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Nepal

UNAIDS-APICT - Research on the Relationship between Drug Use, Drug Policy & HIV/AIDS Vulnerability

Summary of Major Findings

1. Buprenorphine has replaced heroin as the drug of choice among opioid dependent persons and among initiates to drug use in Nepal. It is increasingly administered by injection given the availability of the injectable form. One estimate is that by 1995, 75% of buprenorphine users were injecting;

2. The National Centre for STD and AIDS Prevention estimates that there are between 40-50,000 drug users in Nepal. Other government officials feel this is a substantial over-estimate of the true situation;

3. The use of alcohol is associated with substantial health and social harm in Nepal, however, little attention has as yet been paid to addressing this problem in a formalized and strategic manner;

4. Alcohol is also thought to be associated with substantial HIV risk taking in Nepal, both in relation to unsafe sex and unsafe injecting drug use;

5. There is no specialized drug treatment sector in Nepal. NGOs provide all drug treatment services in Nepal with the exception of the methadone maintenance programme. These organizations generally receive no government funding, policy direction or technical support. They are reliant on donor agencies for these inputs;

6. The law that has most relevance to drug policy and legal response to unsanctioned drug use is the Narcotic Drugs (Control) Act, 2033 (1976). This law is limited in its coverage of drug-related matters, simple in form and content and could benefit from a re-structure and updating;

7. Under section 14 (c) of the Narcotic Drugs (Control) Act, 2033 (1976, drug use is itself illegal in Nepal. The stated goal of the Ministry is to achieve "zero drug use" in Nepal. These two factors serve to inhibit public health responses and open engagement of people who have drug problems with health and other human services;

8. Senior officers of the Ministry of Home Affairs express the view that needle and syringe exchange and methadone maintenance treatment are against the law;

9. Close examination of the relevant laws suggests that NSEP is not unlawful since there are no paraphernalia laws prohibiting the possession of a needle and syringe and no laws that might be taken to mean that the provision or sale of sterile needles and syringes breaches any legal provisions;

10. The public health rationale behind the distribution of sterile needles and syringes is not accepted by many senior officers in government and instead, is seen as counterproductive. The public health arguments may be inadequately understood or alternatively, they may be accorded low weighting in policy analysis and decision making.

11. The specialized HIV/ AIDS sector is not involved at any level in the development, review and reform of drug policy in Nepal and the absence of attention to HIV prevention is reflected in this gap in collaboration. The converse also applies – the Ministry of Home has not been involved in HIV prevention planning.

12. Ninety eight per cent of drug users stated that they shared needles and syringes in a survey of 150 drug users in Dharan. While 74% of drug users were aware of the protection which condoms can afford them, only 10% knew how to use a condom correctly. Forty per cent were found to be HIV positive.
13. Following outreach education, there is reportedly very high awareness of HIV, STDs and knowledge of how to use a condom correctly. One third of the sample stated that they had moved from injecting to oral use;

14. Commercial sex work is illegal in Nepal. It is estimated that as many as 50% of women returning from India where they have worked in the sex industry, are HIV positive;

15. The intersection between commercial sex work, engaging in sex under the influence of alcohol and other drugs and HIV transmission is not easily addressed in the context of current laws and policies in Nepal;

16. In a recently conducted a Rapid Assessment and Response Survey of 1108 of drug users:
   - Most of the respondents (72.2%) admitted to premarital sex with multiple partners and most of these sexual encounters (64.7%) were without a condom.
   - At the time of interview, 51.7% admitted to unsafe sex, (4.3)% with more than one sexual partner.
   - 67.8% had no knowledge of STDs and their risk of infection.
   - Twenty seven percent of the respondents had experienced an STD and most of them (68%) attended a private clinic for treatment.
   - 89.9% had knowledge of HIV/AIDS and its mode of transmission.
   - 33.2% were found to be positive for HIV, 5.4% for HBSAg, 53% for HCV.
   - 8.1% of the non-drug injectors were found to be positive for HIV whereas among injecting drug users, the prevalence was 40.4%.

### Summary of Major Recommendations

It is recommended that:

1. The legal context of illicit drug use in relation to HIV prevention activities be reviewed, with a view to reforming the law in a manner that can facilitate HIV prevention as opposed to current emphasis on the punishment of those who use and/or traffic drugs
2. The hazards and harms associated with alcohol be addressed in the context of the National Drug Demand Reduction Strategy and accorded more weight in policy development and action, based on local and international experiences and scientific evidence on what works best;
3. The legal situation regarding needle and syringe exchange and availability programmes and possession of needles and syringes be clarified and the situation made known to all in the government, non government, private, international aid agencies and general community sectors;
4. Government implement the proposal articulated within its Strategic Plan for HIV and AIDS in Nepal, 1997-2001 to provide sterile needles and syringes to IDU through NGOs;
5. Peer education for drug users be encouraged, facilitated and promoted in legislation, policy and practical support – for example, support of a technical and funding nature;
6. The capacity of the NCASC be strengthened (as noted in the Strategic Plan for HIV & AIDS) and that it pay increased attention to monitoring, evaluation and coordination of government and NGO planning and activity in the area of drug use and HIV vulnerability;
7. The specialized HIV/AIDS sector be actively engaged in the development, review and reform of drug legislation, policy and planning in Nepal, with a view to ensuring that high priority is accorded to supporting HIV prevention approaches;
8. The Ministry of Home be actively engaged in the development, review and reform of HIV prevention policy and planning, with a view to ensuring that drug prevention and intervention is enabled while also ensuring that effective HIV prevention approaches can be implemented.
A. Introduction

A.1 Objectives of the study

It is well recognised that drug users are at a high risk of contracting HIV/AIDS disease through needle and syringe sharing and through unsafe sex. This policy research project has emanated out of the deliberations of an expert and multi-national Task Force established by UNAIDS-APICT to examine the impacts which drug policy may be having on the HIV/AIDS epidemic. The Task Force is also interested to explore ways in which drug policy may be used to best effect in preventing or mitigating the contribution of drug use to the epidemic. The particular task associated with this research project is to identify in seven selected countries in the region:

1) The nature and extent of HIV vulnerability among people who use drugs;  
2) The positive & negative impacts of public policy on HIV vulnerability in relation to the use of drugs;  
3) What is currently being done at the policy level to help prevent HIV transmission amongst and beyond people who use drugs;  
4) The successes and enablers and the difficulties and barriers encountered by governments in supporting drug users & their communities to reduce this risk, and:  
5) Whether and how UNAIDS and its co-sponsors can support Member States in their efforts to reduce HIV vulnerability among people who use drugs, and beyond.

On the basis of the findings of this policy research, available empirical evidence and international experience, the UNAIDS-APICT Task Force will consider how it can best support Member States within the Asia Pacific Region in reducing HIV vulnerability in relation to drug use. It is hoped that this project and its findings can be utilized in a manner that will be useful to Member States in considering their own policy options for limiting the transmission of HIV/AIDS through drug use.

A.2 Methodology

The writer visited Kathmandu and Dharan on 31 March-6 April 1999 and met with senior officers in government, with key informants from the non-government sector and with representatives of several United Nations agencies. These persons and agencies are listed at the end of this report. A framework of questions was drawn upon in exploring the relationship between drug policy, drug use and HIV vulnerability in Nepal and a range of government reports, policy and planning documents, legislation and scientific papers were examined and relevant information extracted.

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1 The selected countries are China, India, Malaysia, Myanmar, Nepal, Thailand and Viet Nam
2 The term ‘drugs’ should be taken to include all psychoactive substances including alcohol, for the purposes of this study. It is appreciated that in some countries, alcohol is an unsanctioned drug whereas in others, it use is legally and socially sanctioned within certain public health and safety limits.
A. 3 Background

A.3.1 Demography, Development Indices & Public Expenditure

The population of Nepal is estimated at 20.9 million (1997). The urban/rural population distribution is 91%: 9%. Nepal is ranked 154th on the UNDP Human Development Index. Life expectancy at birth is 54.5 years. The literacy rate is estimated at about 40% and the infant mortality rate is 97 per 1000 live births. The economy is largely agricultural based, although tourism is growing as an important source of national income. The average annual per capita GNP is about US$200, placing Nepal in the bottom decile of per capita income, globally. Figures provided in the South Asia Report on Drug Demand Reduction suggest that annual Health expenditure is currently about US$505 million, 9.25% of total public expenditure. Per capita expenditure on health is Rs. 58 (US$0.92). Annual per capita expenditure on education is currently about US$742 million, 13.6% of total public expenditure.

There is generally little or no information available on the budget breakup in terms of the range of drug-related strategies and interventions (supply reduction including law enforcement and interdiction, demand reduction including drug treatment and education, harm reduction, research, training, policy review and development etc.)

<table>
<thead>
<tr>
<th>HIV/ AIDS Budget (1997/98)</th>
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<tbody>
<tr>
<td>HMG:</td>
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<tr>
<td>WHO</td>
</tr>
<tr>
<td>UNAIDS</td>
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Government funding for HIV/AIDS has increased during the last several years.

B. Drug Use in Nepal

B. 1 Illicit drug use in Nepal

B.1.1 Drugs that are Commonly Used in Nepal

Heroin was introduced into Nepal in the mid-1960’s and the drug was mainly smoked or chased, until the late 1980’s and early 1990’s when injection emerged as a method of drug administration among a substantial minority (estimated at about 25% during that period). The introduction of buprenorphine in Nepal in 1990 brought about substantial changes in the unsanctioned drug use culture. By 1991 buprenorphine had replaced heroin as the drug of choice among opioid dependent persons and among initiates to drug use. It was increasingly administered by injection given the availability of the injectable form. Injection of buprenorphine soon spread from Kathmandu to other regional and rural areas.

The major populations of heroin users are in the Kathmandu and Pokhara valleys. Formerly, the most commonly used form of heroin was “brown sugar”, of Afghanistan, Pakistan and Indian origin. This form is mostly smoked or inhaled. However, a more pure form of heroin that has appeared on the streets in recent years is commonly injected. Apart from isolated cases, very little opium is grown in Nepal.

³ US$29.8 million
Cannabis has and continues to be used as part of the culture in many rural areas of Nepal. It was estimated by the government that in 1995 that up to 0.5% of the population in some areas of the Terrai use cannabis daily.

B.1.2 High Risk Practices associated with Drug Use

One estimate was that 75% of buprenorphine users were injecting in 1995. A survey of a methadone treatment seeking population in Kathmandu found that 82% were injecting in 1994, increasing to 96% in 1996.

While there are no reliable data on drug-related overdose and mortality in Nepal, anecdotal reports suggest that the incidence of these events is high. One can fully expect this to be the case where polydrug use is highly prevalent, including the use of alcohol in combination with opioids and benzodiazepines. Low levels of knowledge and understanding of drug toxicology can only increase the risks faced by people who use drugs in a hazardous and unsanctioned context.

B.1.3 Estimated Number of Drug Users

The number of people who use unsanctioned drugs is the subject of some debate in Nepal. While there is no persuasive data, it is estimated by the National Centre for STD and AIDS Prevention that there may be somewhere between 40-50,000 drug users in the country. Some government officials state that this is a substantial over-estimate of the true situation. There are plans afoot within the National STD and HIV Prevention Centre to attempt a more accurate estimation.

B.1.4 Initiation to Drug Use among Young People

In Nepal, young people may begin using unsanctioned drugs at the age or 15-16 years. There was one report of a child initiating to injecting drug use at the age of 6 years, but this may be a relatively rare event. There are some anecdotal reports that the use of unsanctioned rugs is occurring at a progressively younger age but there is no quality baseline or follow-up data that would allow any valid or reliable conclusions of this nature to be substantiated.

B.1.4 Drug Use among Females

Contrary to the pattern that is observable in many other countries in the world, there is no evidence that drug use is escalating among females in Nepal. One estimate is that females represent only 2-3% of those who use unsanctioned drugs. Once again, there is no quality baseline or follow-up data that would allow any valid or reliable conclusions of this nature to be substantiated.

B.1.5 Trend towards Multiple Drug Use

A major problem in many countries in the region is the trend towards multiple drug use, one that is of course also observable in other regions of the world. These other drugs included pentazocine, codeine, nitrazepam and diazepam. Heavy consumption of alcohol also became common place among those using these drugs in an unsanctioned manner.

This problem appears to have been magnified by the absence or inadequacy of formal dispensing controls, enhancing access to the point where supplies can be readily obtained without the need for a prescription. Pharmacists may sell pharmaceuticals, often at inflated prices, without clinical evaluation or the provision of legal documentation.
It appears there is limited capacity for formal monitoring, regulation and maintenance of professional standards in pharmacy retail. As noted above, Tidigesic (buprenorphine) has become a drug of choice and it is commonly used in combination with heroin and alcohol. There are no formal reports of use of amphetamine-type stimulants in Nepal, however, there are some isolated anecdotal reports of its recent introduction.

B.1.6 Population Mobility & its Impact on HIV Vulnerability

There is a range of data consistent with the notion that population migration is adding substantially to HIV vulnerability in Nepal. UNDP has implemented programmes targeting people living alongside the major highway in Nepal. The Strategy Plan for HIV and AIDS, Nepal (1997-2001) identifies internal and external mobility and migration as entry points in addressing those factors that fuel the HIV/AIDS epidemic. This risk may be more strongly associated with unsafe sex but drug use is certainly a factor that remains to be addressed in this context.

