

### **Service provision**

IDUs were unanimous in saying no organization provided services or advocated on their behalf and many were jailed. The assessment team noted that Nepalgunj does have many social service organizations working in HIV/AIDS issues related to trafficking in women and migrant populations. Also, Nepalgunj serves as the far western base for a number of INGOs as well. These organizations stated that IDU programming was new to them.

In the past, there was a drug treatment facility that charged NRs.6000 per month; it closed after a year. Drug users also tried to gather together funds for a treatment center

but were unable to mobilize community members around this issue. N'SARC ran a small, one month program in prison with the assistance of NCASC. This program featured acupuncture and use of minor tranquilizers. The rounding up of drug users by the police four years ago was the last major activity related to drug use. This was a specific activity instituted by the DSP and it was seen as a success by the key stakeholder organizations.

The NRCS/Banke has just begun implementation of ward level HIV awareness activities in five Village Development Committee areas. NRCS carried out HIV prevention programs in schools. N'SARC worked with migrant workers using peer educators. There was a single media training by a Kathmandu-based NGO. The Family Planning Association of Nepal and SAFE also provided counseling as a service. SAFE worked with migrant workers and female sex workers. The main issue with all these organizations, other than N'SARC, was that they had no experience working with drug users.

### **Identified programming/service gaps**

There are organizations in Nepalgunj that are already implementing HIV/AIDS programming, but none with experience in IDU issues.

### **Scaling-up**

Despite organizational capacity in HIV programming, little has been done to reach out to IDUs in Nepalgunj. Drug users had no concept of treatment options and very little knowledge of needed services. They unanimously said that they had heard about HIV/AIDS and STDs, but did not know any prevention measures or details of consequences or risks. The demonstrated capacity of the Nepal Red Cross, SAFE and N'SARC needs to be expanded to incorporate the IDU population as a target group. Given the level of the police activity towards drug users, advocacy activities for police, possibly incorporated directly in police training at their camp in Nepalgunj, would be useful.

According to the IDUs, the following services need to be put in place:

- Drug treatment, including substitution
- Education

According to the key stakeholder organizations, the following services need to be put in place:

- Anti-Drug program
- Community-based education for parents and schools.
- Education for drug users
- Drug treatment
- Media awareness

## **HETAUDA**

## **Background**

Hetauda is a town of approximately 150,000 located in Makwanpur district. It is a prime commercial site along the East-West Highway. According to IDUs, there are approximately 1,300-1,500 drug users in the Hetauda area. Key stakeholder organizations felt that the number of drug users is over-estimated that the real figure is closer to 1,000. However, there was general agreement that there were only about 100-150 IDUs. They were divided into those who publicly used drugs and those who injected in the relative safety of their homes. IDUs could not easily identify female drug users within their social network. Ashraya and Asmita NGOs mentioned that they were in contact with two female IDUs and estimated that percentage of female IDUs is below 5% among the 100-150 IDUs.

Buprenorphine was the main drug in use. Historically, brown sugar was the drug of choice until seven years ago. At one point, someone introduced buprenorphine into the Hetauda drug users' circle. This drug user was advised to change from Fortwin, unavailable at that time, to buprenorphine about 10 years by a medical hall 'doctor'. This IDU continued injecting buprenorphine on his own for two years or so before advising his friends who used 'brown sugar' to try it when they were suffering withdrawal symptoms. As the price of 'brown sugar' kept going up, the popularity of buprenorphine grew and it became well established as the preferred drug for IDUs.

Buprenorphine was usually injected in a cocktail with chlorpheniramine, available for NRs.3-4 per 2 ml ampoule. This practice was relatively new and started only about 4 months before the assessment took place. 'Brown sugar', of poor quality, was still available but quite expensive at NRs. 300-400 per gram.

