# “IN THE NAME OF CREATING DRUG FREE SOCIETY": A QUALITATIVE INVESTIGATION ON IMPLICATIONS OF DRUG LAW ENFORCEMENT ON HARM REDUCTION PROGRAMS AND PEOPLE WHO INJECT DRUGS IN KATHMANDU VALLEY NEPAL

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"การสร้างสังคมปลอดยาเสพติด" : การตรวจสอบเชิงคุณภาพเรื่องการบังคับใช้กฎหมายด้านยาเสพติดเกี่ยวกับโปรแกรมการลดอันตรายที่จะเกิดกับผู้เสพยาเสพติดชนิดฉีดในหุบเขากาฐมาณฑุ ประเทศเนปาล

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วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาสาธารณสุขศาสตรมหาบัณฑิต
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บิกัส กูรัง : "การสร้างสังคมปลอดยาเสพติด" : การตรวจสอบเชิงคุณภาพเรื่องการบังคับใช้กฎหมายด้านยาเสพติดเกี่ยวกับโปรแกรมการลดอันตรายที่จะเกิดกับผู้เสพยาเสพติดชนิดฉีดในหุบเขากาฐมาณฑุ ประเทศเนปาล (“IN THE NAME OF CREATING DRUG FREE SOCIETY": A QUALITATIVE INVESTIGATION ON IMPLICATIONS OF DRUG LAW ENFORCEMENT ON HARM REDUCTION PROGRAMS AND PEOPLE WHO INJECT DRUGS IN KATHMANDU VALLEY NEPAL) อ.ที่ปรึกษาวิทยานิพนธ์หลัก: ศ. ดร. ปีเตอร์ ซีนอล, 128 หน้า.

การตรวจสอบที่แตกต่างอย่างสิ้นเชิงกับปัญหาของการใช้ยาเสพติดในประเทศเนปาลโดยกระทรวงมหาดไทย บังคับใช้กฎหมาด้านยยาเสพติด ความผิดทางอาญาที่จะสร้างสังคมปลอดยาเสพติด ในขณะที่กระทรวงสาธารณสุขและประชากรสนับสนุน และรับรองนโยบายลดอันตรายที่เกี่ยวข้องกับการระบาดของเอชไอวี การศึกษานี้เป็นการศึกษาเชิงคุณภาพ เพื่อการสำรวจผลกระทบของการบังคับใช้กฎหมายด้านยาเสพติดต่ออุปสรรคในการเข้าถึงบริการเพื่อลดอันตราย การละเมิดสิทธิมนุษยชน และพฤติกรรมเสี่ยงในหมู่ PWID ในเดือนมิถุนายน พ.ศ.2559 มีการสัมภาษณ์เชิงลึกโดยมีผู้เข้าร่วมจำนวน 28 คน ได้ศึดษาเกี่ยวกับสี่ประเภทของประชากรที่แตกต่างกัน [ระดับนโยบาย (1) , โปรแกรมเกี่ยวกับเอชไอวีระดับชาติ (7) ระดับความอันตรายในการให้บริการ (5) และ ระดับชุมชน (15 ( ชาย -11 / หญิง -4 ) ) ] โดยใช้เทคนิคการสุ่มตัวอย่างด้วยค่าแปรปรวนสูงสุดได้ถูกนำมาใช้

กฎหมายยาเสพติดที่มีอำนาจสูงสุดได้ส่งไปยังหน่วยงานบังคับใช้กฎหมายและความหวาดกลัวต่อ PWID การละเมิดอำนาจดังกล่าวส่งผลให้ในช่วงของการละเมิดสิทธิมนุษยชน รวมทั้งการล่วงละเมิดทางเพศและความยุ่งยากทางการเงินที่ได้รับการฝึกฝนและเชื่อมต่อโดยเจ้าหน้าที่ภาคสนามและการบำบัดการติดยาอุปสรรคในการเข้าถึงบริการเพิ่มขึ้นทำให้การเพิ่มขึ้นของพฤติกรรมเสี่ยงในหมู่ PWID เพิ่มขึ้นเช่นเดียวกัน การบังคับใช้กฎหมายที่เกี่ยวข้องกับยาเสพติดราคาสูง ซึ่งมีความสัมพันธ์กับผู้ที่กระทำผิดทางอาญาและพฤติกรรมที่มีความเสี่ยง ผลการวิจัยชี้ให้เห็นว่าการผลักดันให้มีการบังคับใช้กฎหมายก่อให้เกิดอุปสรรคอันเนื่องมาจากการขาดความตระหนักและความล้มเหลวของข้อมูลในหน่วยงานราชการและหน่วยงานที่มีอำนาจบังคับใช้กฎหมาย ความรู้เกี่ยวกับการให้บริการการลดอันตรายส่งผลให้เกิดการเปลี่ยนแปลงในกิจกรรมการบังคับใช้กฎหมาย เช่น การแนะนำและบริการการบริโภคภายในห้องขัง การประสานงานอย่างเสมอต้นเสมอปลาย การตรวจสอบกลไกและการศึกษาสำหรับหน่วยงานบังคับใช้กฎหมายควรเริ่มทันทีเพื่อปรับปรุงสถานการณ์เลวร้ายของ PWID แต่การพัฒนาสุขภาพในระยะยาวของ PWID ไม่สามารถมองเห็นได้โดยปราศจากนโยบายที่ดีและการปฏิรูปกฎหมายที่ได้รับความยินยอมตามหลักสูตรโรงเรียนตำรวจและกฎหมายควบคุมยาเสพติดที่ผ่านมุมมองจากสาธารณสุข สิทธิมนุษยชน และการลดอันตรายตามหลักฐานวิธีการสร้างความมั่นใจในกระบวนการมีส่วนร่วม

สาขาวิชา สาธารณสุขศาสตร์ ลายมือชื่อนิสิต .....