B.1.7 Socio-Economic Factors influencing Drug Use & Intervention

The economic situation is an important factor influencing drug use and HIV vulnerability in Nepal.

“After we help people with their drug problem, what then? We have nothing to offer.”

It is thought that the gap between the small number of economically well to do and the poor is widening, however, the government has implemented social policies in an effort to redress this problem. In an environment where per capita health expenditure is less than US$1.00 and average per capita GNP is about US$200, resources for addressing drug problems are naturally limited.

The government recognizes that drug use and dependence can exacerbate poverty and make it very difficult for people to extricate themselves from their disadvantaged economic circumstances (National Drug Control Policy of HMG/Nepal, 1995). It has also paid recognition to the effects which drug use may have on the quality of personal and family of life, on productivity and on economic development.

B.1.8 Alcohol-Related Harm

The use of alcohol is associated with substantial health and social harm in Nepal, however, it was not addressed in the context of the National Drug Demand Reduction Strategy, 1995. Alcohol-related violence is common but little attention has as yet been paid to addressing this problem in a formalized and strategic manner. Alcohol is thought to be associated with substantial HIV risk taking in Nepal, both in relation to unsafe sex and unsafe injecting drug use.

B.1.9 Rapid Assessment and Response Survey

A Rapid Assessment and Response Survey was carried out during early 1999 covering most of the urban area of the southern part of the country, Kathmandu and Lalitpur cities and the tourist area of the Pokhara valley (Upreti, 1999).
Until this survey was carried out it was generally accepted that there were about 50,000 drug addicts in the country out of which 20,000 used injection and possibly about 50% of them were already HIV positive. The survey was aimed at determining the prevalence and nature of substance abuse in different urban areas in Nepal.

**B.1.9.1 Objectives of RAR Survey**

i. To assess the extent, nature and types of drug used.

ii. To assess the extent of adverse health consequences, especially like HIV and other viral infections (HBV and HCV), syphilis and tuberculosis among Drug Users.

iii. To assess the risk behavior associated with injecting drug use leading to adverse health consequences

iv. To identify the resources available at the local level and possible future interventions acceptable to local communities.

**B.1.9.2 Methodology of RAR Survey**

A central core group prepared a detail plan for the survey. The survey sites included 19 major urban areas with a total population of 1.8 million.

Following the training of FRCs and Field Research Assistants (FRAs) advocacy meetings were organized in 17 of the 19 sites that were surveyed. There very high interest and support for the project in most areas but it was notable that this same interest and support was not shown in Kathmandu where many key informants did not attend the pre-arranged interview. Great disappointment was expressed by researchers from the National Centre in response to this outcome.

**B.1.9.3 Results of RAR Survey**

In other areas of Nepal, many key informants expressed their support for harm reduction and made promises to begin services of this nature in their local areas. On this core, the data from Kathmandu was noted to be “quite discouraging”. The best responses were obtained from the Eastern Region of Nepal, which might reflect a greater sense of concern about the issues.

Most of the respondents felt that peer pressure and unemployment were the main determinants of drug use.

Eleven hundred and eight (1108) current drug users were interviewed. Surprisingly, only four women were identified or came to interview. The majority of drug users interviewed (36.5%) had education up to 9-10 class, 17% up to 6-8 class and 9.8% up to intermediate level. Almost 7% of drug addicts were illiterate.

About 24% of drug users started taking drugs at the age of 15, 51.2% at the age of 16-20 years and 17.8 % at the age 21-25 years. The majority (46.4%) started with Marijuana, 28.3% with Phensidyl, 11.6% with Heroin, 2.4% with Tidigesic or 5.4% with Nitrazepam. Once again, users stated that the decision to begin using drugs was largely that of peer pressure (80%), curiosity (44%) or frustration for one of a number of reasons (3 0%). At the time of interview, the majority of drug users were taking Tidigesic (65.2%), Nitrazepam (46. 1%), Phensidyl (30.3%) and Marijuana (42.3%).

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4 This finding is likely to be influenced by selection bias (those with better education may be more likely to agree to be interviewed)
### Types of drugs currently being used

<table>
<thead>
<tr>
<th>Name</th>
<th>Number of drug users</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tidigesic (Buprenorphine)</td>
<td>722</td>
<td>65.2</td>
</tr>
<tr>
<td>Nitrazepam</td>
<td>511</td>
<td>46.1</td>
</tr>
<tr>
<td>Phensidyl</td>
<td>336</td>
<td>30.3</td>
</tr>
<tr>
<td>Marijuana</td>
<td>469</td>
<td>42.3</td>
</tr>
<tr>
<td>Heroin</td>
<td>176</td>
<td>15.9</td>
</tr>
<tr>
<td>Hashish</td>
<td>113</td>
<td>15.9</td>
</tr>
<tr>
<td>Tidigesic + Nitrazepam</td>
<td>76</td>
<td>6.9</td>
</tr>
<tr>
<td>Phensidyl + Nitrazepam</td>
<td>47</td>
<td>4.2</td>
</tr>
</tbody>
</table>

A large proportion of drug users (72.7%) administered their drugs by injection while 63.5% used the oral route and 41.4% smoked. The frequency of daily drug use was found to be once: 35%; twice: 35.3% and three times: 25.5%. About 74.8% admitted to injecting and 65.1% of them freely shared injection equipment with others because they had insufficient financial resources to purchase their own needles and syringes or because they could not easily access them in the market place. Most respondents reported attempting to clean their used injection equipment with ordinary water (77.2%), sometimes by boiling in water (2.7%), sometimes with bleach (20.9%) and sometimes with sputum (44.6%) or urine (4.2%). About 35% of drug addicts stated that they did not share their needles and syringes mainly because of fear that they might get STD or HIV.

Respondents admitted to various “social evils” including quarrelling (87.2%), theft (73.6%), accidents (50.9%) and sexual relations with prostitutes (12.4%). About 78.6% of them stated that they had experienced a variety of health problems including loss of appetite (80.4%), disturbed mental condition (35.1%) and abscesses at the site of injection (26.6%).

A small minority of respondents (26.4%) stated that they had attempted to enter drug treatment. About 14.7% went for counseling, mainly on advice of their parents and friends although some went on their own accord. A very small percentage (8.8%) had ever been admitted to a facility of some kind for detoxification, mainly in Kathmandu (28.8%), Pokhara (18.2%), India (16.7%), Lalitpur (12.1%) and Dharan (4.2%). Once again, their parents or friends prompted most of these treatment-seeking episodes. Some were self-motivated in origin. Of those who attempted detoxification, only a small percentage were able to access these services locally. 7.6% stated they withdrew in their own house.

Most of the respondents (72.2%) admitted to premarital sex with multiple partners and most of these sexual encounters (64.7%) were without a condom. At the time of interview, 51.7% admitted to unsafe sex, (4.3%) with more than one sexual partner. 67.8% had no knowledge of STDS and their risk of infection. Twenty seven percent of the respondents had experienced an STD and most of them (68%) attended a private clinic for treatment. It was of surprise to the researchers to find that 89.9% had knowledge of HIV/AIDS and its mode of transmission.

Of the drug users interviewed, 33.2% were found to be positive for HIV, 5.4% for HBSAg, 53% for HCV. 8.1% of the non-drug injectors were found to be positive for HIV whereas among injecting drug users, the prevalence was 40.4%. The odds ratio for HIV infection among those who inject compared to those that do not is therefore 13.5:1.

The researchers observed that one of the major objectives of this study was to estimate the total number of drug users and among them the number of injecting drug users. For different reasons this activity could not be carried out and remains an objective for the near future.

The researchers added that the study proved to be a most difficult one. They lamented that:
“lots of (the) difficulties (were) mostly man-made (and yet) so much could be achieved”.

B. 2 Drug policy in Nepal: Mechanisms for Drug Control

B.2. 1 Drug Related Legislation & its Application

B.2.1.1 Narcotic & Psychotropic Drug Laws

The law that has most relevance to drug policy and legal response to unsanctioned rug use is the Narcotic Drugs (Control) Act, 2033 (1976). This law is limited in its coverage of drug-related matters, simple in its form and content and could benefit from updating. It was last amended in 1993 (2050).

It defines “addiction” as “an act of consumption of narcotic drugs in more than the dosage and quantity prescribed by a recognized medical practitioner or without the prescription of such medical practitioner.” This definition is in itself highly problematic from both legal and technical perspectives.

The Narcotic Drugs (Control) Act, 2033 (1976) states that a person convicted of transacting more than one hundred grams of opium poppy of coca bush shall be punished with imprisonment for a term of fifteen years to life imprisonment and with a fine of between five hundred thousand rupees and twenty five hundred thousand rupees (US$7,500-US$37,000). One key informant in government stated that the maximum penalty for drug trafficking in Nepal is 33 years imprisonment, greater than “life imprisonment” which is 20 years. This statement is inconsistent with the provisions listed in the Narcotic Drugs (Control) Act, 2033 (1976). There are no provisions for the death penalty in Nepal.

B.2.1.2 Nepalese Drug Laws Regarding Treatment

The laws on drug use and treatment in Nepal are seen by some clinicians as being quite vague at present. One key informant advised that the laws:

“…allow a doctor to treat drug dependent persons with substitution treatment for many months without necessarily seeing the patient. The doctor can merely advise the patient over the telephone to continue taking the medication and that is sufficient for the purposes of professional accountability”.

Reference to the Narcotic Drugs (Control) Act, 2033 (1976) reveals that there are provisions (Chapter 2, sub-section 14 (Penalties), sub-sub-section (e), for a bond that replaces imprisonment with an undertaking to enter and remain in treatment for three months and for the treating agency to submit fortnightly reports on the individuals concerned.

The Narcotic Drugs (Control) Act, 2033 (1976) also contains provisions for withholding or remitting punishment for minor and first offences (Chapter 2, sub-section 19). Specifically, if a person is found to have purchased or possessed cannabis or medicinal opium, without commercial motive and in a small quantity, or has consumed only a small dose and if he has committed such an offence for the first time, the Narcotics Drug Control Officer may, after keeping a record of such person, make him sign a bond undertaking not to commit such offence again and release him after recording the reason for withholding the prosecution. Even when prosecution has already commenced, the court may, if it deems the offence to be of a minor nature and if the person has committed the offence for the first time, fulfil the above processes and release him without applying any punishment.
B.2.1.3 Role of Criminal Justice System in HIV Prevention

It is not clear that the criminal justice system has played any substantive role in HIV prevention in Nepal. Rather, some aspects of the criminal justice system would appear to be adding to HIV vulnerability among people who use drugs and their sexual partners. A number of key informants observed that Police officers may sometimes use the illegal status of specific drug to their own financial advantage, harassing people and coercing bribes or personal favours in lieu of their arrest. Section 11C (e) of the Narcotic Drugs Control Act States: Anyone who consumes opium, coca or any other narcotic drug made therefrom shall be punished with an imprisonment for a term of up to one year or with a fine up to ten thousand rupees. In other words, drug use is in itself an offence. Such provisions can serve to increase HIV vulnerability among people who use drugs.

B.2.1.4 HIV Risk in Jails, Prisons, Police Lock-ups & Detention Centres

Drug dependent persons are not generally provided with any medication for symptom relief or clinical safety when imprisoned. They withdraw “cold turkey”. They may be discriminated against while in prison and generally receive no specialized treatment. No aftercare is available following their release.

Prisoners are not routinely tested for HIV. The Ministry of Home Affairs concedes that illicit or unsanctioned drug use does occur in Nepalese prisons and where detected, it is met with increased punishment. When asked about the risk of HIV transmission through unsafe sex in prisons, it was suggested that:

“"This is not a problem because men are separated from women in prisons".

Senior officers of the Ministry suggested that men having sex with men (MSM) does not occur in Nepalese prisons and that indeed, it is uncommon in Nepalese culture. The questions of drug use and unsafe sex in prisons are matters that, as in this case, government officials may not feel comfortable in discussing. However, advice received from an NGO working within three prisons in Nepal confirmed that both risk behaviours do occur. MSM is very common in Nepalese prisons according to this key informant. However, this person added that there is no clear evidence of injecting drug use in prisons.

It is important to note that condoms are now available in these three prisons following extensive discussions between staff of these NGO and prison officials. 1500-2000 condoms are now reportedly distributed each month. However, the great majority of prisons do not allow condoms and the risk of HIV transmission appears real and substantial. The absence of drug injecting that is thought to exist in these three prisons may not exist in others in Nepal, but this is of course conjectural.

B.2.2 International Frameworks for Drug Control
The Narcotic Drugs (Control) Act was passed in 1976 and amended in 1981 and 1987 and Nepal became a party to the 1961 Single Convention and the 1972 Protocol amending that Convention. In July 1991 it became a party also to the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. A Drug Control Unit was established within the Ministry of Home and a nation-wide network for drug abuse control was created with the Chief District Officers designated as drug control officers. The Police Department, which carries the main burden of narcotic drug enforcement in the country and makes virtually all the seizures and drug-related arrests, established a drug section within the Crime Investigation Department that currently supervises drug squads and drug seizures and enquires in seventy-five district police offices. The Department of Customs is also nominally responsible for drug enforcement activities at customs posts along the borders and the airports, however with few seizures to its credit (HMG/N, 1992).

B.3 Responsibility for Drug Policy & Strategic Planning

The responsibility for Drug planning in Nepal resides solely within the Ministry of Home Affairs. The Ministry of Health has had no direct involvement hitherto and the Ministry of Home Affairs has not as yet placed substantial emphasis on the public health aspects of drug use.