The price of buprenorphine was NRs. 40 in Hetauda and IRs.20 (NRs. 32) in Raxaul, India. Raxaul was the main location for purchasing and/or using drugs. IDUs reported that most of the drug users to be found in Raxaul were Nepali, although there were many Indian drug users as well. Drug users from surrounding areas such as Narayanghat, Tandi, Parsa (all in Chitwan district) and even Kathmandu purchased drugs in Hetauda because they were too frightened to cross the border into Raxaul. Buprenorphine and nitrozepam were the most common drugs purchased. Nitrozepam was the favorite among the visiting buyers. Buprenorphine was only available in Raxaul. In Hetauda and Raxaul, Phensedyl was available on the black market. IDUs were very aware of the fake Phensedyl in the market.

## **Drug use patterns and risk behavior**

Syringes were available on both sides of the border. A 1ml syringe cost NRs. 10 and a 2ml cost NRs.5. Until recently, access had not been an issue, but needles/syringes were becoming more difficult to buy at pharmacies. Often, drug users purchased needles/syringes from the same pharmacy and, over time, such a pharmacy ran the risk of being seen as a drug-dealing medicine shop by the community, thus affecting their business adversely. Direct observation of IDUs also revealed that they collected discarded needles/syringes from hospital and pharmacy sites and used these for

injecting. New needles/syringes in unopened packages could be re-sold. Needles/syringes were often used 6-8 times before the needle became too dull for use.

Sharing was quite common. The Duncan Hospital/ACT project and Ashraya considered that some IDUs had made an effort to reduce sharing since their educational efforts were carried out. A safe injecting center where IDUs could inject and store their needles/syringes for later re-use was also mentioned. Some IDUs said that they approached health care providers and ask for spirit (70% isopropyl alcohol) to clean their syringes. They pretended to have minor cuts and abrasions and took the spirit in a bottle cap.

IDUs injected about 3 times a day on average. It was common practice for two IDUs to split a 2ml ampoule of buprenorphine. Two overdose deaths were reported, as well as abscesses. Common ways of disposing of the bodies of those who died of overdose in Raxaul was to throw them into the river or to put the body on the train tracks.

Gaining access to medical care was becoming increasingly difficult. A few years ago, the link between drug use and HIV was not well known and IDUs were able to access health care without much difficulty. However, the 1998-99 rapid assessment conducted by NCASC as well as other publicity drew attention to IDUs. Increasingly, health care providers were demanding HIV test results before undertaking health care for IDUs. This applied to the simplest medical treatment, such as dressing wounds.

IDUs were sexually active, although daily drug use reduced their sex drive. They reported using condoms although their knowledge of STDs was very limited.

Community attitudes towards drug users were negative. However, some families gave money to their sons to purchase drugs because they did not want them to steal and do other bad things to get money for drugs. The law was very strict on heroin users and dealers. IDUs reported that if police found drugs on them, they had to pay a bribe to avoid being imprisoned or having their ampoule smashed. Recently, two or three IDUs died in jail, allegedly due to withdrawal, so police officials were very leery about having IDUs in jail. While in prison, it was common to have access to alcohol and other drugs – “money is the only barrier”.

### **Service provision**

A few NGOs were attempting to provide services to IDUs. Their responses to these efforts were mixed. IDUs unanimously accused Ashraya of taking a lot of money from donors but not spending on programming. They reported that Ashraya held meetings for IDUs where they were fed and had discussions on what programs are needed, but then no real programming followed. Some IDUs did mention that they had been informed about HIV/AIDS by Ashraya. Despite such bad feelings on the part of IDUs, it was clear to the assessment team that Ashraya had made attempts at reaching IDUs. They had run a drop-in center and counseling services. Part of the problem between IDUs and Ashraya seems to have been that the IDUs perceived Ashraya exposed them to the community without having sustainable programs in place.

General Welfare Pratisthan (GWP) had recently begun IDU programming on a pilot basis. As they had no funds, these initiatives were quite informal. One key service provided by GWP was primary health care to IDUs. More recently, an ex-drug user who works at Duncan Hospital in Raxaul had begun giving out needle/syringes to IDUs, four times in the past two weeks. It was not clear if this was part of a specific program or just the activities of an individual. IDUs were advised by this ex-user to burn their used needles/syringes. The DALO was also mentioned as someone who has assisted IDUs, usually with money for health care. There were no drug treatment facilities available in Hetauda.