ปีการศึกษา 2558 ลายมือชื่อ อ.ที่ปรึกษาหลัก .....

# # 5878817553 : MAJOR PUBLIC HEALTH
KEYWORDS: DRUG LAW ENFORCEMENT / HARM REDUCTION / PEOPLE WHO INJECT DRUDS / NEPAL

BIKAS GURUNG: “IN THE NAME OF CREATING DRUG FREE SOCIETY": A QUALITATIVE INVESTIGATION ON IMPLICATIONS OF DRUG LAW ENFORCEMENT ON HARM REDUCTION PROGRAMS AND PEOPLE WHO INJECT DRUGS IN KATHMANDU VALLEY NEPAL. ADVISOR: PROF. PETER XENOS, Ph.D., 128 pp.

Polar approaches to the issue of drug use endure in Nepal, where Ministry of Home Affairs (MoHA) enforces criminal drug law to create a drug free society, while Ministry of Health and Population (MoHP) advocates and endorses harm reduction policies to reduce drug-related harms and HIV epidemics.This study employs qualitative methods to explore the implications of drug law enforcement on barriers to accessing harm reduction services, human rights violations and risky behavior among PWID. In June 2016, 28 in-depth interviews were conducted with four distinct population categories [Policy level (1), national HIV program level (7), harm reduction service delivery level (5) and community level (15 (Male -11/Female -4))]. A maximum variance sampling technique was applied.

Drug law provided ultimate power to law enforcement authorities and concomitant fear to PWID. Abuse of such power resulted in range of human rights violations, including sexual harassment, brutal torture and financial hassle practiced by nexus of some field authorities and drug rehabs, and increased barriers to accessing harm reduction services as well as increased risky behavior practices among PWID. Law enforcement implicated high drug price, which was associated with delinquent activities and risky behavior. Findings suggested most of the law enforcement related impediments were occurring due to lack of awareness and failure in flow of information within government agencies and law enforcement authorities. Knowledge of harm reduction services resulted in changes in law enforcement activities such as referrals and service intake inside custody.Consistent coordination, monitoring mechanisms and education for law enforcement authorities should be initiated as an immediate response to improve the dire situation of PWID. But the long-term health development of PWID cannot be envisaged without favorable policy and law reform around age of consent, police academy curricula and drug control law through the perspective of public health, human rights and evidence-based harm reduction approaches ensuring a participatory process.

Field of Study: Public Health Student's Signature .....

Academic Year: 2015 Advisor's Signature .....

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# ABBREVIATIONS

| | |
|---|---|
| AIDS | Acquired Immune-deficiency Syndrome |
| ART | Anti-Retroviral Therapy |
| ATM | Automatic Teller Machine |
| CBS | Central Bureau of Statistics |
| CBT | Computer Based Training |
| CCC | Community Care Centre |
| DIC | Drop-In-Centre |
| DIGP | Deputy Inspector General of Police |
| DVT | Deep Vein Thrombosis |
| FDDR | Federation of Drug Demand Red |
| HBV | Hepatitis B Virus |
| HCV | Hepatitis C Virus |
| HIV | Human Immune-deficiency Virus |
| HTC | HIV Testing and Counseling |
| IBBS | Integrated Bio-Behavioral Survey |
| MDG | Millennium Development Goal |
| MLM | Male Labor Migrant |
| MoHA | Ministry of Home Affairs |
| MoHP | Ministry of Health and Population |
| MSM | Men who have Sex with Men |
| NCASC | National Centre for AIDS and STI Control |

| | |
|---|---|
| NCB | Narcotics Control Bureau |
| NDC | Narcotics Drug Control Act |
| NDCLEU | Narcotics Drug Control Law Enforcement Unit |
| NEDUPA | Nepal Drug Use Prevention Association |
| NGO | Non-Governmental Organization |
| NSP | Needle and Syringe Program |
| NUNN | National Users' Network Nepal |
| OST | Oral Substitution Therapy |
| PWID | People Who Inject Drugs |
| RN | Recovering Nepal |
| SAARC | South Asian Association Regional Cooperation |
| SC | Save the Children |
| SSP | Senior Superintendent of Police |
| STD/STI | Sexually Transmitted Diseases/Infections |
| SWC | Social Welfare Council |
| TB | Tuberculosis |
| TG | Transgender |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNODC | United Nations Office on Drug and Crime |
| WHO | World Health Organization |

# CHAPTER I

# INTRODUCTION

## 1.1 Background

The health of populations is determined not by health sector activities alone but also by the policies and actions beyond the mandate of the health sector (World Health Organization, 2016). The health is concomitantly exacerbated in presence of any controversy between intersectoral approaches pertaining to dealing with a single problem. Such controversy of perspectives and approaches exist in Nepal regarding the issue of drug use, where Ministry of Home Affairs (hereinafter MoHA) enacts and enforces criminal law to create a drug free society, while Ministry of Health and Population (hereinafter MoHP) advocates and endorses harm reduction policies to reduce drug-related harms and HIV epidemics in the country (Narcotics Control Bureau Nepal, n.d.; National Centre for AIDS and STD Control, n.d.).