B.3.1 Legislation and Policy Pertaining to Drug Use & HIV Prevention

Senior officers of the Ministry of Home Affairs expressed the view that needle and syringe exchange and methadone maintenance treatment are against the law. They observed that the Ministry would however be comfortable with the use of methadone as a reduction treatment (drug-free treatment goal).

Under Section 14 (e) of the Narcotic Drugs (Control) Act, 2033 (1976), drug use is in itself illegal in Nepal and is punishable.

Anyone who consumes opium, coca or any other narcotic drug made therefrom shall be punished with an imprisonment for a term of up to one year or with a fine of up to ten thousand rupees. However,

Provided that in case of a person who is in the responsibility of a person or institution, who have made bond for doing treatment up to three months, in the treatment centre, the judicial authorities may not punish such person on the condition of submitting the information of treatment fortnightly from the treatment centre.

The stated goal of the Ministry is to achieve “zero drug use” in Nepal.

One key informant observed:

“Drug addicts are criminals, according to our law because they are creating a problem in the society. Stealing, rape, killing, murder – these are all things that are related to drugs.”

The public health rationale behind the distribution of sterile needles and syringes is not accepted by many senior officers in government and instead, is seen as counterproductive. The public health arguments may also be inadequately understood or alternatively, they may be accorded low weighting in policy analysis and decision making. Reasons given for rejecting the idea of sterile needle and syringe exchange and availability programmes included:

“….because they share the needles that are given.”

“Drug users cause problems to whole society. Therefore, they are more dangerous than a murderer. We don’t allow users or pushers early release as we people who commit other crimes. However, we pay most attention to punishing pushers.”
In response to a question about the relative emphasis of the government’s drug policies and their associated goals (maintaining socio-cultural traditions, safeguarding law and order, safeguarding national security, protecting and promoting public health, protecting and promoting economic development and prosperity and upholding the spiritual and religious beliefs, values and laws), it was noted that it depends on the mandate of the sector involved rather than there being any consensus or shared vision across government. This is of course what one may witness in most countries of the world. However, certain priorities have been laid out in the country’s 9th National Five Year Plan.

On a more positive note, one senior officer of the Ministry of Home Affairs noted that the laws of drugs were drafted more than 10 years ago and at a time when HIV/AIDS was not at issue in Nepal. Consideration was now being given to whether needle and syringe exchange (NSEP) should be made legal, or not. While the Ministry of Home Affairs does not agree with the implementation of NSEP, the Ministry of Health has advocated for this strategy to be implemented. Notwithstanding, the Ministry of Home Affairs indicated that it:

> “…might re-examine the law in relation to needle and syringe exchange and methadone maintenance treatment” (with a view to making them legal). However, it is doubtful that the law would be amended within a year”.

Close examination of the relevant laws suggests that NSEP is not unlawful since there are no paraphernalia laws prohibiting the possession of a needle and syringe and no laws that might be taken to mean that the provision or sale of sterile needles and syringes breaches any legal provisions. However, that drug use is itself an offence might be interpreted to mean that any activity that promotes or facilitates the use of illicit drugs is also illegal, including education about safer ways of injecting drugs and strategies which increase access to sterile injection equipment.

The main emphasis on drug strategy within the Ministry of Home Affairs remains in the area of “demand reduction”. There is growing concern about the rising number of illicit drug users, however, the Ministry of Home Affairs does not accept the Ministry of Health estimate of 40-50,000 drug users. They view this as a gross over-estimate of the true number, although the officers concerned did not articulate the basis upon which had arrived at their own estimate.

Commercial sex work is illegal in Nepal. The trafficking of women or girls is a matter of great concern in Nepal as it is in the region. It is estimated that as many as 50% of women returning from India where they have worked in the sex industry, are HIV positive. Nepal has signed the International Convention on the Trafficking of Women.

The specialized HIV/AIDS sector is not involved at any level in the development, review and reform of drug policy in Nepal. The converse also applies – the Ministry of Home has not been involved in HIV prevention planning. The concept of intersectoral responses developed through integration, collaboration and coordination has not as yet impacted on government planning and activity in the areas of drug policy and HIV prevention. However, an intention has been signaled to do so in the National Drug Control Policy of HMG/Nepal, 1995, which was formulated in 1995 by the Ministry of Home Affairs, in collaboration with UNDCP, together with a National Drug Demand Reduction Strategy.

The National Drug Control Policy of HMG/Nepal notes “the tendency for drug-related problems to be considered as sectoral issues, mostly bordering health” (p. 7). It adds that there is often a “tendency towards sectoral and indeed compartmentalized and isolated action”. The Policy notes the need to address the harms associated with alcohol, tobacco and some medicinal drugs alongside those arising from the use of illicit drugs. It also notes that there has been a tendency to equate prevention with preventive education and that “reduction of harm, especially in the face of emerging threats such as AIDS, has failed to adequately enter the ambit of prevention.”
Harm reduction is mentioned as one of the goals of the policy alongside law enforcement, demand reduction, social support, treatment and rehabilitation, legislative support, international obligations and attention to implementing agencies and systems. Preventive education has often been based either on moralizing or scaring, it adds. The aims of this National Drug Control Policy of HMG/Nepal are stated as the creation of a climate:

“... where the non-medical use of drugs is virtually non-existent, ....”

B.3.2 The Master Plan for Drug Abuse Control in Nepal (1992) in Co-operation with the United Nations International Drug Control Programme

The Master Plan for Drug Abuse Control in Nepal (1992) was drawn up by the Ministry of Home in Co-operation with the United Nations International Drug Control Programme and was signed by HMG/N and UNDCP in July 1992. Key Issues in the Master Plan were as follows:

- Revision of Existing Legislation
- Upgrading of the Drug Control Administration
- Strengthening of Law Enforcement
- Policy Changes for Demand Reduction
- Preventive Education and information
- Key Areas for Government Intervention
- Revision of current narcotics legislation
- Strengthening of the law enforcement
- Expansion of treatment and rehabilitation services:
- Elimination of illicit cultivation and production
- Policy formulation in the field of preventive education and information
- Key areas for external assistance

The Master Plan comprised two project plans for external support in the sectors of legislation and law enforcement, and treatment, rehabilitation and other demand reduction activities, with a total contribution of US$ 1,003,700.

1. Sector plan for Legal Assistance and Law Enforcement Support US$ 560,700
2. Sector plan for Treatment, Rehabilitation and other Demand Reduction Activities US$ 443,000

B.3.2.1 Policy Changes for Demand Reduction

The Master Plan made the following observations in relation to policy changes required for demand reduction:

The policy of placing drug addicts in the custody of police or confining them in jails is acceptable as a short-term interim measure, but its medium and long-term viability is open to questioning on legal, medical and moral grounds. This issue is closely linked to the lack of capacity for detoxification and rehabilitation in the present system and, obviously, the difficulties for the families in handling drug dependent family members. The problem of who should provide this additional service must also be addressed.
At present, the Government has largely delegated the responsibility for detoxification and rehabilitation to the non-governmental organisations which is a commendable policy consistent with experience elsewhere in the region. However the current policy of relying on these services without moral or financial support needs to be revised. The present capacity problem is to find a more permanent and satisfactory solution.

Rehabilitation and after-care services are not provided within the government sector whereas the non-governmental organisations, without compensation, provide an insufficient variety of services. This situation does not provide any encouragement to private organisations to support the drug demand reduction policies of the Government.

The lack of support by the Government also has other consequences of which a lack of supervision of the standard of services provided by the non-governmental organisations is one result. The Ministry of Health which in other countries takes a direct and active role in the formulation of policies and advocacy and acts as a repository of technical knowledge on treatment and rehabilitation has in Nepal not yet assumed a similar role.

The Master plan comprises three volumes entitled:

- Volume I: Main document
- Volume II: Sector Plan for Law Enforcement and legal assistance
- Volume III: Sector Plan for Treatment, Rehabilitation and other Demand Reduction Activities

Mid-term and terminal evaluations were carried out and reported on in September 1996. There are two significant observations to be made about the Master Plan and its impacts and outcomes. It proved exceedingly difficult to obtain a copy of the Master plan from government and from the UN office in Kathmandu. Key persons in government who would have a keen interest in the plan did not seem to know much about it and did not refer to its activities, findings, outcomes and follow up action recommended as a result of the evaluation.

The Plan contained no reference whatsoever to HIV prevention as a central element of drugs policy, planning and action. The opportunity costs of committing a government to a programme of action while ignoring this aspect of drug policy and action is substantial and difficult to reconcile with the local and international experience.

### B.3.2.1 Addressing Alcohol & tobacco in Context of Drug Policy & Planning

Alcohol and tobacco are mentioned in the National Drug Control Policy of HMG/Nepal and its associated Strategy, however, at a practical level little progress appears to have been made to date.

Control of licit substances: while the tremendous degree of harm caused by illicit drugs is taken into serious cognizance, that caused by licit substances such as alcohol and tobacco will be considered no less important.

Alcohol and tobacco advertising are banned in Nepal (check §).
Senior government officials state that drug problems are accorded high priority by Government, however, other key informants expressed concern that this expression on intent has not as yet been translated into practice. Nothing of a serious nature, it was suggested by some, is happening to address drug use and drug-related harm at present. The Master Plan of UNDCP ran its natural course during the 1992-1996 period but does not appear to have made an impression. Several small scale training projects for drug treatment and law enforcement officers were held recently drawing upon some funds that were left over from the Master Planning process, but nothing of a sustainable nature continues.

B.3.3 Intersctoral Mechanisms for Addressing Matters of Drug Use & HIV Prevention

Since 1992, the National AIDS Project (NAP) has come under the umbrella of National AIDS Coordination Committee (NACC). This committee chaired by the Minister for Health and various sectors, including NGOs and INGOs, are represented as members. The committee which is the highest policy making body was restructured in 1995 with a total of 40 members and is supported by an executive committee under the chairmanship of the Secretary of Health.

An Executive Committee carries out its activities through the National Center for AIDS and STD Control (NCASC), Department of Health Services. It is semi-autonomous and functions as a focal point for AIDS and STD prevention activities.

District AIDS Coordination Committee (DACC) have been established as a means of decentralizing and building capacity at grass root level with a view to promoting sustainability of AIDS & STD prevention activities.

A coordination mechanism has also been established between the Narcotic Drug Control Division (NDCD) and NCASC. The Under Secretary of the NDCD is appointed as a focal point for drug abuse and HIV/AIDS related matters.

A high-level drug control coordination committee has been constituted under the chairmanship of the Home Minister. This committee is comprised of the Secretaries as member from the Ministries of Health, Finance, Industry, Foreign Affairs, Social Welfare, Home Affairs, National Planning Commission, the Chief of the Police and others. A Narcotic Drug Control Division is headed by the Joint Secretary, who also serves as the chief Narcotic Control Officer, in the Ministry of Home Affairs. This officer has responsibility for policy, planning and programme formulation and for coordination of activity. An Executive Committee has representation from the Department of Drug Administration, Commerce, Costumes, Industry, Civil Aviation, Police Head Quarters and Narcotic Drug Control Law Enforcement Unit (NDCLEU) (Shrestha, 1999).

An Inter-departmental Coordination Committee on Precursor Control has been constituted under the coordination of Chief Narcotic Control Officer with the representation from various departments such as Costumes, Commerce, Industry, Drug Administration, Police Headquarters and NDCLEU to regulate precursor imports and monitor the use of chemicals. In addition to this, the Chief District Officer, as a narcotic control officer, has been assigned to look after all the drug related issues in the local level.

The National Center for AIDS and STD Control (NCASC) through which the executive committee carries out its activities, has been established within the Department of Health Services. It enjoys some autonomy and serves as a focal point AIDS and STD prevention planning and activity.

The NDCD has responsibility for a Drug Abuse Demand Reduction Project that aims to promote drug awareness within the community. It involves NGOs and various training programmes have been provided for school teachers. A curriculum “against drug abuse” has been developed and is currently being implemented.
In the area of supply control, a Narcotic Drug Control Law Enforcement Unit has been established within the centre and in eight other satellite strategically chosen sites including Tribhuvan International Airport (Shrestha, 1999).

While the intersectional mechanisms for HIV/AIDS prevention appear both extensive and comprehensive, there is in truth much work to be done before consistent and evidence-driven intersectoral policies, strategies and activities are in place. Knowledge, attitudes and practices remain inadequate and outdated among many key decision-makers. Some District level officials with dual drug control and HIV responsibilities are also unsympathetic to the principles of HIV/AIDS prevention that have been shown to work best internationally and continue to believe that repressive measures are more appropriate. These repressive measures continue to hinder effective HIV prevention activity targeting people who are at risk.

A community recovery centre has been established within the context of the Drug Abuse Demand Reduction Project to provide drug treatment and rehabilitation. However, government has elected not to take any responsibility for the establishment, design, delivery, monitoring and evaluation of drug treatment and rehabilitation services. It has instead assigned these responsibilities to the non-government sector but without any technical, administrative, quality assurance or financial support.

The government has entrusted and encouraged the NGOs and COs to launch the treatment and rehabilitation programmes in the different parts of the country too.

This presents reason for grave concern given the experience with unmonitored drug treatment services internationally. The drug treatment field is one that is highly vulnerable to marginal religious influence and other unhelpful or harmful practices.