### **Identified programming/service gaps**

The lack of a drug treatment facility was seen as the greatest gap in services. The second biggest gap, mentioned by IDUs, was the lack of community/family support. Both IDUs and key stakeholder organizations felt that the gaps left by unsustainable programming, e.g. a drop-in center that is now closed and inconsistently available counseling, adversely affected the establishment of rapport and trust with IDUs.

Many IDUs stated that, prior to the recent Rapid Assessment and Response (RAR) undertaken by the NCASC and to the activities of Ashraya, they had no difficulties accessing medical services from hospitals and other facilities. However, when the RAR and Ashraya activities were undertaken this indelibly linked drug use with HIV infection and access to services decreased, while stigmatization and discrimination increased. Also many of the IDUs did not receive the promised serology results and were unsure of their status.

### **Scaling-up**

Hetauda is ready to implement HIV prevention programs among drug users. It will be essential not to lose the momentum of GWP and Ashraya efforts. GWP in particular has a good understanding of HIV prevention programming with marginalized populations. Their activities can be easily scaled-up to include IDUs once they have received proper training. The existing links between GWP and Bhoruka AIDS Project in Raxaul should be an integral part of this program.

According to the IDUs, the following services need to be put in place:

- Drug treatment
- Narcotics Anonymous meetings
- Camp/hostel for those in recovery
- Primary health care
- Harm reduction services
- Community advocacy and awareness
- Counseling/education
- Outreach – for those who do are not prepared to go into treatment.

According to the key stakeholder organizations, the following services need to be put in place:

- Community-based education
- Integrated awareness package on HIV/drug use
- Drop in center/s
- Training of health workers
- Peer education
- Outreach program
- Income generating activities for PLWHA
- Drug treatment

## **BIRGUNJ**

### **Background**

Birgunj is a town of approximately 100,000 located in Parsa district. According to IDUs, there were approximately 800 drug users in the Birgunj area, 700 of whom were IDUs. Key stakeholder organizations considered the number of drug users under-estimated and that the real figure was closer to 2,000 with 300-500 IDUs. As in Hetauda, IDUs were divided into those who openly used drugs and those who injected in the relative safety of their homes. Also, as in Hetauda, IDUs could not easily identify female drug users within their social network. The general understanding is that there are very few, if any, female IDUs.

'Brown sugar' was the primary drug of choice for injectors. Historically, buprenorphine had been the drug of choice until 18 months previously. Buprenorphine had been around for 12 years and displaced 'brown sugar' at that time. IDUs reported that in the past 18 months 'brown sugar' had flooded Birgunj. This meant that they did not have to risk going across the border for buprenorphine. At the time of this assessment, 'brown sugar' was the only drug not available in Raxaul. The switch back to 'brown sugar' occurred also because police control was very slack, according to the IDUs.

'Brown sugar' was available at NRs. 300 per gram. Of poor quality, it was said to be mixed with mud and hair dye. In comparison to buprenorphine at a cost of NRs.38, the price for 'brown sugar' was high. Other than for 'brown sugar', Raxaul remained the main location for purchase and use of drugs. The prices varied and IDUs stated that medical halls examined the person before quoting a price. Drugs available in Raxaul were Fortwin (NRs. 13), Phensedyl (NRs. 57), Corex (NRs. 55), Phenergan (NRs. 6) and Avil (NRs. 6).

### **Drug use patterns and risk behavior**

Syringes were available on both sides of the border. There was also a needle exchange programme that operated for half a day on Tuesdays and Saturdays. This exchange was limited to five needles/syringes and five additional 26-gauge needles. Needles and syringes could be exchanged in Raxaul every day of the week. Despite the needle exchange program, IDUs reported collecting discarded needles/syringes from the hospital dumps and using these to inject.