In Nepal, the law that has most relevance to legal response to drug use is the *Narcotic Drugs (Control) Act, 2033 (1976) (hereinafter NDC act or drug law)*. Chapter 3, Article 14(e) explicitly states drug use as illegal activity and subject to penalty and punishment ("Narcotics Drugs (Control) Act, 2033," 1976). Governed by the act, in 1992, a special team of trained police officer called Narcotics Control Bureau (NCB), formerly known as Narcotics Drug Control Law Enforcement Unit (NDCLEU) was established to enforce NDC law to combat drug problems in the country (Narcotics Control Bureau Nepal, n.d.).

Having had a long history of Cannabis from mythologies of Lord Shiva in Hindu religion, it is believed that its use became increasingly fashionable among adolescent, youth and students since early 1960s with the influx of hippies. Later during mid 60's and early 70's, Nepal realized drug use as a problem with entrance and incidences of orally (smoking or chasing) administered drugs like Brown sugar, morphine and other hard drugs. The drug law enforcement facilitated the shift in drug from smoking or chasing to psychoactive substances followed by Tidigesic, an injecting drug, during early 80's, as they were comparatively difficult to be detected by the law enforcement authorities. This shift from smoking to injecting drug led to the transmission of Human Immunodeficiency Virus (HIV) among people who inject drugs (PWIDs), which was for the first time identified in 1988 in Nepal (National Centre for AIDS and STD Control; Shrestha, 2011).

HIV prevalence among the PWIDs in Nepal was below 2% up to 1995. By 1999 the figure rose substantially to 40%. In Kathmandu Valley alone, the prevalence among the IDUs was around 1.57% in 1991 and within a decade it rose to a high prevalence of 68% in 2002 (National Centre for AIDS and STD Control, 2010). As of October 2004, the Ministry of Health and Population (MoHP) reported 4,354 HIV cases, 835 AIDs cases and 226 HIV related deaths (Lawyers Collective HIV/AIDS Unit, 2007).

As an emergency response, a short term AIDS control plan was devised in 1988, which was followed by a medium-term plan (1990-1992), long term plan (1993-1997) and strategic plan (1997-2001). During the process, NCASC proposed the need to integrate sterile needles to PWIDs through NGOs and review legal framework around illicit drug use. In October 2002, the MoHP formulated a

comprehensive five-year HIV/AIDS strategy (2002-2006), which for the first time amongst developing countries identified the significance of non-governmental organization (NGO) run harm reduction programs including needle and syringe program (NSP) for PWIDs (Lawyers Collective HIV/AIDS Unit, 2007). The strategy also recognized PWIDs as the population sub-group in which HIV threatened to rise most rapidly and expressed serious concern for need of intersectoral collaboration to effectively respond drug use and HIV (United Nations Office on Drug and Crime, 2005).

Through the focused effort of national HIV program, NGO-run harm reduction programs and support of different partners, Nepal successfully halted the HIV prevalence and significantly curtailed overall HIV epidemics but UNAIDS and SAARC report still shows significant gap in coverage and high prevalence of HIV within the population sub-groups (National Centre for AIDS and STD Control, 2010; SAARC, 2015; UNAIDS, 2014a, 2015). Yet the public health rationale behind the distribution of sterile needles and syringes is not accepted and conceived to be against law by many law enforcement authorities and senior officers in Ministry of Home Affairs. Instead, it is seen as counterproductive measure. As a result, these arguments are accorded low weighting in policy analysis and government (MoHA) continues to prioritize drug law enforcement over preventive or treatment-based responses to drug use. A study by UNAIDS and UNODC revealed that the specialized HIV/AIDS sector was not involved at any level in the development, review and reform of Narcotics Drug Control Act in Nepal and the converse also applies (UNAIDS & UNODC, 2000; Werba et al., 2011).

Nepal has made tremendous efforts in endorsing different evidence based policies, programs, strategies, and investments but the NDC act, which is the sole base for endeavors of drug law enforcement to combating drug use problem, remains punitive and unchanged. For harm reduction programs to work effectively an enabling environment is most - that is supportive initiatives from law enforcement and other concerned agencies (Law enforcement and HIV network, 2013). The polar contrast between the approaches of drug law enforcement and harm reduction programs has a serious risk to inaccessibility of health services, well-being of PWIDs and community as a whole (Maher & Dixon, 1999b).