Programmes may be based on the personal opinions and beliefs of people rather than on empirical evidence or may be used as a means of profit generation by entrepreneurs. Patients and their families are often misled and taken advantage of, financially, emotionally and sometimes physically without any transparency and accountability in decision-making. Importantly, an unmonitored and unevaluated drug treatment programme forgoes any opportunity that may exist for improving the process of treatment delivery and maximizing outcomes. It does not make good sense from an economic or public health perspective.

**B. 4 Approaches to Drug Treatment & Rehabilitation**

**B. 4.1 Role played by Government**

There is no specialised drug treatment sector in Nepal. Treatment and rehabilitation of drug dependent persons are almost exclusively undertaken by non-governmental organisations although two governmental hospitals in Kathmandu have reserved a small number of beds for inpatient detoxification. A methadone maintenance programme is also operated from at the the Mental Hospital in Kathmandu. Two non-governmental organisations also provide a very limited detoxification service but the majority of addicts are placed in safe custody at police stations or confined in jails, often referred by their families. Rehabilitation services are provided by non-governmental organisations both in institutions and on an out-patient basis. Aasara, is a non-government involuntary drug rehabilitation programme in Kathmandu, which receives Police support for security purposes. It receives limited external funding, so it must charge for its services.
NGO's providing drug treatment and rehabilitation services receive no financial support from the Government. Many of these services are therefore highly reliant either on the financial and technical support of external donor agencies or they survive by charging patients for services. This policy creates an unfortunate inequity in access to services between those who can afford treatment and those who can not. (HMG/N, 1992).

Those drug treatment services that are available are limited to urban settings. While illicit drug use occurs more commonly within these same settings, alcohol and tobacco problems are widespread. It appears that to date, government not managed to pay very much attention to policy development and activity aimed at addressing alcohol and tobacco use and related problems.

At Pokhara Valley, detoxification is carried out at the General Hospital. Although drug problems are prevalent in all parts of the country, people must either come to Kathmandu or go to India, given the absence of treatment facilities, depending on their ability to pay. It is estimated that treatment and rehabilitation services are available for approximately 10% of the drug dependent population.

Within the urban setting, only those with capacity to pay are able to reliably access treatment services. In some drug treatment settings those who are HIV or HBV positive are not admitted. Those with a history of repeated relapse (five times) and those who are not accompanied by a family member may also be rejected.

Treatment services may not necessarily be seen as user friendly and young people may often only come for treatment under substantial pressure if not coercion from their family. Notwithstanding, there are often waiting lists for entry into these drug treatment programmes. Whether this is due to family requests and pressure or demand from people with drug problems is unclear.

Staff attitudes towards patients are reported to be generally supportive. However, staff may often have unrealistic expectations for drug free outcomes and feel frustrated when their hopes and expectations are not met. Staff are reported to be “burning out” quickly. Relapse rates among patients are invariably high.

If patients are found to have used unsanctioned drugs during their admission they will often be discharged. Alternatively, their treatment plan may be re-negotiated and their freedoms limited.

Treatment programmes are generally of a uniform nature for all patients rather than being tailored to meet the individual patient’s assessed problems, needs, intellectual and contextual capacities and deficits, coping styles and treatment preferences. There is an untested assumption that the duration of inpatient treatment needs to be extensive and that a longer admission is likely to be better than shorter admission in terms of treatment outcome. Questions relating to treatment efficacy per se and of cost-effectiveness of one approach versus another do not appear to have been examined in any serious manner.

The Master Plan (HMG/N, 1992) reported as follows:

> However, the relapse rate is high. Addicts are often rounded up by the police and put into Dhulikhel Jail as mentally disturbed persons or in the district or zonal jails. Treatment here is being done by the ‘Cold Turkey’ method due to the lack of other facilities. Rehabilitation and social reintegration programmes which are more difficult to manage are being carried out by the non-governmental organisations after detoxification. It is encouraging to note that due to the lack of available resources in terms of capacity, manpower and funds, the NGO’s have developed programmes complimentary to each other

The situation does not appear to have changed. A senior government officer from the Ministry of Health observed that detoxification has invariably been associated with high relapse rates within a short period of time (3 months). A trial of methadone reduction (over 6 weeks) was abandoned when it was realized that relapse rates were so high, as elsewhere in the world.
The Master Plan also made the following observations regarding respective roles and responsibilities in addressing drug problems:

The Ministry of Home has so far acted as a technical ministry for the implementation of its drug abuse policies, as drug abuse was mainly perceived as a problem of law enforcement. With the increase in the rate of addiction, the abuse problem has shifted its main focus to the treatment and rehabilitation of drug addicts, an area where the Ministry of Home has little technical competence, having to rely on other ministries for implementation of its policies and programmes. The Ministry of Health and the Ministry of Education should therefore assume a more active role, not only in the formulation of policies and strategies, but also in providing technical expertise in the formulation of standards of service, supervision of programmes and implementation of projects. In addition certain institutional arrangements to reflect this new role should be contemplated.

Once again, the situation does not appear to have altered in any substantive way since that time.
B.4.1.1 Training of Human Service Providers involved in Drug Intervention

There has been little attention paid to training health care personnel in the area of drug treatment. Some training was provided as part of the UNDCP Master Plan related projects.

B. 4.2 Role played by NGOs in Drugs & HIV/ AIDS Intervention

There is a very extensive network of NGOs in Nepal. One estimate is that there are over 1600 NGOs involved in the HIV/ AIDS area and 102 INGOs, although many of these organizations are inactive. The government has, as in many other countries, adopted a policy of outsourcing many of its programmes and activities to these NGOs and INGOs, without any ongoing technical support and supervision of activities and without programme monitoring and evaluation, or standards development. This is worrisome as the drug and alcohol field is renown for the adoption of occult-type and sometimes harmful practices, when left to its own devices or at least, the pursuit of personal–opinion based “treatment” practices that are invariably ineffective and sometimes dangerous to the physical or mental health of patients. Unfortunately, Government does not appear to possess the technical and financial resources at present to provide the necessary level of external service provider screening, direction, supervision and support.

B.4.2.1 NGOs Working in Drug-Related HIV Prevention in Nepal

There are only a very limited number of NGOs working in the area of drug-related HIV prevention in Nepal: LALS and the MMT programme in Kathmandu, INF in Pokhara and Kamal Tigela Limbu (KTL) in Dharan. There are a larger number of NGOs working in the area of “drug demand reduction”.

B.4.2.1.1 Punarjiwan Kendra, Kirat Yakthung Chumlung (KYC) Drug Treatment Centre, Dharan

Punarjiwan Kendra, Kirat Yakthung Chumlung (KYC), (“Revival Centre”) is a drug treatment and rehabilitation programme in Dharan. It provides non-medical supported withdrawal (‘detoxification’) and rehabilitation services over a period of six months. The programme has received funding support from SCF/ US, as a pilot.

The severity of withdrawal seen among clients at this centre are reported to be generally of mild to moderate nature. This may reflect the mixed agonist nature of the main drug of dependence, buprenorphine. In 1998 the major drug used by persons admitted to this treatment centre were as follows: Tidigesic (buprenorphine) 83%, brown sugar (heroin) 9% and alcohol 6%. In a separate report in 1997, the profile of drug use was much different. Tidigesic was the primary drug of use in 32% of patients, nitrazepam in 25%, codeine linctus in 24%, cannabis preparations in 14%, heroin in just under 3% and other drugs in 3% of cases.

Some staff of KYC (and LALS) expressed the view that alcohol is responsible for more health and social harm than any other drug in Nepal. Police in Dharan reportedly agree that alcohol is generally a greater problem than illicit drugs but they feel this is not the case in their own city. However, police point out that community violence is mostly alcohol-related while street crime is more motivated by illicit drugs. As is often the case in other countries, people with alcohol problems do not get on well with those with illicit drug problems within a drug treatment setting. Each may often see the other as having a more morally repugnant problem, perhaps reflecting prevailing attitudes within the community in general.
Ninety eight per cent of drug users stated that they shared needles and syringes in a survey of 150 drug users in Dharan. While 74% of drug users were aware of the protection which condoms can afford them, only 10% knew how to use a condom correctly. Forty per cent were found to be HIV positive. Following outreach education, there is reportedly very high awareness of HIV, STDs and knowledge of how to use a condom correctly. One third of the sample stated that they had moved from injecting to oral use.

Staff of KYC believe that the essence of overcoming drug dependence is “will power” and self-confidence. The programme incorporates many of the elements of an American-style therapeutic community, including confrontation, work therapy, recreational therapy, group counseling and individual counseling. It is stated that “psychotherapy” is offered but staff are not adequately trained or formally qualified to offer such treatment.  

Importantly, the programme also provides harm reduction information and education through peer support and outreach. Bleach and clean water is also distributed. The outreach workers received training from LALS Kathmandu and at present, are each seeing 5-6 people who use drugs, each day. They work from two centres in Dharan and keep a log on their daily activities.

There is a waiting list for people wishing to enter this treatment setting and police say they could bring many people to the centre each day, if more beds were available. There are plans to double the current bed capacity of ten. A random survey undertaken in 1997 identified 2,450 persons in the Dharan area who use illicit drugs.

The police inspector with whom the consultant met stated that police are very supportive of this treatment program and have reportedly moved from a view that drug use is essentially a criminal problem towards the view that it is more a social and health problem. In this context, they are also supportive of the idea of establishing a needle and syringe exchange programme. They like the harm reduction programme offered by LALS in Kathmandu and do not believe that punishment-based approaches are effective in helping people with drug problems.

B.4.2.1.2 Aasara Sudhar Kendra Drug Rehabilitation Centre

“Aasara” is a secured reform camp for drug dependent persons. It was established in Kathmandu in June, 1997 with the objective of “giving a new lease of life to those youths who comprise an important force of our society but who have deviated from their path by falling into the bog of drug addiction, and establishing them as reputed citizens.” It is operated by the Police Women’s Association and Police provide 24 hour security services to the camp. The programme includes work and recreational therapy, group therapy, personal, spiritual and family counseling, yoga, work and personal skills development, moral education, social work and psychological interventions of an unspecified nature. Patients must advance Rs 14,000 (US$210.00) prior to admission to cover the costs of the programme for the first three months and thereafter, a further Rs 3,500 (US$52.00) is levied per month.

This means that only those who can afford to pay can access this treatment service. In Nepali terms this treatment programme is very expensive – more than the average per capita GNP. People who are HIV or HBV positive are excluded from admission. HCV is not tested for. Those who transgress certain camp rules may be discharged early. Many young people are brought to the treatment centre by their parents. There is often a waiting list. The admission notes suggest that:

“the time needed to fully cure addiction to drugs depends on the person’s condition and circumstances … and normally it takes six to 18 months”.

5 It is relevant to note that there is no evidence in the western research context that psychotherapy is effective in altering drug use behaviours, except where in the presence of mental co-morbidity that may respond to such treatment (e.g. depressive illness).
When asked about relapse rates, it was suggested that “maybe one fourth can follow the principles of the programme after three months of treatment. In response to a question as to whether harm reduction strategies such as education on ways of reducing injection-related risk should be available where relapse occurs and people are at real risk of becoming infected with HIV, there was agreement that they should.

During the last 18 months, a total of 262 persons have gone through this treatment programme. Of these, 102 used Tidigesic as their primary drug, 36 used brown sugar (heroin), 33 used cannabis, 47 used alcohol, 13 used codeine linctus and 29 used other psychotropic medications.

On follow up, 62% were said to have relapsed within 12 months following treatment, however, one must take into account possible selection bias (those with a worse prognosis may be selected out from admission) and measurement bias (self-report is relied upon in a context where admission of relapse may be seen as undesirable). If one accepts the estimate that one fourth of these benefited from the treatment programme, only 40 persons will have benefited in a period of 12 months.

If one takes the more optimistic figure of 62% relapse rate at 12 months, about 70 persons will have benefited in an enduring manner. This serves to illustrate the serious limitations of a resource intensive drug free treatment approach in reaching those at risk of HIV infection and other drug-related harms. There are plans to increase the number of treatment slots at Aasara.

B.4.2.1.3 Life Giving & Life Saving Society (LALS)

LALS is an NGO that has worked with IDU in Kathmandu since 1991. It enjoys an international reputation for its harm reduction work which has included information and education of drug users on ways that they can reduce their risk of HIV infection, outreach work, distribution of bleach, sterile water and condoms and NSEP services. It has also provided counseling to drug users, drug treatment referral services and primary health care. An early evaluation of the drug use situation in Kathmandu was that knowledge of HIV prevention had increased among drug users and that the HIV sero-prevalence had remained low – falling from 1.6% in 1991 to 0% in 1994. However, a more recent assessment has revealed that this situation has changed dramatically.

Up to 45% of IDU tested have been found to be HIV positive and the proportion of all HIV positive cases attributable to drug injection is similarly high (although this is without doubt an over-estimate of the true sero-prevalence given the over-representation [selection bias] of people who use drugs among populations tested).

A HIV sero-prevalence survey was undertaken in Kathmandu in 1997 on 200 persons randomly selected for voluntary admission (‘given an option to leave’) to Assara from a population of drug users found on the streets, in shooting galleries, in hotels and in temples. They were tested for HIV using a single ELISA method and the results were analyzed in terms of whether they had attended the LALS needle and syringe exchange programme at some stage. While one would need to be very cautious about these results of this analysis, what it suggests is that those attending the LALS needle and syringe exchange service experienced a degree of protection from HIV infection. This data suggests that NSEP has not contributed to the recently detected rapid increase in HIV sero-prevalence among IDU as claimed by some opinion leaders in Nepal. Rather, this data suggests that the needle and syringe exchange services of LALS has if anything exerted a discernable public health impact, notwithstanding its very limited reach in terms of the proportion of injecting drug users attending the services and in terms of the number of sterile needles and syringes provided.