'Brown sugar' was usually injected two to three times a day. The process of preparing the drug for injection is pretty standardized – water, vitamin C tablet, cigarette tip filter and using a match/lighter to heat the drug solution. If buprenorphine was used, cocktails made of buprenorphine, chlorpheniramine and promethazine hydrochloride were common. This cocktail usually 'dried out the veins' and led to vein damage more rapidly. Increasingly, IDUs were obliged to use veins in the neck area or even under the tongue.

IDUs reported they used to share more often when there was no needle exchange program. If IDUs had to share, they tried to clean with saliva and water. Some IDUs reported using cloth and/or paper to wipe off the needle before sharing.

Five deaths were reported in the last month due to 'malnutrition' and overdose. On being asked how IDUs prevented overdose deaths, it was clear that they were well aware of the indications of overdose but most were not sure how to avert overdose deaths. Many IDUs reported passing out following injection but then they woke up on their own. No specific mention was made about health consequences such as abscesses. It was noticed that quite a number of IDUs were suffering from common medical ailments. Primary health care is available but as some IDUs reported, it is not uncommon for them to sell prescribed medication for illicit drug money.

IDUs were sexually active, although daily drug use reduced sex drive. Condoms were distributed through the needle exchange and IDUs were aware of STDs and contraception. Some even reported using condoms with FSWs. No details about actual sexual activity were provided.

Community attitudes towards drug users were negative. Many IDUs reported having been incarcerated at some stage. Drugs were easily available in prison for a higher price than outside. Key stakeholder organizations reported some medical services were provided in prison, but this could not be verified with IDUs. The prison in Birgunj was large with a capacity of 300-400. Interactions between IDUs and police involved bribery and the usual harassment. Key stakeholder organizations were of the opinion that enforcement of drug laws was difficult due to budgetary constraints, rather than lack of knowledge on the part of the police force.

### **Service provision**

Birgunj had a number of good services reaching out to IDUs. There were other social service organizations involved in HIV/AIDS education too. The most beneficial services had been provided by the Emmanuel Hospital Association's Duncan Hospital through the AIDS Control & Treatment Project (ACT project). The Duncan Hospital is based in Raxaul and provides services to IDUs in Raxaul and Birgunj. Duncan offered drug treatment for two IDUs per month at a treatment center located in Delhi, India. No drug treatment centers existed in Birgunj or Raxaul. The ACT Project was working as part of a coalition providing harm reduction services in Birgunj. Coalition members included the Birgunj Municipality, Bijam, CHES, Bhoruka AIDS project and General Welfare Pratisthan. Together, the coalition operated a drop-in center near the new bus park. This center offered counseling, information on safer injecting practices, and medical

services. Needle exchange was also provided two days a week from this site. There were no outreach services for IDUs. The ACT project also had home-based care for persons with AIDS. To date there were 88 clients of whom 25 already died. Services offered were medications and nursing care. Future plans included a 6-bed hospice, at Duncan Hospital, that would admit Nepali drug users. There were 8 full-time staff and some of the workers provided services in Nepal four days per week and in Raxaul two days per week. Other initiatives include TOT training of staff nurses and community health workers.

Since 1999, the municipality established a youth development program focusing on literacy, health and environmental programs. The budget for this was NRs. 300,000. The Peace Corps, Bijam and CHES Nepal worked together on a 3-year HIV/AIDS awareness and advocacy program that reaches completion in 2002. These initiatives provided training to students, drug users and hotel staff, including FSWs, as part of the municipality program.

GWP provided HIV prevention services with FSWs and their clients and is involved in the coalition's drop in center. The Birgunj Jaycees had HIV counseling and education at the Ward level for women and provided awareness and girl trafficking orientation in schools. The NRCS sponsored the Junior Circle with initiatives on HIV but thus far had not included drug prevention activities.

### **Scaling-up**

Existing linkages and coalitions should be strengthened as much as possible. The municipality has demonstrated its willingness to work on HIV/drug issues and this kind of government commitment should be encouraged and supported.