It is not clear that the criminal law and its enforcement have played any substantive role in HIV prevention in Nepal. Rather, some aspects of the drug law enforcement has been fueling the HIV vulnerability among people who use drugs and their sexual partners (UNAIDS & UNODC, 2000).

**1.2 Rationale**

Most of my tasks on exploring existing literatures are carried out online and I did not find a single study that is specifically conducted around drug law enforcement and its implications in Nepal. However, I located some relevant papers on the issue that were conducted in countries in other regions of the world, which were specifically focused to police activities.

During my search, I found few studies conducted about a decade ago, that were related to NDC law and review of its development. Though these papers recommended need for intersectoral initiatives to effectively implement harm reduction programs, they failed to address adverse menace of enforcing the law to well-being of PWIDs. I also went through some of the service delivery level reports

on HIV programs, which addressed legal barriers in general or drug law enforcement in particular as one of the challenges in delivering harm reduction services. These reports just bulleted one sentence and did not discuss the breadth and depth of the implications of drug law enforcement.

Other existing studies on PWIDs or HIV services focused on the drug user as the unit of analysis, labeling drug use status, attitudes toward services, and individual conditions as factors in effective service delivery (Wolfe, Carrieri, Shepard, Carrieri, & Shepard, 2010). These researchers failed to understand that the situation of PWID or effectiveness of harm reduction programs in Nepal might be induced by systematic barriers rather than emerging from the individual.

Therefore, in contrast to the existing papers, this study sought to investigate the implications of the drug law enforcement in the three major areas - Barriers to access harm reduction services, Human rights violations and Risky behaviors among PWIDs.

**1.3 Research questions**

This study aims to be able to answer following questions:

- What implications do the drug law enforcement have on barriers to access harm reduction services among PWIDs?
- What implications do the drug law enforcement have on violations of human rights of PWIDs?
- What implications do the drug law enforcement have on risky behavior practices among PWIDs?

- Are there any implications of drug law enforcement other than that mentioned in the study?

**1.4 Objectives**

The general objective of this study is to determine implications of law enforcement on barriers to access harm reduction services, violations of human rights and high-risk behavior practices among people who inject drugs (PWIDs) in Kathmandu Valley in Nepal.

In order to achieve the general objective, following specific objectives are derived:

- To determine the implications of drug law enforcement on barriers to access harm reduction services among PWIDs.
- To determine the implications of drug law enforcement on violations of human rights among PWIDs.
- To determine the implications of drug law enforcement on risky behavior practices among PWIDs.
- To identify implications of drug law enforcement on areas other than that mentioned in the study.

**1.5 Conceptual Framework**

Based on the review of literatures, as many implications as possible were identified among which three major implications were prioritized specifically for this study. But any further implications that appear during the qualitative analysis of the interview transcripts will be considered as findings of this study.

| | | Implications |
|---|---|---|
| **Drug law enforcement (Police-based system: Narcotics Control Bureau)** | → | **Barriers to access harm reduction services**<br>**Human rights violations**<br>**Risky behaviors** |

**1.6 Operational Definitions**

Some of the key words or phrases that are building blocks of the study are defined as per the general definitions and following operational definitions are inferred as per the scope of this study:

*1.6.1 Drug law enforcement*

Law enforcement is any system by which some members of society act in an organized manner to enforce the law by discovering, deterring, rehabilitating, or punishing people who violate the rules and norms governing that society (New Law Journal, 1974).

For the purpose of this study, Drug law enforcement is defined as police-based system in response to illicit drugs that emphasize the imposition of criminal laws for drug use or consumption of cannabis and narcotic drugs as stated in the Narcotics Drug Control Act, 1976 (drug law) of Nepal. To be particular, Narcotics Control Bureau, a special team of trained police officers is the authorized drug law enforcement system to enforce the NDC act in Nepal. Through out the document, it is also termed as one of the following: NCB, law enforcement authorities, police, police department/administration.

*1.6.2 People who inject drugs (PWID)*

People who inject drugs refer to people who inject non-medically sanctioned psychotropic (or psychoactive) substances.

These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes (World Health Organization, 2015).

*1.6.3 Harm Reduction services*

According to UNODC, WHO and UNAIDS, the implementation of a 'comprehensive package' of nine interventions for the prevention, treatment and care of HIV among people who inject drugs is essential. This package of nine interventions are widely referred to as the 'harm reduction' approach – among which following five interventions are selected for the purpose of this study:

- Needle and syringe programs (NSPs) - access to clean injecting equipment.
- Opioid substitution therapy (OST) – e.g. Methadone Maintenance treatment.
- HIV testing and counseling (HTC).
- Antiretroviral therapy (ART).
- Vaccination (as available), diagnosis and treatment of viral hepatitis (HCV Testing).

(National Drug and Alcohol Research Centre, University of New South Wales, & Access Quality International, 2011; World Health Organization (WHO), United Nations Office on Drug and Crime (UNODC), & Joint United Nations Programme on HIV/AIDS (UNAIDS), 2009)

*1.6.4 Barriers to access*

Barriers to access can be defined as such factors that prevent an individual gaining access to health services. It may be physical, financial, geographical or legal barriers ("Access and barriers," 2012).