This analysis shows that the odds of being infected by HIV are reduced by a factor of 1.39 if attending the NSEP services compared to those not attending. While this finding is by no means conclusive (nor substantial), it is consistent with findings elsewhere in the world.

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6 While acknowledging that admission to an institutional setting can keep people safer at a critical high risk time in their lives and can afford them an opportunity to recover over time. Relapse following treatment does not mean that an individual has not benefited in other ways. They may well have. Treatment of this nature can also save lives.
<table>
<thead>
<tr>
<th></th>
<th>HIV+</th>
<th>HIV-</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSEP*</td>
<td>24</td>
<td>37</td>
<td>61</td>
</tr>
<tr>
<td>NSEP*</td>
<td>66</td>
<td>73</td>
<td>139</td>
</tr>
<tr>
<td>Totals</td>
<td>90</td>
<td>110</td>
<td>200</td>
</tr>
</tbody>
</table>

$\text{OR} = \frac{1752}{2442} = 0.71 \quad (1/0.71) = 1.39$

To emphasize the point about limited reach more clearly, a rapid assessment undertaken recently indicated that drug injectors are injecting 16 times each week on average while those attending LALS received only 5 sterile needles and syringes each month. A UNDCP Report on Demand Reduction in South Asia (UNDCP/ROSA, 1998) mentions that the total number of ever contacted persons at LALS increased from 450 in 1993 to 1025 in 1997. About 60% of these persons are in regular contact (at least once in 4 weeks) with LALS. There are about 1500 visits to the service each month.

It is of great concern to note that this data also suggests that those with a history of imprisonment in Nepal are 4.6 times more likely to be HIV positive than those without such a history.

<table>
<thead>
<tr>
<th></th>
<th>HIV+</th>
<th>HIV-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prison*</td>
<td>75</td>
<td>59</td>
</tr>
<tr>
<td>Prison*</td>
<td>15</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>90</td>
<td>110</td>
</tr>
</tbody>
</table>

$\text{OR} = \frac{3825}{885} = 4.64$

Unfortunately, it may soon prove necessary to close LALS. LALS receives funding from the Dutch Government (SNV), from the European Commission and from DGIS. Continued funding from SNV (through SCF/US) is in serious jeopardy because the Dutch Development Corporation is restructuring its international aid programme and is reducing the number of countries assisted from 80 (plus 50 in receipt of small grants) to 19. The budget for LALS in 1997/98 was US$22,000. Nepal is not on the list of countries to receive social sector support, however, SNV Nepal is discussing the possibility with its government that funds might be provided to support a second phase of the project. Even if these discussions are successful they will in any case not provide a sustainable support base for LALS and its harm reduction activities. There have in addition been problems in sustaining a stable and skilled management structure within LALS.

While UNAIDS has described the LALS prevention programme as one that is illustrative of the manner in which harm reduction can work, its survival is on the basis of this series of events, quite uncertain. The Director of the National Centre for AIDS and STD Control expressed the view that the closure of LALS would be both painful and regrettable given its achievements and international standing.

It would seem important for Nepal to make it a priority to secure new and sustainable funding for LALS and to consider expanding its role to one of a national training centre in harm reduction. LALS has played an important role in advocating for harm reduction policies and practices in Nepal. Government could helpfully formalize this role.
C. The HIV/ AIDS Epidemic in Nepal

C. 1 HIV/ AIDS Data

C.1.1 Cumulative HIV & AIDS Incidence

<table>
<thead>
<tr>
<th>Date</th>
<th>Males</th>
<th>Females</th>
<th>Total HIV *</th>
<th>AIDS (M/F)</th>
<th>AIDS Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 January 1999</td>
<td>811</td>
<td>395</td>
<td>1206</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>31 March 1999</td>
<td>860</td>
<td>402</td>
<td>1262</td>
<td>-</td>
<td>213</td>
</tr>
<tr>
<td>30 April 1999</td>
<td>870</td>
<td>406</td>
<td>1276</td>
<td>160/94</td>
<td>254*</td>
</tr>
</tbody>
</table>

C.1.2 Cumulative HIV Infection by Sub-Group and Sex

<table>
<thead>
<tr>
<th>Sub-groups</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex workers (SW)</td>
<td>306</td>
<td>306</td>
<td></td>
</tr>
<tr>
<td>Client Sexually transmitted Disease</td>
<td>701</td>
<td>15</td>
<td>716</td>
</tr>
<tr>
<td>Housewives</td>
<td>78</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td>Blood Transfusion/ Transplant</td>
<td>/1</td>
<td>/1</td>
<td>2</td>
</tr>
<tr>
<td>Injecting Drug use</td>
<td>160</td>
<td>1</td>
<td>161 **</td>
</tr>
<tr>
<td>Perinatal transmission</td>
<td>8</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>870</td>
<td>406</td>
<td>1276</td>
</tr>
</tbody>
</table>

C.1.3 Cumulative HIV Infection by Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 Yr.</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>6-13 Yr.</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>14-19 Yr.</td>
<td>54</td>
<td>129</td>
<td>183</td>
</tr>
<tr>
<td>20-29 Yr.</td>
<td>529</td>
<td>213</td>
<td>742</td>
</tr>
<tr>
<td>30-39 Yr.</td>
<td>232</td>
<td>50</td>
<td>282</td>
</tr>
<tr>
<td>40-49 Yr.</td>
<td>40</td>
<td>7</td>
<td>47</td>
</tr>
<tr>
<td>50 yr. &amp; above</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>870</td>
<td>406</td>
<td>1276</td>
</tr>
</tbody>
</table>
C. 1.4 Detection of HIV Infection by Year & Sex

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Sample Tested</th>
<th>Total HIV Infection Male</th>
<th>Total HIV Infection Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988</td>
<td>9,016</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>1989</td>
<td>59,180</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>1990</td>
<td>8,619</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>1991</td>
<td>17,000</td>
<td>12</td>
<td>14</td>
<td>26</td>
</tr>
<tr>
<td>1992</td>
<td>33,995</td>
<td>39</td>
<td>38</td>
<td>77</td>
</tr>
<tr>
<td>1993</td>
<td>38,228</td>
<td>41</td>
<td>40</td>
<td>81</td>
</tr>
<tr>
<td>1994</td>
<td>16,523</td>
<td>18</td>
<td>22</td>
<td>40</td>
</tr>
<tr>
<td>1995</td>
<td>21,867</td>
<td>71</td>
<td>39</td>
<td>110</td>
</tr>
<tr>
<td>1996</td>
<td>10,457</td>
<td>50</td>
<td>85</td>
<td>135</td>
</tr>
<tr>
<td>1997</td>
<td>9,475</td>
<td>394</td>
<td>95</td>
<td>489</td>
</tr>
<tr>
<td>1998</td>
<td>39,611</td>
<td>166</td>
<td>54</td>
<td>220</td>
</tr>
<tr>
<td>Total</td>
<td>1573,971</td>
<td>796</td>
<td>393</td>
<td>15189</td>
</tr>
</tbody>
</table>

C. 2 HIV Infection among Drug Users

13% of HIV cases to date are attributable to drug use. However, the recently implemented rapid assessment suggests that the sero-prevalence may now be as high as 45%. This is viewed as extremely worrisome to officers in the Ministry of Health. The projected true number of persons infected with HIV was 27,000 by end of 1997.

C. 3 HIV related Legislation, Policy & Planning

C.3.2 Strategic Plan for HIV and AIDS in Nepal, 1997-2001

The issue of drug use as it relates to HIV transmission is addressed within the Strategic Plan for HIV and AIDS in Nepal, 1997-2001. This plan provides a broadened view of the determinants of HIV vulnerability. It points out that strategies focussing on individual behavioural change are limited in their vision and in their likely impact in preventing or containing HIV transmission. It raises the issue of systemic factors that lay the foundation for HIV vulnerability including the “values of the economic, educational, cultural, social, Legal and political systems which structure the world, within which HIV is transmitted and within which the epidemic has its impact.” While these matters “cannot all be addressed given the limits on resources, this does not mean these factors cannot be changed through public policy”, adds the report.

Concern is expressed that “many activities have been established without much thought being given to sustainability with obvious consequences for development and maintenance. Furthermore, there is weak monitoring and evaluation”. Comment is made on the importance of building the conditions for comprehensive collaboration both within the NGO community and between government and NGOs. This requires among other things a substantial strengthening of the capacity of the NCASC and improved coordination of NGO planning and activity.

The plan proposes that institutions for drug treatment be strengthened and that policy development includes:

- Strengthening access to drug treatment and rehabilitation for IDU;
- Provision of sterile needles and syringes to IDU through NGOs;
- Including strategies for preventing initiation to drug use through school curricula;
- Reviewing the legal context of illicit drug use in relation to HIV prevention activities.

Institutional strengthening activities proposed are as follows:

- Expansion of counseling services for drug treatment and rehabilitation;
- Encouraging peer education for drug users;
- Involving the Sports Council in prevention activities;
- Training police officers to refer IDU to NGOs involved in prevention, care and support for IDU;
- Convening a legal workshop to examine the legal aspects of current Nepali law for HIV prevention efforts with a view to reforming the law in a manner that can facilitate HIV prevention as opposed to current emphasis on the punishment of those who use and/or traffic drugs;
- Assessing the adequacy of current HIV counseling and testing services;
- Strengthening training programmes for counselors addressing issues pertaining to the specific problems of female IDU who are also CSW.

UNAIDS, WHO and UNDP supported the NCASC in developing this plan. UNDCP was not involved. Nor was the Ministry of Home Affairs.

C. 4 Responses from the UN & NGOs

C.4.1 UN Theme Group on HIV/ AIDS

The recently appointed Chairman of the Theme Group on HIV/ AIDS in Nepal advised that the Theme Group on HIV/ AIDS could not be said to be making good progress at present. He added that the Theme Group has not as yet considered “big picture” matters and that the process needed a lot of life breathed into it if it is to have an impact. The Chairman observed that it will be important to fill the recently vacated CPA in order to move UNAIDS activities along.

The Chairman put the view that enhanced attention needs to be placed on several fronts to move the HIV prevention agenda along. Firstly, there is a need for better quality information on the situation nationwide. To this end, the National Centre for STD and AIDS Prevention recently undertook a rapid assessment of drug use and HIV risk. This consisted of the following information sources:

1) Focus groups involving people who use drugs
2) Key informants
3) Survey of drug users
4) Literature review

However, concern is expressed that the quality of the data collected is not to a standard that will allow reliable and valid conclusions to be drawn nor guide planning.

The Chairman suggested the need for information on best practice strategies that have been found to be important in preventing HIV epidemics. The Chairman observed that “we have workshops coming out of our ears” when what is needed is a lot of homework and door knocking”. To this end, The Chairman and the WR/ WHO, plan to visit the Secretary of the Ministry of Home Affairs and put forward arguments for a more proactive response from the government in relation to HIV prevention.
The Chairman suggested that a video on HIV prevention would be more effective in persuading decision-makers on the need for policy reform than a written report.

C.4.2 Information, Education & Information Strategies

The writer was unable to gain a clear understanding of what has been done in the area of IEC in Nepal as it pertains to drug use and HIV vulnerability. However, it appears from the responses of key informants that those who use drugs generally possess inadequate information and understanding of the health risks associated with drug use, be they related to unsafe drug injection or to unsafe sex. The Master Plan (1992) made the following observations on Preventive Education and information

Preventive education and information have been pursued by both public bodies and agencies and nongovernmental organisations. Public information has concentrated on creating awareness using television, radio, newspapers and magazines, whereas the non-governmental organisations have focused on seminars, workshops and campaigns directed, at least partly, at specific audiences. There is reason to believe that these approaches have been reasonably effective in view of the evidence presented by the development of the heroin epidemic.

Nevertheless, preventive education is not yet part of the general curricula in secondary-and post-secondary educational institutions, medical schools or non-formal education programmes.

Also prevention programmes aimed at particularly vulnerable groups, including parents groups, are conspicuously absent from existing programmes. Most important, however, is a general lack of a policy in this vital area and of a more systematic approach including evaluations of the impact of particular programmes.

Government is aware of these gaps as planning a range of activities to raise awareness both in the community and within government, on HIV/AIDS.

C.4.2.1 Promotion of Safer Sexual Behaviour through increased Awareness

The provision of “appropriate information” on HIV/AIDS and STDs is seen as a constitutional right of all citizens (Shrestha, 1999). It is planned that AIDS and STD education will be provided from lower secondary level grade 6 to grade 9. Education on AIDS and STDs will be provided to students in grade 10 and above as well as in Technical and vocational colleges. The Ministry of Education will request all universities to include HIV/AIDS and STD education in their curriculum. HIV/AIDS and STD topics will also be incorporated into textbooks, training manuals, guidebooks, and other instructional materials in all learning institutions, Ministries, departments, offices and training centers. The messages on HIV/AIDS/STD prevention will be included on cigarette boxes, Bidi, Match boxes, Alcohol containers, Tea containers, Soaps labels, etc., to create public awareness (Shrestha, 1999). HIV/AIDS awareness has also been promoted through seminars and workshops for parliamentarians, local leaders, bureaucrats, teachers, social workers and volunteers.