## **POKHARA**

### **Background**

Pokhara is a town of at least 120,000 (1991 Census Bureau – 119,774) located in Kaski district. According to male IDUs, approximately 15,000 drug users are present in the Pokhara area. Female drug users were much more conservative, estimating a range of 5,000 to 10,000 drug users. Key stakeholder organizations also estimated the number of drug users to be between 5,000 and 10,000 with 60 to 70% injectors. Six months ago the Drug Abuse Control Center conducted a survey, through New Era with UNICEF funding, that estimated number of drug users at 5,545. Approximately 5 to 7% of the IDUs were said to be female and of all the non-injectors 40% were females.

According to female drug users, who were also FSWs, about a third of all FSWs were involved in drug use. Pokhara had about 5,000 FSWs of whom 40% were migrant workers from Nepalgunj, Bhairawa and Kathmandu. Male drug users made clear at the beginning of the meeting that they represented only one area in which drug users congregate, thus they could not be considered representative of all drug user networks in Pokhara. They estimated that about one third of all users, i.e. 5000 persons, injected

buprenorphine, 'brown sugar', Avil, Phenergan and diazepam. Buprenorphine was introduced to Pokhara 12 to 13 years ago at which time heroin and Fortwin were the primary injecting drugs. At the time of this assessment, buprenorphine was the preferred drug and was available in Pokhara, though brought in from elsewhere. The average price for buprenorphine was NRs. 60 – 120 per ampoule, up to NRs.300 when supplies were scarce. Some female drug users said it cost NRs. 100 to 150 per ampoule and still other female IDUs reported paying between NRs 50 to NRs 300 per dose. The team observed that the female drug users were paying the males more money than was needed for the purchase of the drug. Female drug users indicated that they did not purchase drugs such as buprenorphine directly from dealers, but from their male friends.

Heroin ('brown sugar') was purchased at the border in Sunauli, Birgunj for NRs. 500 per gram and sold in Pokhara for NRs. 1,000 per packet after being cut, by the dealer, with ash from mosquito coils and incense, and then re-packaged. Female drug users said that most heroin was sold to western tourists for large sums of money. However, there were only two or three female drug users who had heard of 'brown sugar'. Similarly, many of the female drug users did not seem to know the names of the drugs that they were ingesting as they all relied on their male friends or partners to purchase the drugs for them. Tablets such as Nitrosun were not well known. They just referred to all tablets generically as 'tabs', without any distinction.

Nitrosun was available but very expensive and could only be purchased in strips of 10 for NRs. 150 to 200. Phenergan was NRs. 6 but many chemists requested NRs.10 if they suspected the buyer to be a drug user. Spasmo Proxyvon and Fortwin were also available but used to a lesser extent. Female drug users indicated that, if they could not get buprenorphine or other drugs, they would smoke ganja (cannabis) or drink alcohol, rather than go to the medical halls themselves to purchase drugs. The women stated that they exchanged sex for drugs on occasion, but preferred to pay for drugs. Of the non-injectable drugs available in Pokhara, Phensedyl, diazepam and ganja were taken. The women indicated that Phensedyl, Corex and Nitrosun were difficult to obtain.

### **Drug use patterns and risk behavior**

According to the men, many IDUs injected in public and restaurant toilets, along the lakeside, in their own houses or in the jungle. Female drug users reported that male IDUs tended to be more open about their drug use, while they prefer to use drugs in more secluded settings. About half of male IDUs preferred to inject only buprenorphine, while the other half prepared cocktails. Various body sites were used for injecting, starting from the arm and legs then moving to the hands/fingers and feet/toes, and finally the neck. None indicated that injecting in the groin was common practice but the female drug users said that they have seen men do this. Women IDUs injected in the same locations, although feet seemed to be more popular with women than men.