For the purpose of this study, only the barriers that are related to enforcement of drug law through NCB (police-based system) will be taken into consideration. As per the review of available literatures, these might be in form of fear of arrest, harassment, and incarceration amongst PWID due to law enforcement authorities' deterrence, police interference and scrutiny around the periphery of service delivery sites.

*1.6.5 Human Rights Violations*

Human rights violations occur when actions by state (or non-state) actors abuse, ignore, or deny basic human rights (including civil, political, cultural, social, and economic rights).

In this study, the scope of human rights violations refers to any physical tortures, compulsory detention, unfair trials, breach of confidentiality, discrimination, restriction of freedom of expression and denied access to health services faced or perceived by PWIDs as a result of enforcement of drug law on streets by NCB.

*1.6.6 Risky behaviors among PWID*

Risky behaviors are those that potentially expose people to harm, or significant risk of harm, which will prevent them reaching their potential (London Borough of Richmond upon Thames, 2014).

For the purpose of this study, risky behaviors refer to any behavior practiced by PWID that keeps them in potential exposure to HIV, HCV and any other diseases'

infection. Based on review of available literatures, these behaviors could be sharing of syringes, unsafe injecting attempts, repeated use of same syringes, unsafe shooting locations, shift from oral to injecting drugs and overdose.

# CHAPTER II

# LITERATURE REVIEW

## 2.1 Review of related literatures

### *2.1.1 Context*

The health of populations is determined not by health sector activities alone but also by the policies and actions beyond the mandate of the health sector. It is thus important for the health sector to work in collaboration with other sectors. A 'whole of government' approach to health works closely with other sectorial ministries such as home, finance, education, environment etc., to examine how their policies can help achieve their own objective while also improving health. Such intersectoral collaboration could lead to reduction of adverse consequences whereas if replaced by stark controversy could result more devastating ends (World Health Organization, 2016).



A key issue in shaping drug policies is the choice that has been posed between two targets: between the prevention of HIV transmission and the prevention of drug abuse. Preventing the physical disease of AIDS has now been given priority over concerns with drug problems. In this paradigm prevention takes on a new meaning - the key prevention task is not the prevention of drug use, but the prevention of HIV infections and transmission (N. McKeganey, 2011). This is one of the perfect contemporary instances of intersectoral controversy upon intersectoral collaboration experienced in most of the countries, including Nepal.

Nepal, in South Asia is one of the countries with such controversy regarding the approaches to deal with the issue of illicit drug use. This contrast exists between the Ministry of Home Affairs and Ministry of Health and Population, who are the two major government bodies responsible for shaping the drug and health related policies. The MoHA enacts and enforces criminal law to create a drug free society, while MoHP advocates and endorses harm reduction policies to reduce drug-related harms and HIV epidemics in the country (Narcotics Control Bureau Nepal, n.d.; National Centre for AIDS and STD Control, n.d.). Under MoHA, Narcotics Control Bureau (NCB) is established to prevent the drug use through demand and supply reduction strategies and MoHP appointed the National Centre for AIDS and STD Control (NCASC) to prevent harm through implementation of harm reduction programs. Senior officers of the Ministry of Home Affairs express 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). Though needle and syringe programs are not unlawful, it is considered as a means to promote or facilitate the use of illicit drugs. The public health rationale behind the distribution of sterile needles and syringes is not accepted instead, it is seen as counterproductive measure. As a result, these arguments are accorded low weighting in policy analysis and government (MoHA) continues to prioritize drug law enforcement over preventive or treatment-based responses to drug use. A study by UNAIDS and UNODC revealed that the specialized HIV/AIDS sector was not involved at any level in the development, review and reform of Narcotics Drug Control Act, 1976 in Nepal and the converse also applies (UNAIDS & UNODC, 2000; Werba et al., 2011).

*2.1.2 Narcotics Drug Control Act (2033), 1976, Nepal*

Addiction, described as *'the serious evil that states have the duty to prevent and combat'* in the Single Convention's preamble (United Nations, 1961), has led the overall development of most of the national narcotics drug control act including Nepal. From more than half a century, national drug control policies focus on supply reduction and law enforcement against any drug use, and people who use drugs are often collateral victims of those interventions trailed by long prison sentences, compulsory detention treatment and even death penalty. Though, in recent decades, people who inject drugs have been catered range of evidence informed intervention such as community based harm reduction services, they continue to face punitive legal environments, a variety of human right abuses and poor access to services escalating their risk of acquiring HIV and other blood borne viruses (UNAIDS, 2014a).

In Nepal, the law that has most relevance to legal response to drug use is the *Narcotic Drugs (Control) Act, 2033 (1976) (hereinafter NDC act or drug law)*. It was 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* (UNAIDS & UNODC, 2000).