Mass media will be utilised to create awareness on AIDS and STD. Importantly, the National Center for AIDS and STD Control will be given responsibility for quality control for all kinds of information, education and communication materials before they are printed, published, staged, broadcasted, aired and disseminated, with a view to better ensuring that the people are provided with “correct, simple, true, and relevant messages” (Shrestha, 1999).

The emphasis in HIV prevention in Nepal appears to be on information and awareness, which presents reason for concern. It appears that some key decision-makers may believe that knowledge is sufficient to change drug use and sexual behaviour. In relation to the risk of HIV transmission through injecting drug use it is observed:
"It is, therefore, necessary to launch the awareness activities among the addicts including IDUs about the
demerits of drug abuse and sharing common needles and HIV/AIDS."

C.4.3 Outreach, Peer Education & User Self-Organizations

There are no policies on peer education, outreach work and user self-organizations in Nepal and
these strategies do not appear to have been actively considered for adoption. There are no
government operated or government funded peer education, outreach or drug user self-
organizations. There are however examples of peer education and outreach work being
undertaken in Kathmandu by LALS, in Pockhara by INF and in Dharan by KYC.

Police are very supportive of the outreach work that is being carried out in Dharan. However,
there is a perception that Police in Kathmandu are not necessarily supportive of this aspect of the
work undertaken by LALS and that they may sometimes place barriers before those undertaking
HIV prevention work.

In an effort to overcome these difficulties, staff of LALS have provided Police with training on the
rationale and importance of public health responses to drug problems. The Strategic Plan for HIV
and AIDS in Nepal, 1997-2001 places emphasis on these strategies as a means of reducing HIV
transmission among and beyond people who use drugs.

C.4.4 Drug Substitution Treatments

C.4.4.1 Legal & Policy Situation

The legal situation pertaining to the use of methadone or other opioids for the purposes of drug
substitution treatment, is unclear. While some government officials believe that the use of drug
substitution treatments is not sanctioned by the government of Nepal at present, the law is silent
on this matter. The Narcotic Drugs (Control) Act, 2033 (1976) is the legislation that is relevant to
this matter. This law makes no specific reference to methadone treatment. However, there are a
number of sections which give reason to conclude that MMT is legally sanctioned and legitimate
practice for the purposes of medical treatment and scientific investigation in Nepal, consistent with

Chapter 1, Section 3, Definitions, sub-section (7) refers to a “narcotic drug” meaning “any natural
or synthetic narcotic drug or psychotropic substances and their salts and other substances as
may be specified by HMG by a notification published in the Nepal Gazette, from time to time.
Chapter 2, Section 6, Prohibition not to be applied to HMG: makes reference to the legality of
using narcotic drugs for purposes of medicine or scientific research. Chapter 2, sub-section 23
makes reference to the governance of any such medical use under the auspices of the Medicine
Act, 2035

A senior officer from the Ministry of Home Affairs suggested that the Medical Council of Nepal
may not support methadone substitution, however, the writer was not able to verify this
proposition.

It is of relevance to note that the National Drug Demand Strategy of Nepal has as an indicator of
“…appropriate and affordable services of treatment and rehabilitation: 50% of hard core and
chronic addicts will avail of methadone and other drug substitution therapy in the mental hospital.”
The inference one might safely draw from this is that government policy is generally supportive of
methadone substitution treatment.
C.4.4.2 Access to Methadone Maintenance Treatment

A small methadone maintenance treatment programme has been operating out of the outpatient services of the Mental hospital in Kathmandu, since 1994. At present, there are about 100 patients on the programme. A senior psychiatrist established and continues to manage the programme.

The programme has been well accepted by patients and the doctor in charge feels that the programme now needs to be extended in capacity in Kathmandu and also in other parts of Nepal. However, the government has signaled its wish that the programme first be independently evaluated by an international agency such as WHO or UNAIDS.

In response to specific questions, the following situation is apparent in relation to opioid substitution treatment in Nepal: Government policy is supportive in a limited and non-formalized sense, but there is no written policy on the matter. There are no laws that specifically prohibit the use of methadone or other opioid substitution treatment. While methadone is only used in one location in Nepal, from an outpatient programme operated from the Mental Hospital in Kathmandu, buprenorphine has been offered in the context of supported drug withdrawal and in a limited sense in the context of a maintenance programme, in Pokhara.

The latter programme is provided by an INGO. There is some support for the expansion of MMT into other regional and rural areas of Nepal where opioid dependence is substantial in prevalence.

C.4.4.3 Cost of Methadone & Buprenorphine treatment

In the year April 1998-March 1999, 30 bottles containing 25,000 tablets of 40 mg strength have been used in the treatment of about 100 patients. The actual cost of this medication was US$4,000 (US$0.16/day) and the costs have been more than covered by patient payments of Rs.20/day (about US$0.30/day). The government purchases its methadone supplies from Switzerland through the local WHO office, utilizing the WHO Regular Country Budget. The price paid is more than two times greater than that which available from other sources.

The average dose of methadone administered each day is 40 mg. Some receive only 20 mg and appear to be doing quite well. A small number receive doses of up to 80 mg. There has been some discussion as to whether the doses that are being prescribed are sub-optimum. Drop-out rates have been higher than in some programmes internationally but treatment retention is still quite good. Unsanctioned use is thought to continue in about 30% and once again, this is quite within the range that might be expected. It is possible however that treatment is still not as yet optimized in terms of dose for some, perhaps many patients. Ancillary services and enhanced counseling and other support from staff might also contribute in this regard, but that is conjectural. These would be important questions for exploration should an evaluation of the programme be undertaken.

Buprenorphine costs about Rs.4 (US$1.00 ~ Rs. 66.7) for a 0.2 mg tablet, and the average dose used is 2mg (this is the price to patients if purchasing from a pharmacy). A minimum effective dose may be around 8-16 mg/day (buprenorphine has a long elimination half-life and may be administered second or even third daily if the dose is adequate: 16-32 mg).

This would place a minimum effective dose at around Rs.160-320, making it 12-24 times as expensive as methadone purchased from Switzerland. (methadone can be purchased at a lesser cost from other countries). Buprenorphine injectable (0.3 mg) costs the government ~ Rs. 10 while its price on the black market may range from Rs. 70-100. This is now the drug of choice on the illicit market. 90% of patients on the MMT programme give histories of buprenorphine rather than heroin use prior to entering treatment.
There is local pharmaceutical manufacturing capacity in Nepal - the Royal Drug Laboratory. This laboratory manufactures codeine-based liquids and tablets ephedrine and certain antibiotics. Methadone is not technically difficult to manufacture and there is no patent, so in theory, it could be produced locally at lesser cost to the government and with a saving on precious foreign reserves.

C.4.5 Needle & Syringe Exchange & Availability

C.4.5.1 Drug Injection Risk Practices

Administration by injection and sharing of drug injection paraphernalia is, as mentioned above, commonplace in Nepal. These practices place many people who use drugs and their sexual partners, at high risk of HIV infection.

C.4.5.1.1 Methods of Needle & Syringe Decontamination

An attempt of sorts may be made to clean contaminated syringes with water, sputum or urine. Few drug injectors appear to have sufficient knowledge, personal skills and access to practical means of effectively cleaning used drug injection equipment. The legal and policy environment is also not conducive to strategies aimed at promoting access to sterile needles and syringes and effective cleaning of used injection equipment.

C.4.5.2 Legal & Policy Situation Regarding Injection Equipment

As noted above, there is no specific mention within the law to needle and syringe exchange (NSEP). The possession of a sterile needle and syringe is not in itself an offence, however, some respondents suggested that Police may sometimes arrest people found in possession of injection equipment. These reports could not be verified.

There is no specific government policy on NSEP. The LALS programme has a policy of one for one exchange but does not adhere rigidly to this policy. The actual return rate is estimated to range from 50% to 65%. Staff endeavor to meet the preferences among clients for injecting equipment as much as they are able, within the limitations of available resources. Female IDU remain largely hidden and are not accessing these services.

C.4.5.3 Access to sterile Injection Equipment

Pharmacists are often unwilling to sell needles and syringes to people whom they believe use illicit drugs. Others are reported to sell needles and syringes at inflated prices. A one ml plastic disposable needle and syringe costs Rs. 10-15, which is expensive given average earnings. People who use drugs will always prefer to expend such sums on the drug itself rather than on sterile injection equipment.

There is differing opinion as to whether pharmacies are lawfully able to sell sterile needles and syringes to people who intend to use them for the purposes of unsanctioned drug injection. It may be that it is not widely known that there are no paraphernalia laws in Nepal. However, there may be a professional code of conduct, which precludes such action. In the absence of alternative means needle and syringe availability, it is often very difficult for people to obtain sterile needles and syringes. Once again, that drug use is in itself an offence could be taken to mean that any action, which is seen to encourage, or facilitate illicit drug use including safer drug use, is illegal.
There are two needle and syringe exchange programmes in Nepal – one operating out of LALS in Kathmandu and a second operating out of INF in Pokhara. The Pokhara exchange is not officially recognized and it was suggested by some that it is better to avoid speaking publicly about this service, lest it attract attention and force the government’s hand in closing the service. Services at LALS and INF are only open during the business hours of 9 a.m. – 5 p.m., Monday to Friday. This means that IDU must plan ahead and ensure that they obtain their supplies during these hours. Forward planning is not a behavioural trait that is commonly exhibited by people who are drug dependent and living a disorganized way.

Some government officers expressed their concern that needle and syringe exchange is problematic because:

"….drug users will sell the needles and syringes that they obtain from these services".

In summary, while needles and syringes might be said to be available in urban and provincial (but not rural) settings in Nepal, they do not appear to be accessible in the broadest sense of the meaning of the term. This would serve as a substantial disincentive to the use of sterile needles and syringes and would add to HIV vulnerability. In many circumstances, people are simply unable to access sterile needles and syringes regardless of any intentions they may have to avoid using or sharing contaminated injection equipment.

D. Reducing Risk of HIV Infection among Drug Users: Policy & Practice

D.1 Planning Commission, HMG Nepal

Current government priorities in health reform are focussed on developing primary health care services, addressing communicable diseases and improving hospital services. It is conceded that government has not as yet examined the interface between empirical evidence and policy decision-making in any focussed or detailed manner. Government is generally more responsive to the “demands” and “wishes” of its citizens. There are no processes by which government policy is reliably guided by best available scientific evidence. There is no system whereby research is undertaken to inform decision-makers. However, there is a government coordination committee mechanism through which reports can be received and discussed. Government is said to be receptive and willing to discuss new ideas, although progress may be slow. To this end, a view was expressed that technical assistance from UNAIDS would be welcomed above financial assistance at this stage. However, it was recognized that others may not view matters in this manner.

Nepal recently had a general election and many changes within government ministries and departments will follow, should there be a change in government. Independently of this election, substantial turnover at Secretary level is occurred in many ministries just prior to the election and this could also be expected to change the government decision-making landscape considerably.

E. Role of the Primary Health Care System in Addressing Alcohol & Other Drug problems

The primary health care sector does not play any substantive role in the prevention or treatment of alcohol and other drug problems in Nepal and there are no plans to build such capacity at present. However, LALS does provide primary health care services of a minor nature as part of its outreach work. It also refers people to primary and secondary health care services as appropriate to the circumstances.
E.1 HIV/AIDS Prevention through Community Level Mobilisation

Effective mobilisation of the local institutions (Village Development Committee and District Development Committee) is seen as essential by government:

“because these agencies are working in the development and social arena of the grass-root level. These agencies can mobilise local leaders, social volunteers and local NGOs to aware the people against the drug use and HIV/AIDS. We have experienced that the results so far found are encouraging where the HIV/AIDS programmes were implemented in collaboration with local institutions.”

Increases in the number of people with HIV/AIDS is already placing pressure on health care services which are not geared to provide the necessary services. There are limits in terms of the availability of diagnostic facilities, trained personnel and other medical services in both urban and rural settings.

F. The Concept & Jargon of Harm Reduction

Senior officers in government in Nepal are said to react to the terms “harm reduction” and “harm minimization” in different ways. Some react quite adversely. Many believe the terms refer only to drug substitution treatment and needle and syringe exchange programmes. It was suggested that it is important that they be educated that the term refers to strategies that go beyond this.

F.1 Government Position in Relation to Harm Reduction

To reduce the transmission of HIV through instruments/equipment, sterilization and safer injecting practice will be promoted. NGOs will also be encouraged to carry out such activities among IDU. Condoms will be made widely available and accessible for HIV/AIDS and STD prevention. (Shrestha, 1999).

Notwithstanding, there is serious doubt about the effectiveness of harm reduction strategies within the Ministry of Home:

Some of the NGOs have introduced harm reduction activities for the drug addicts to prevent them from HIV/AIDS, hepatitis B and C through needle exchange and drug substitute programmes. The government has been closely watching the procedures and results of these programmes although these programmes have no any government approval. But it is found that in the absence of effective follow up, on going monitoring and evaluation, the programmes do not seem effective to discharge desired results – Shrestha, 1999

On the other hand, the Ministry of Home believes that law enforcement and interdiction are proving to be effective, although the precise outcome indicators to which this conclusion applies remain unstated.

It is believed that with the effective surveillance of law enforcement unit and seizures of drugs show that the trafficking of hard drugs in the kingdom is in the decreasing trends.