Many injectors purchased 2.5 ml and 1 ml syringes together and placed the 26-gauge needle on the 2.5 ml syringe. Medical halls usually sell 2.5 and 1 ml syringes for NRs. 5 and NRs. 7, respectively, but if the person is suspected of being an IDU then the price

increased to NRs. 7 to 9 or NRs. 10 to 12. Some IDUs were known to use 5 and 10 ml syringes when injecting large quantities of buprenorphine. The women stated they purchased syringes through their male partners/friends and paid NRs. 6 to 10 per syringe. Male drug users stated that a syringe on average was used three times before replacing. Others in the group said that 50% of the drug users they knew used one new syringe per injection. The only time that sharing occurred was when there was only one syringe available for a group of injectors. This expression of safety was in stark contrast to female IDUs, as they did not have any concept of harm associated with the sharing of injecting equipment.

According to the female IDUs, it did not matter who injected first and mainly depended on who had the drugs and syringe. There was no indication of any attempt to clean or sterilize the syringe before passing it on. Male IDUs stated that sharing had been common in the past, but since the implementation of the International Nepal Fellowship (INF) harm reduction program and the exchange of syringes, the frequency of sharing had decreased. They also indicated that syringes were cleaned with saliva, urine, dew and water. Many IDUs injected one to three times per day and, if money was plentiful, may inject as much as two to three ampoules at one time.

Male IDUs stated that abscesses were more common when injecting cocktails. In the last year there had been 5 to 6 overdose-related deaths. Many IDUs did not know what measures to take when a person overdosed and ran away for fear that the police would accuse them of killing the person. However in this group of male drug users, some knew of CPR and a few reported methods such as continuously slapping the affected person. Many in this group knew about hepatitis B, C, TB and HIV from INF. They indicated that voluntary testing, with pre- and post-test counseling was available at INF. TB was generally known among male drug users and treatment was available through the DOTS program in Pokhara.

One of the benefits the women drug users enjoyed was that the police mainly focused their attention on the male drug users. The male drug users stated that the police consistently harassed any drug user by stopping them on the street and taking money or other items of value. If a person was sent to prison, he could obtain drugs in prison from police or friends at any time as long as he had money. If arrested for possession of heroin, he might receive 5 to 15 years in prison. The minimum sentence used to be 90 days but this had been reduced to 24 days, according to the male drug users. Some men indicated they were picked up by the police at night and while incarcerated, forced to provide free labor on construction projects. Once released, many drug users and families were required to 'donate' money for such items as petrol for police cars or construction projects. Women drug users said that in some cases they were required to perform sexual favors while in prison, but this was not a common occurrence.

Male drug users reported that the medical services at the clinics were satisfactory despite some stigmatization. Women drug users said that they relied on SEDA for all their health needs. In general community attitudes towards drug users were negative.

### **Service provision**

During the group discussion with female drug users, all requested that a drug treatment center be opened for females. Condoms were not an issue, as SEDA provided a sufficient amount of condoms. This group also felt that outreach, health and other services currently being provided by SEDA should to be continued.

Until recently male drug users were the sole beneficiaries of the services provided in Pokhara. International Nepal Fellowship (INF) had been the main service provider for drug users. INF had a drug rehabilitation and AIDS program (DRAP). Until 2001 this was a joint program but now it ran two separate programs. Programs under DRAP included outreach, treatment counseling, a therapeutic community, AIDS care, training and awareness, harm reduction activities, research and evaluation activities. Since the split and recent financial problems INF, was no longer able to maintain core services for IDUs.

As a result INF was planning a limited program for IDUs consisting of a 10 to 12 bed rehabilitation center and drop-in center. The drop-in center was not designed for IDUs alone but would include drug users as well as the general community. The assessment team was informed that INF plans to dissolve the drug program and constitute the activities under a new NGO. The timeline for this is estimated to be completed by 2003. At the same time INF will be up grading their HIV/AIDS care activities. Green Pastures Hospital (100-bed capacity) currently has two beds allocated for PLWHAs. INF has been providing clinical care, home-based care and counseling for HIV infected persons. They plan to convert the Green Pastures Hospital into a facility for persons with HIV by 2003, including hospice care. INF also provided VCT services. INF staffed the regional hospital with a trained counselor. All testing by INF used HIV rapid tests (HIV Spot, Biosign, and Tridot) including confirmation tests with results provided in one day.