The NDC act was subject to a comprehensive and important amendment in 1993. The Act was revised by the Ministry of Home Affairs and reviewed by the Ministry of Law. The amendment which came into force on 14 June 1993 included: (i) incorporation of the SAARC convention of 1992 on Narcotics Drugs and Psychotropic Substances; (ii) inclusion of the provisions of the 1961 Single

Convention (including the 1972 Protocol amending that Convention) and the 1988 UN Convention on Illicit Trafficking of Narcotic Drugs and Psychotropic Substances; (iii) legalization of controlled delivery; (iv) increased penalties for drug offences; (v) an asset seizure section; (vi) a section on money laundering (including a bank secrecy act); (vii) legislation of advanced investigation techniques and methods of gathering evidence such as wire tapping (including room and telephone bugging) and surveillance photography; (viii) authorization of Narcotics Drug Control Law Enforcement Unit (NDCLEU) to prosecute drug law offences; (ix) a reward scheme; and (x) the destruction of seized drugs (United Nations Office on Drug and Crime, 2005).

The NDC act prohibits cultivation, production, preparation, purchase, sale, distribution, export or import, trafficking, storing or consumption of cannabis and other narcotic drugs. Chapter 3, Article 14(e) explicitly states drug use as illegal activity and subject to penalty and punishment ("Narcotics Drugs (Control) Act, 2033," 1976). Addiction has been defined as an act of consumption of narcotic drugs in more than the dosage and quantity under the prescription of recognized medical practitioner or without the prescription of such medical practitioner. Consumption of cannabis is punishable with 1-month imprisonment or fine up to Nepalese Rupees (NRs.) 2,000. Consumption of opium, coca or any other narcotic drugs made therefrom is punishable with one-year imprisonment or fine up to NRs. 10,000. If a person becomes addicted to any natural or synthetic narcotic drugs and psychotropic substances, as notified by the government, s/he will be liable for punishment up to 2 months and up to a fine of NRs. 2,000 or both. However, it has been liberal with provisions for consumption of drug for medicinal purpose with prescription from

recognized medical practitioner, bond that replaces imprisonment with three month treatment in a treatment center in condition of submitting information fortnightly, withholding or remitting punishment for minor and first offences. (Lawyers Collective HIV/AIDS Unit, 2007; "Narcotics Drugs (Control) Act, 2033," 1976). Governed by the act, in 1992, a special team of trained police officer called Narcotics Control Bureau (NCB), formerly known as Narcotics Drug Control Law Enforcement Unit (NDCLEU) was established to enforce NDC law to combat drug problems in the country (Narcotics Control Bureau Nepal, n.d.).

*2.1.3 Drug Law Enforcement in Nepal*

According to the New Law Journal (1974), Law enforcement is any system by which some members of society act in an organized manner to enforce the law by discovering, deterring, rehabilitating, or punishing people who violate the rules and norms governing that society (New Law Journal, 1974).

Drug law enforcement is defined as police-based system in response to illicit drugs that emphasize the imposition of criminal laws for drug use and drug-related crime (cultivation, production, preparation, purchase, sale, distribution, export or import, trafficking, storing or consumption of cannabis and other narcotic drugs) ("Narcotics Drugs (Control) Act, 2033," 1976; Werba et al., 2011). The law enforcement response to the illicit drug use can vary as per the resources provided by the country. Traditional predictive policing is an effective way to get better results with fewer resources. While as new technology unfolds, law enforcement adapt techniques and amend policies to better serve and protect communities. Such technology may include crime mapping technology, lie detection developments, DNA

mapping, video surveillance systems, and continual training and education to law enforcement officials (Fortenbery & M.J.A., 2016).

Narcotics Control Bureau (NCB) is the authorized department as drug law enforcement authorities in Nepal. Formerly known as NDCLEU, it was instigated in June 7, 1992 with a vision to create a drug free society through effective control of drug supply. The initial structure comprised of 75 police personnel unit headed by Senior Superintendent of Police (SSP) with a concept of total integrated approach to combat drug problems in the country. Later on Nov 29, 2012 Deputy Inspector General of Police (DIGP) led the bureau with 102 specialist police officers of Nepal. NCB is governed by the Narcotic Drug Control Act (NDC Act) 1976. It also acts as a nodal unit to liaise with Drug Offences Monitoring Desk of South Asian Association for Regional Cooperation and other International Drug Law Enforcement Agencies with nine satellite stations spread across the country in all the five regions and major border checkpoints, including one in the international Airport (Narcotics Control Bureau Nepal, n.d.).



The NDC act has provided the NCB with special authority including control of Narcotic Drug Production, delivery and abuse; power to enter, search, seize and arrest without warrant; legal telephone tapping and censorship; punishment up to life imprisonment and confiscation of property; punishment to those who fail to cooperate by concealing particulars of document pertaining to narcotic drugs investigation; destruction of narcotic drugs; extra territorial applicability; reward to informers and investigators; exemption from punishment for any consequences that may occur out of good faith (Narcotics Control Bureau Nepal, n.d.).

The 2014 annual report of NCB proposed for increment of 156 new recruits on existing 102 Special Forces. It also recommended a continual capacity building training for the NCB team. During the fiscal year, major program and activities conducted by the NCB included basic trainings; Computer based training (CBT) on drug ID, drug testing, performing different search and assessment, undercover operations, risk management etc.; Education, awareness and interaction program; Internal coordination and collaboration with government and non-governmental organizations; International and regional coordination and information sharing; arrest and concealments; destruction of concealed or natural drugs; and drug use counseling. Furthermore, the comparison chart depicted an increasing trend of prosecution on drug offence (2163 in 2011, 2600 in 2012 and 2673 in 2013). As per the report, among the 16336 inmates in entire prison of Nepal, 15.3 percent (2487 inmates) were prosecuted for drug related offence (Narcotics Control Bureau Nepal, 2014).