It is conceded that interdiction effort levelled against plant-based drugs is being circumvented by a reversion towards the use of synthetic drugs:
But the addicts have changed their habits towards the psychotropic substances and synthetic drugs due to its easy availability and cost involvement. His Majesty's Government of Nepal has banned some drugs under the Drug Administration Act and has regularised some of the drugs to be sold only under the prescription of the doctor from the limited drug stores.

The following observations (Shrestha, 1999) suggest government intends to pursue harm reduction activities and amend legislation and policy so these activities are sanctioned and supported by government. These activities will be closely monitored and evaluated, as is appropriate in the circumstances. This is signals pro-active intent to foster approaches that can provide health protection to the people of Nepal.

“Lack of effective monitoring, follow up action and evaluation mechanism on needle exchange and drug substitution programme, drug dependency of addicts remains continue thereby increases economic burden for the government. Therefore an effective monitoring and evaluation mechanism along with practically designed follow up action should be established while launching the harm reduction programmes. To regularise the activities mentioned above, necessary amendments on acts and regulation should be made.”

G. Drug Policy & Intervention Research

G.1 Key Research Questions Identified by Key Informants

Key questions asked by key informants included the following:

1) What is the best intervention strategy to prevent HIV infection among IDU?
2) What is the best way to sustain the discontinuance of drug use among IDU?
3) How might we best convince policy makers to support strategies that have been proved effective by scientific investigation?

H. Discussion

H. 1 Constraining factors

H.1.1 Gaps in the National Drug Control Policy of HMG/Nepal, 1996

The National Drug Control Policy of HMG/Nepal, 1996 is the current policy in Nepal. Unfortunately, this policy does not clearly describe the drug policies of Nepal. It is more a series of statements on some of the determinants and harmful effects of drug use, the sectors that have a role to play in addressing drug problems and the mechanisms of proceeding. Most of the goals that are as described are not really goals in a formal sense. They might be better described as areas in which certain outcomes are to be sought (goal areas).

7 This principle ought to be applied in relation to all drug policies and interventions including those in the areas of drug treatment and law enforcement.
A goal of “attaining a climate where the non-medical use of drugs is virtually non-existent” is one that has particular importance for policy development and planning. It would be of concern if this ideal were to inhibit the implementation of less ambitious but nevertheless important public health measures. In the context of the difficult economic and other social challenge in Nepal today, this goal would seem far distant, particularly in a local, regional and global environment where drug use appears to be increasing.

It would seem that although UNDCP was able to provide substantive technical support to the government in developing these policies and its associated strategy, there is not as yet sufficient technical and financial capacity within the country to implement these policies and strategies.

H.1.2 Clarification of the Legal status of possessing Needles and Syringes

As noted above, Police Officers may sometimes arrest persons found in possession of a needle and syringe on the basis of a argument that since the use of a narcotic drug is illegal, the possession of a needle and syringe can be seen to aid and abet this illegal act. However, this argument is not supported in law by paraphernalia provisions and could not in any case be verified. This uncertain legal situation merits close attention by government. The best solution in terms of facilitating the development of strategies which can serve to reduce HIV vulnerability among people who use drugs would be to repeal the law which renders drug use illegal. Possession of drugs could remain an offence without interfering with benefits that would arise with this change in law.

H.1.3 Government Outsourcing of Services to the Non Government Sector

The government has, as in many other countries, adopted a policy of outsourcing many of its programmes and activities to NGOs and INGOs. This may be seen to offer a number of benefits, for example, it allows government to facilitate the implementation of politically controversial and sensitive programmes (such as needle and syringe exchange) while at the same time avoiding politically motivated controversy. NGOs can usually mobilize more rapidly and at lesser cost because they usually face less “red tape” in acting upon decisions.

On the other hand, a strategy of outsourcing may be associated with a number of undesirable outcomes. Governments adopting this strategy may lose their opportunity for ensuring that adequate, good or best practice interventions are implemented. Outsourcing may make it difficult to implement programs and activities to scale and in a sustainable manner. Outsourcing may foster a policy decision-making environment that avoids formal commitment to strategies, even if they have demonstrated public interest benefits. Many NGOs do not possess the necessary institutional and individual capacity to offer interventions in a manner that can make a public health difference. This is particularly true in the alcohol and other drugs arena internationally where so much of that which is offered is based on the opinions, values and beliefs of individual clinicians, administrators and entrepreneurs.

This is not to suggest that NGOs working in the drugs and HIV/AIDS areas are not often effective and are not important sources of service delivery. Clearly, they are in so many cases. However, it is to signal the need for the establishment of more comprehensive and analytical mechanisms for evaluating the technical and other competence of NGOs seeking to undertake the work that is tendered out. It may often be preferable to decline an offer of support from an NGO if its intentions are based on personal opinion, beliefs and values rather than empirically supported or plausible strategies, programmes and activities. Of course, in reality governments are reluctant to decline any offer of external support.
There are only a very limited number of NGOs working in the area of drug-related HIV prevention in Nepal: LALS and the MMT programme in Kathmandu, INF in Pokhara, Kamal Tigela Limbu (KTL) in Dharan. There are a larger number of NGOs working in the area of “drug demand reduction”. These NGOs offer a sound foundation for HIV prevention among people who use drugs. However, a closer engagement between government and these non-government and international non-government agencies would help maximize their collective input in a way that is not occurring at present. Review of certain laws and policies would also clarify matters and would be important in enabling these NGOs and INGOs to offer services that work best in preventing or containing HIV transmission.

H.1.4 Limited Models of Understanding & Responding to Drug Problems

Staff of one NGO expressed a belief that the essence of overcoming drug dependence is “will power” and self-confidence. Their programme incorporates many of the elements of an American-style therapeutic community, including confrontation, work therapy, recreational therapy, group counseling and individual counseling.

It is stated that “psychotherapy” is offered but staff are not formally qualified to offer such treatment. 8

While these views and these programme elements are commonplace in many countries, it is doubtful that these approaches actually help many people to stop using drugs in an enduring manner. Unfortunately, governments do not necessarily possess institutional capacity to challenge these assumptions. Rather, decision-makers invariably find these ideas appealing and perceive them to be intuitively correct. The result is that scarce resources continue to be invested in programmes that reach only a small number of people with drug problems and that enjoy only limited success in helping people to attain a drug-free treatment goal.

H.1.5 Criminalisation, Stigmatisation & Marginalisation of Drug Use & Drug Users

One senior Officer in Government explained that he perceived people who use drugs as criminals who are responsible for the dastardliest of acts in society. As such, they deserved to be severely punished. He viewed them as being more dangerous than a murderer and believed they should be imprisoned for lengthy periods without the option of early release. This view would be commonplace in many societies. It reflects the sense of moral outrage that invariably emerges in response to the crime against persons and property that is so commonly associated with the use or procurement of drugs.

The challenge for decision-makers in government is to consider firstly whether this response is one of a “downstream” nature and whether the focus on the individual as responsible for wrongdoing overlooks the “upstream” structural determinants of human behaviour. Punitive societal responses of this nature are likely to provide some people with a sense of moral satisfaction, however, they may be accompanied by no real advancement in addressing the underlying social maladies.

8 It is relevant to note that there is no evidence in the western research context that psychotherapy is effective in altering drug use behaviours, except where in the presence of mental co-morbidity that may respond to such treatment (e.g. depressive illness). This is not to suggest that the same findings will hold true in all socio-cultural contexts. However, it would seem prudent to beg the question.
Fear and punishment have been eschewed by those working in the HIV/AIDS area, given the lessons that have been learned about the counterproductive impacts of such approaches from a public health perspective. The challenge facing those working in the alcohol and other drugs area is to place the evidence before decision-makers and the community at large, demonstrating that these same principles apply equally to people with drug problems. While it is appreciated that the individual must take responsibility for their actions at some level, arguably, blaming, punishing, marginalising, stigmatising and criminalising people who use unsanctioned or illicit drugs is not a recipe for moving forward. More attention needs to be paid to establishing socio-political and economic environments that are conducive to healthful and socially desirable behaviours, if individuals are to have some chance of responding in accordance with these ideals.

H.1.6 Public Health Arguments in Support of Needle & Syringe Exchange

The public health rationale behind the distribution of sterile needles and syringes is not well accepted or understood by many senior officers in government. Rather, this approach may be seen as counterproductive. Alternatively, the arguments may be accorded low weighting in policy analysis and decision making. One government officer stated that he rejected the idea of sterile needle and syringe exchange and availability programmes:

“….because they share the needles that are given.”

Such thinking reflects how easy it is to analyse a problem in a superficial manner. While it is true that people who access needles and syringes through needle exchange, the reasons are many-fold and will likely include the fact that not enough sterile needles and syringes are able to be accessed and public policies and laws may make it dangerous from a law enforcement perspective for people to always use a sterile needle and syringe.

H.1.7 Ideal setting, Content & Optimum Duration of Drug Treatment & Rehabilitation Programmes

There is an untested assumption that drug treatment must always be provided in an institutional setting and that a longer admission is likely to be better than shorter admission in terms of treatment outcome (“more is better”). These assumptions do not accord with evidence that has amassed in both the highly industrialized nations of the world and in developing countries. The Government of Nepal might usefully revisit this issue in the context of its evaluation of progress to date and in its forward planning.

H.1.8 Can Drug-Free Treatment Help Prevent an HIV Epidemic?

It is often hoped that drug-free treatment programmes provide governments with a means of preventing a drug-fueled HIV epidemic. The international experience clearly indicates that they cannot. The universal experience with drug-free treatment approaches internationally is that they reach only a small minority of those with drug problems, manage only limited throughputs due to the long duration of programmes (2 years or longer in some countries), have high drop-out rates (when of a voluntary nature), and high relapse rates following treatment.

By way of example, a typical drug-free treatment programme might reach 5% of the in-need population in a city, in any one-year. 30-60% of these people might drop out of treatment before completion and 70-90% of those remaining in treatment would characteristically relapse within 3-6 months of their discharge.

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9 High perceived risk of being arrested for possession of needle and syringe
Taking a mid-point average of these figures provides for an outcome of only 0.5% of those in need being reached and remaining drug free at 6 months following treatment. Relapse rates experienced with involuntary treatment programmes are just as high or higher. Many report 90-100% relapse rates within 3-6 months of discharge from lengthy institutional rehabilitation.

This observation provides one of the more pressing arguments in favour of HIV prevention oriented programmes such as agonist substitution pharmacotherapies, peer education and programmes that facilitate access to sterile injection equipment. If the current state of knowledge, understanding and technology does not allow us to reliably help people stop using drugs and stay stopped, there are powerful public health arguments for doing what is possible to keep them safer, until and unless they are able to stop using drugs through natural processes of change and recovery over time.

There are few treatment programmes in Nepal. The Dharan situation provides a reasonable example of this mismatch between treatment ‘need’ and treatment provision. The rehabilitation center has only 10 beds and if it offers a 12-month treatment programme, it will only reach 15 people in any 12 month period (assuming a 50% drop-out rate). There is a waiting list for people wishing to enter this treatment setting and police say they could bring many people to the centre each day, if more beds were available. There are plans to double the current bed capacity of ten.

Contrast this with the findings of a random survey undertaken in 1997, which identified 2,450 persons in the Dharan area who use unsanctioned drugs. Many of these will not need or benefit from residential treatment. Indeed, many will benefit just as much from information, brief counseling and social support as they will from extended inpatient treatment. On the other hand, it is likely that this survey identified only a minority of those who use drugs, some of whom would benefit from specialized treatment.

The mathematics of the situation demonstrate very clearly that drug-free treatment models of the type commonly offered in so many countries in the world can exert but a very limited impact on HIV transmission in the absence of far broader ranging strategies which are based on sound health protection principles.

The Aasara drug rehabilitation programme in Kathmandu provides what is essentially an involuntary treatment programme although many young people are brought to the centre by their parents and admitted on a “voluntary” basis. In Nepali terms this treatment programme is very expensive – it costs more than the average per capita GNP for a three month admission and staff recommend longer periods of treatment.

“The time needed to fully cure addiction to drugs depends on the person’s condition and circumstances …. and normally it takes six to 18 months”.

This means that only those who can afford to pay the high cost can access this treatment programme. This is another example of a treatment model that offers limited hope to few and remains out of the reach of most. Of course, these comments must be tempered by an understanding of the economic limitations, which face the Nepali people in responding to problems of this nature.

To this might be added an observation that governments in developing countries might place most importance on identifying and implementing the most affordable and cost-effective approaches to drug problems that are available and discontinue or not start those that offer too little to too few.

The inevitable conclusion towards which one is drawn is that drug-free treatment is not a proven technology and as such, any programme of this nature should only be undertaken in the context of seeking to disprove a (“no treatment effect”) null hypothesis. On the basis of this same body of empirical evidence, health protection approaches might correctly be viewed as the mainstay of treatment and prevention strategy rather than as a hypotheses which remains to be disproved.
H. 2 Facilitators, Levers & Opportunities

H.2.1 Strengths of the National Drug Control Policy of HMG/Nepal

The National Drug Control Policy of HMG/Nepal, 1996 notes the challenge of addressing drug-related problems in an inter-sectoral manner, the need to address the harms associated with alcohol, tobacco and some medicinal drugs alongside those arising from the use of illicit drugs. It also notes that there has been a tendency to equate prevention with preventive education and that “reduction of harm, especially in the face of emerging threats such as AIDS, has failed to adequately enter the ambit of prevention.” These are important observations that deserve priority attention in future policy development and planning. These aspects of the policy provide opportunities and levers for action of a positive nature.