SEDA will be conducting a needle exchange program for female IDUs until February 2001 when funding will be exhausted. In the near future services for IDUs, male and female, will be severely curtailed due to lack of funds.

### **Identified programming/service gaps**

There is a severe lack of drug user services, but not due to lack of commitment or interest on the part of key stakeholder organizations. Both INF and SEDA have established good working relationships with their target populations.

Gaps mentioned by IDUs were: programs such as Narcotics Anonymous, post- drug treatment follow-up, and the inclusion of families. NGOs have not been able to provide primary health care either. Many drug users also requested that needle exchanges stock a variety of syringe and needle combinations, e.g. 2.5 ml syringes with a 26-gauge needle.

### **Scaling-up**

According to the IDUs, the following services need to be put in place:

- Residential drug treatment

- Free treatment and rehabilitation for persons without money.
- Day care facilities for follow-up
- Resumption of harm reduction services and outreach
- Allocation of safe injecting areas.
- Inclusion of primary health care at fixed sites as well as outreach.
- Condom distribution, IEC material,
- Family counseling/education for families of IDUs
- Narcotics Anonymous meetings established

According to the key stakeholder organizations, the following services need to be put in place:

- Increased availability of drug treatment
- Comprehensive harm reduction programs
- Drop-in centers
- Community-based education for parents and schools.
- Replication of INF's model of HIV/AIDS training and awareness in the community
- Increased number of trained teachers
- Home based care for PLWHAs

## OVERALL PROGRAMMING RECOMMENDATIONS

This assessment demonstrated the urgent need in many areas of Nepal for IDU- related HIV prevention services. The acute lack of outreach and peer education throughout the country reflects the uncertain and often negative legal and policy environment. Effective national HIV prevention among IDUs will require a network of services able to provide easily accessible, free or inexpensive injecting equipment, skills-based education, STD and abscess treatment services, safer sex counseling and opiate dependency treatment. Few NGOs or INGOs presently have skills in these fields, although some show interest and some are already engaged in HIV prevention activities. The tension between investing in demand reduction, drug treatment and harm reduction was evident everywhere. Without policy consensus at both the local and national levels, any efforts to reduce the spread of HIV among and from IDUs are likely to be small and short-lived as in the past. For these reasons the following activities are suggested:

- *Advocacy for Donors, INGOs, NGOs and Government of Nepal Authorities.* Drug treatment and harm reduction programs must be carried out with the full approval of the relevant authorities. Consensus must be reached as to what is allowable at the present time. As these programs will cost more than any single donor can provide, collaborative funding should be explored as well as ways to integrate some of the needed services into existing programmes.
- *National Forum on Drug Treatment Options.* A series of meetings in which all drug treatment options with proven effectiveness are reviewed; delivery modes discussed in relation to local needs; resources assessed and infrastructural, commodities, and training needs established.
- *National Estimation Training Workshop.* The current estimates of drug users and IDUs are not accurate. Efforts to provide comprehensive, sustainable programming for IDUs will need to consider issues of coverage. To ensure that optimal coverage is reached, each site needs to estimate, in a sound manner, the number of IDUs in existence.
- *Female IDUs.* Specific HIV prevention efforts, including drug treatment regimes, should be designed with and for female IDUs. In preparation, short qualitative studies are required.
- *Cross border issues* play a major role in Nepalese drug use. The possibility of sponsoring a major meeting with Indian and Nepalese HIV/AIDS and drug authorities should be explored, with the help of appropriate UN agencies.
- *Regional Workshops to Design IDU HIV Prevention Programs.* The immediate reduction of the spread of HIV among and from IDU communities should be undertaken by those agencies ready for the challenge. These workshops should result in full proposals with budgets for submission.
- *HIV Education and Prevention for Police.* Given the great influence police have at the street-level over access to IDUs by NGOs, and their own levels of risk, much effort is warranted on police HIV education, with peer educators and curriculum development for police training programmes.