*2.1.4 Harm Reduction Programs in Nepal*

Curtailing the rapid spread of HIV among drug-using population as well as preventing transmission to the general population has always been the primary goal behind every action since the beginning. In order to achieve these goals, according to UNODC, WHO and UNAIDS, the implementation of a 'comprehensive package' of nine interventions for the prevention, treatment and care of HIV among people who inject drugs is essential. This package – also widely referred to as the 'harm reduction' approach – consists of interventions for which there is a wealth of scientific evidence supporting their efficacy in preventing the spread of HIV:

***Comprehensive Package:***

- Needle and syringe programs (NSPs) - access to clean injecting equipment.

- Opioid substitution therapy (OST – e.g. Methadone Maintenance, Buprenorphine, Suboxone, Naltrexone...) and other drug dependence treatment.
- HIV testing and counseling.
- Antiretroviral therapy (ART).
- Prevention and treatment of sexually transmitted infections.
- Condom distribution programs for people who inject drugs and their sexual partners.
- Targeted information, education and communication for people who inject drugs and their sexual partners.
- Vaccination (as available), diagnosis and treatment of viral hepatitis (HBV, HCV).
- Prevention, diagnosis and treatment of tuberculosis (TB).

(National Drug and Alcohol Research Centre et al., 2011; World Health Organization (WHO) et al., 2009)

National Centre for AIDS and STD Control (NCASC), originally established as STD Control Committee in 1986 is a semi-autonomous government organization under the Ministry of Health and Population (MoHP) responsible for HIV/AIDS and STD control. Since the inception of the first AIDS control plan in 1988, there has been continuous development of national HIV/AIDS strategic plans. The 2002-2006 strategy identifies sex worker and their clients, PWIDs, mobile labor population, men having sex with men and prisoners as a 'nucleus' for a generalized epidemic. After NCASC commissioned situational assessment, it noted that sex workers and PWIDs

need treatment interventions and advocated for a rights-based strategy, keeping the increasing HIV infection among these two populations. Nepal is the first developing country to identify the importance of intervention among IDUs and implement the NGO-run 'Harm Reduction Programs' including needle and syringe program for PWIDs. (Lawyers Collective HIV/AIDS Unit, 2007).

The national HIV/AIDS strategy is a national guiding document and a road map for all the sectors, institutions and partners involved in the HIV response to meeting the national targets. The current strategy 2011-2016, therefore, builds two critical strategies as HIV prevention and Treatment, care and support to infected and affected. To ensure the achievements of program, crosscutting strategies are devised to support - creating enabling environment; health system strengthening; legal reform and human rights and community system strengthening; and strategic information. Specific package of harm reduction services are designed for different key populations keeping the variance in their characteristic and specific needs. In order to prevent HIV infection among PWIDs, evidence-based harm reduction program advocates lessening the harms of drugs through education, prevention, and treatment, enabling people to know their HIV status, HIV treatment and care, promoting and supporting condom use, detection and management of sexually transmitted infections, prevention and treatment of viral hepatitis, tuberculosis prevention, diagnosis and treatment and are linked with the specific programs like Needle and syringe program (NSP); Oral substitution therapy (OST); HIV prevention of Female who inject drugs; Advocacy for PWID rights and need with local law enforcement, health service providers and stakeholders; Identify and change policies and laws that restrict and hinder effective harm reduction program; Behavior change and communication

(BCC); condom promotion; aftercare services and linkage of harm reduction with drug detoxification services (National Centre for AIDS and STD Control, 2011).

*2.1.5 Situation of People who inject Drugs (PWID)*

People who inject drugs refer to people who inject non-medically sanctioned psychotropic (or psychoactive) substances. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes (World Health Organization, 2015).

The joint UNODC/WHO/UNAIDS/World Bank estimate for the number of PWID worldwide for 2013 is 12.19 million corresponding 0.26 percent of adult population aged 15-64 (United Nations Office on Drug and Crime, 2015). According to UNAIDS estimates, approximately 13 percent of PWIDs are living with HIV and 30 percent of the new HIV infections outside Sub-Saharan Africa can be attributed among PWIDs. (UNAIDS, 2014a)

Nepal has a concentrated HIV epidemic with prevalence rate of 0.2 percent among adults aged 15 to 49 (UNAIDS, 2014b). The HIV prevalence among the adults has not changed much over the last five years and has remained within the range of 0.2 - 0.3% in Nepal. It is estimated that currently there are around 39,249 people living with HIV in 2014, decreasing from 40,723 in 2013. An estimated number of 2,576 deaths were due to AIDS in 2014 and new cases reported as 1493 in 2014 as compared to 1,408 in 2013. The HIV epidemic remains concentrated among people who inject drugs (PWID), men who have sex with men (MSM), transgender people (TG), sex workers (male and female) and male labor migrants (MLM) including their spouses (National Centre for AIDS and STD Control, 2015a).