H.2.2 Importance of Structural Reform as a Basis for Change at the Population Level

Comment is made on the importance of building the conditions for comprehensive collaboration both within the NGO community and between government and NGOs. This requires among other things a substantial strengthening of the capacity of the NCASC and improved coordination of NGO planning and activity.

The plan proposes that institutions for drug treatment be strengthened and that policy development includes:

1. Strengthening access to drug treatment and rehabilitation for IDU;
2. Provision of sterile needles and syringes to IDU through NGOs;
3. Including strategies for preventing initiation to drug use through school curricula;
4. Reviewing the legal context of illicit drug use in relation to HIV prevention activities.

These strategies stand as important levers for change of a nature that can reduce HIV vulnerability in relation to drug use. Indeed, the proposal relating to review of the legal framework and provisions for responding to drug use as it impacts on HIV vulnerability would seem crucial, as are the proposals for advancing the strategies of peer education and needle and syringe availability.

However, a serious barrier to the advancement of these aspects of the National HIV prevention strategy would appear to be that their development did not involve key Ministries such as the Ministry of Home Affairs. These Ministries may not accept yet alone own these strategies. That is a serious deficit in this planning process, one that must be overcome as a priority by the government of Nepal.

H.2.3 Withholding Or Remitting Punishment For Minor And First Offences

The Narcotic Drugs (Control) Act, 2033 (1976) contains provisions for withholding or remitting punishment for minor and first offences (Chapter 2, sub-section 19). Similarly, other provisions (Chapter 2, sub-section 14 (Penalties), sub-sub-section (e), provide for a bond in place of imprisonment providing an undertaking is made to enter and remain in treatment for three months and for the treating agency to submit fortnightly reports on the individuals concerned.
These are commendable provisions. However, this does raise the question about why a second offence should be treated any differently than a first, or for that matter, a third offence. This provision is presumably founded on an argument of natural justice – that all human beings should be afforded a second chance providing there is no evidence of maleficence associated with their actions.

An underlying assumption may be that a warning such as this can act as an effective deterrent to further drug use. No doubt, it does in some cases. However, it is clearly not the case that deterrence-based strategies are effective in reducing drug use at a population level over even a limited period of time. The international experience certainly does not provide support for any such hypothesis. This reflects the complexity of the determinants of drug use and drug dependence. Drug dependence is by its very nature a chronic relapsing condition, not one that is readily addressed by processes of fear of negative consequences or deterrence. To add to the complexity, there is an over-representation of mental health problems among people who use drugs, adding further to the difficulty, indeed, unrealistic expectations of achieving ambitious drug-free outcomes in any society.

Of course, these are considerations that go well beyond the scope of this policy research project and cannot be effectively addressed in the limited context of any such project. Suffice it to say that there is increasing interest within law enforcement sectors in a number of countries in the idea of drug warnings and diversion to treatment, in lieu of harsh penalties for all.

H.2.4 Harm Reduction Interventions provided in the Context of Drug Rehabilitation

Admission to any drug treatment and rehabilitation programme affords an opportunity for the provision of key information and instruction on ways in which people who use drugs can minimize their risks for HIV infection.

Arguably, to miss this opportunity is to abrogate a key responsibility among drug treatment workers. This argument might be seen to hold true even in centres where a drug-free treatment goal is universally followed, given the observation that relapse rates are invariably very high among those entering such programmes.

One drug-free rehabilitation programme in Dharan offers such harm HIV prevention information and education as a component of its inpatient programme and within the community through peer support and outreach. Bleach and clean water are distributed. These outreach workers received training from LALS Kathmandu and at present are seeing 5-6 people who use drugs, each day. This is an important programme in as much as it offers a broader base of services to the community than just drug-free treatment alone.

H.2.5 When is it Necessary to Replicate International Research Findings?

The government of Nepal wishes to have an external independent review of its methadone programme before expanding the strategy in Kathmandu and in other parts of the country. This raises an important issue more generally. To what extent is it necessary to replicate research and evaluation of strategies such as methadone treatment, where these have been demonstrated to be effective and acceptable across numerous countries and cultures internationally, particularly in an environment where health resources are invariably so scarce?

Bearing this caution in mind, it would seem desirable that any evaluation that is to be undertaken in relation to MMT should focus on process, with a view to ensuring that the intervention is being implemented in a manner that is congruent with internationally demonstrated good clinical practice methodology.

For example, are the doses that are being prescribed adequate to suppress craving for additional unsanctioned opioid use? Are clinical responses empathic, non-judgmental, supportive and of a nature that engenders trust and confidence among patients?
Is treatment retention maximized by current clinical policies and practices? Is supportive
counselling available to those in crisis? Can and should counselling be made available as a core
component of the programme? If so, what are the technical, human and financial resource
implications?

The doctor who is in charge of the programme suggested that the focus of attention be on short-
term impact indicators, namely:

1) Unsanctioned drug use: measured through combination of self-report, collateral
   report, clinical examination looking for signs of drug use and urinalysis.
2) Social responsibility: measured through self-report and collateral report
3) Gainful employment
4) General health
5) Criminality

The cost of urinalysis may be the most expensive and difficult element of any evaluation and the
need for its utilization depends upon the purpose of any evaluation that is undertaken. If the
emphasis is to be on process evaluation and it is well understood by clients that there are to be
no negative contingencies for self-disclosure of unsanctioned drug use, self-report supplemented
by collateral report and clinical examination would be acceptable surrogate measures. It would
be important for those undertaking an evaluation of the MMT programme to ascertain the
requirements of decision-makers including the effect size that would be accepted as constituting
“effective” and “worthwhile” under what circumstances, before embarking upon any such
evaluation.

The methadone prescriber tentatively suggested that an effect size of 50% reduction in
unsanctioned opioid use would be viewed a worthwhile treatment effect. That is very reasonable.
He added that wives and mothers often asked him to put their husbands or sons back on
methadone because they fared so much better when in treatment previously. This is a low tech
but good surrogate indicator of treatment effectiveness in his experience.

The government might consider approaching WHO/ SAB and UNAIDS-APICT in a formal
manner, requesting technical support in undertaking a review of its methadone programme. This
represents an opportunity for advancing the implementation of HIV prevention policies and
strategies in Nepal.

H.2.6 Training & Ongoing Professional Development

There has as yet been little attention paid to training health care personnel in the area of drug
treatment. Some training was provided as part of the UNDCP Master Plan related projects. The
observation that staff are “burning out” suggests that training and ongoing professional
development would help and support staff in their often difficult work. This would provide an
important opportunity to introduce, enhance and strengthen HIV prevention interventions within
the context of drug treatment and rehabilitation programmes in Nepal. “Burnout” is often the result
of unrealistic expectations among staff in terms of clinical outcomes and the application of
inflexible clinical policies and practices which are inevitably associated with conflict and resistance
among patients. These are important issues for ongoing training, supervision and experienced
clinical mentorship in any drug treatment setting.
H.2.7 Investing in Health – Identifying Priorities for Action

The Chairman of the UN Theme Group on HIV/AIDS asked a very important question in relation to drugs policy and intervention – what level of resources should a developing nation invest in these matters when there are so many other fundamental health and development issues to be addressed?

What level of priority should be accorded HIV prevention among people who inject drugs in comparison with efforts to ensure adequate levels of sanitation, nutrition, housing, education, primary health care, access to safe water, high-level immunization coverage etc?

In response, one might suggest - lesser priority than in a developing country where these basic services are in place but sufficient priority to prevent drug-related HIV transmission from rising to the point where it one day places an additional and substantial health, economic and social burden on the country. While it is true that drug-related harm may in many countries be of far less importance than many other problems, the evidence that is available suggests that those countries which began early in the implementation of harm reduction strategies (before HIV sero-prevalence among IDU exceeded 5%) are those that have to date avoided a drug-related HIV/AIDS epidemic.

In response to this request, it is suggested that a copy of the recent WHO publication, *Drug Injecting and HIV Infection*, edited by Stimson, Des Jarlais and Ball (1998) be sent to the Chairman as a basis for discussion with Theme Group members.

It is important to add that failure to respond early and adequately to drug problems and HIV risk can lead to a reversal of the increase in life expectancy and development gains made over many years. Effective HIV prevention among people who use drugs and their sexual partners is not only a crucial public health issue, it is also a key development issue.

H.2.8 Unsafe Sex & Unsafe Drug Use in Prisons

A key informant from an NGO working in prisons observed that unsafe sex is a matter of substantial concern in the three prisons in which they currently work, adding however that there is no evidence that drug injection is occurring. Following extensive discussions between this NGO, government officers, condoms were made available in these three prisons. 1500-2000 condoms are distributed each month.

This is a commendable situation and if the reports of no injecting drug use have veracity, it augurs relatively well for avoiding or at least limiting any spread of HIV that might otherwise occur within these three prisons. However, the great majority of prisons do not allow condoms and the risk of HIV transmission appears real and substantial. The absence of drug injecting that is thought to exist in these three prisons may not exist in others in Nepal, but this is of course conjectural. Nevertheless, that health protection measures have been accepted in three prisons offers hope that these and other interventions might be introduced in all prisons and detention settings through appropriate intersectoral situational and policy analysis and planning processes.
Recommendations

It is recommended that:

1. The legal context of illicit drug use in relation to HIV prevention activities be reviewed, with a view to reforming the law in a manner that can facilitate HIV prevention as opposed to current emphasis on the punishment of those who use and/ or traffic drugs.

2. The provision in law which makes it illegal to use drugs might helpfully be re-examined in terms of its intent and the range of outcomes associated with its promulgation, with a view to its repeal;

3. The hazards and harms associated with alcohol be addressed in the context of the National Drug Demand Reduction Strategy and accorded more weight in policy development and action, based on local and international experiences and scientific evidence on what works best;

4. The legal situation regarding needle and syringe exchange and availability programmes and possession of needles and syringes be clarified and the situation made known to all in the government, non government, private, international aid agencies and general community sectors;

5. Government implement the proposal articulated within its Strategic Plan for HIV and AIDS in Nepal, 1997-2001 to provide sterile needles and syringes to IDU through NGOs;

6. Peer education for drug users be encouraged, facilitated and promoted in legislation, policy and practical support – for example, support of a technical and funding nature;

7. Training be provided to police officers by the Ministry of Health in collaboration with the Ministry of Home and NGOs that are active in the drugs and HIV prevention area, in the principle and applications of HIV prevention among injecting drug users;

8. Police officers be officially encouraged and supported in referring injecting drug users to government services and NGOs involved in prevention, care and support for IDU;

9. The capacity of the NCASC be strengthened (as noted in the Strategic Plan for HIV & AIDS) and that it pay increased attention to monitoring, evaluation and coordination of government and NGO planning and activity in the area of drug use and HIV vulnerability;

10. The specialized HIV/ AIDS sector be actively engaged in the development, review and reform of drug policy and planning in Nepal, with a view to ensuring that high priority is accorded to supporting HIV prevention approaches;

11. The Ministry of Home be actively engaged in the development, review and reform of HIV prevention policy and planning, with a view to ensuring that drug prevention and intervention is enabled while also ensuring that effective HIV prevention approaches can be implemented.

12. Government become actively engaged in the monitoring, evaluation and delivery of specialized alcohol and other drug treatment, counseling and support services, with a view to enhancing access to such services throughout the country;

13. The government formally request technical support from WHO/ SAB (Geneva) and UNAIDS-APICT (Bangkok) for an independent evaluation of the pilot methadone maintenance programme in Kathmandu;

14. That attention be paid to identifying alternative and sustainable sources of funding support for LALS in Kathmandu, that its mandate, roles and responsibilities be expanded to that of a national HIV/AIDS prevention training and policy advice & advocacy centre and that its capacity to provide practical HIV prevention education and practical support also be strengthened.
J. Documentation Referenced in Preparation of this Report

3. Medicine Act, 2035;
4. Narcotic Drugs (Control) Act, 2033 (1976);
7. Shrestha, KC, UNAIDS Inter-country Technical Workshop on Preventing Drug Use and HIV/AIDS, held in New Delhi on 1-4 June 1999;
9. Upreti, UNAIDS Inter-country Technical Workshop on Preventing Drug Use and HIV/AIDS, held in New Delhi on 1-4 June 1999;
10. The Master Plan of UNDCP for Drug Abuse Control in Nepal (1992);
   - Volume I: Main document;
   - Volume II: Sector Plan for Law Enforcement and legal assistance;
   - Volume III: Sector Plan for Treatment, Rehabilitation and other Demand Reduction Activities;
11. Maharjan, Shiba Hari, UNDCP Regional Office for South Asia, Drug Demand Reduction Report, New Delhi, 1998;

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**Narcotic Drug Abuser Reform Camp (AASARA)**
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Mr. Narendra Nath Bhattarai

**Police**
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Dr. Bill Piggot, WR

UNICEF
Mr. Stewart McNabb, OIC & Chairman, UN Theme Group on HIV/AIDS

UNAIDS
Dr. Amaya Maw Naing, Former CPA - telephone interview

LALS
Ms Sujata Rana, President
Ms. Manisha Singh (former Supervisor & Board member)
Freedom Centre
Father Bill Robbins

Wicom
Ms. Pradipta Upadhaya (prisons programme) – telephone interview

INF Drug Education Program, UMN, Pokhara
Klaasjan Pol, Manager