The Central Bureau of Statistics (CBS) Nepal estimated number of hard drug users to be 91,534, which significantly increased from 46,310 in 2007. It also estimated total number of PWIDs to be 51,808 in 2013 (MoHA, 2013). The latest IBBS 2015 survey conducted by the National Centre for AIDS and STD Control (NCASC) in Kathmandu and Pokhara valley found HIV prevalence among PWIDs as 6.4 and 2.8 percent respectively. It also found 22 percent and 9.6 percent prevalence of Hepatitis C virus in Kathmandu and Pokhara respectively (National Centre for AIDS and STD Control, 2015b, 2015c).

## 2.2 Implications of law enforcement

### *2.2.1 Barriers to access Harm Reduction services*

Barriers to access can be defined as such factors that prevent an individual gaining access to health services. It may be physical, financial, geographical or legal barriers ("Access and barriers," 2012).

Removal of legal barriers to syringe access has been identified as an important part of a comprehensive approach to reducing HIV transmission among PWIDs. Legal barriers include both “law on the books” and “law on the streets,” i.e., the actual practices of law enforcement authorities. Policy changes designed to increase PWID access to sterile injection equipment cannot be successfully implemented without the co-operation of the law enforcement authorities who enforce drug control laws (Beletsky, Macalino, & Burris, 2005).

In a qualitative study in Canada, service providers, specifically outreach indicated negative impacts of law enforcement, as they were compromised due to heavy police presence and the displacement of PWIDs. The study concluded that law

enforcement negatively influenced PWIDs access to harm reduction program and their willingness to carry syringes (Small, Kerr, Charette, Schechter, & Spittal, 2006). For harm reduction programs to work effectively an enabling environment is most - that is supportive initiatives from law enforcement and other concerned agencies (Law enforcement and HIV network, 2013). The polar contrast between the approaches of drug law enforcement and harm reduction programs has a serious risk to inaccessibility of health services, well-being of PWIDs and community as a whole (Maher & Dixon, 1999b).

*2.2.2 Human rights violations among PWID*

Human rights violations occur when actions by state (or non-state) actors abuse, ignore, or deny basic human rights (including civil, political, cultural, social, and economic rights).

Among people who use drugs, PWID are one of the most vulnerable and marginalized groups having far greater HIV prevalence than among rest of the adult population. People who inject drugs are almost universally criminalized; either for their drug use or for their lifestyle adopted in order to maintain their drug use. Estimates suggest that 56-90 percent of PWIDs will be incarcerated at some stage during their life. This criminalizing or punitive drug law hinders the HIV response (UNAIDS, 2014a). In addition to the legal barrier, a range of other contextual realities, including human right abuses, abusive police practices, and widespread use of arrest, detention, and incarceration had an impact on health, wellbeing, and lives of PWID. Many of these abuses, including police brutality, have been shown to increase HIV risks by limiting PWID access to services, syringe exchanges, and drug treatment (Dutta et al., 2013).

For an instance, Methadone and Buprenorphine are most commonly used medicines for oral substitution treatment (OST) that are included in the WHO's Model List of Essential Medicines. OST has well established evidence base to decrease or eliminate injecting practices among PWID, thus significantly reducing HIV, hepatitis C, overdose, drug related deaths and crime as well, yet global coverage is extremely low due to lack of access as a result of stigmatizing environment created by national drug control act or the single convention preamble (Global Commission on Drug Policy, 2015).

*2.2.3 Risky behavior*

Risky behaviors are those that potentially expose people to harm, or significant risk of harm, which will prevent them reaching their potential (London Borough of Richmond upon Thames, 2014).

Drug law enforcement can prompt changes in injection behavior that exacerbate risk for adverse health outcomes. The presence of law enforcement authorities in the drug using locations increases legal vulnerability towards the drug purchasing and consuming behaviors. Studies have shown modification in the behavior of PWID. In order to consume before confiscated, they rush during injection process, which can lead to several harms (K. Dovey, J. Fitzgerald, & Y. Choi, 2001; Kerr, Small, & Wood, 2005a).

A review of secondary data indicates that law enforcement have substantial potential to produce harmful health and social impacts, including disrupting the provision of health care to PWIDs, increasing risk behavior associated with infectious disease transmission and overdose, and exposing previously unaffected communities to the harms associated illicit with drug use (Kerr et al., 2005a).

The qualitative study in Canada discussed that the intensified police presence impacted the drug use patterns among PWIDs and prompted rushed injections in public venues, riskier environment, as well as discouraged safer injection practices and safe disposal of syringes (Small et al., 2006).

A study in Australia has also discussed on the impact of presence of law enforcement is not limited to creation of climate of fear and uncertainty but has resulted in a number of unforeseen negative consequences like oral and nasal storage and transfer of drug, reluctance to carry injecting equipment, increase in injection related risk-taking, and displacement. The study illuminates that the law enforcement with high arrest and conviction rates may be judged a reasonable success, but in the long term may cost highly undesirable drug market shifts (Maher & Dixon, 1999b).

Furthermore, a systematic review of reports about determinants of HIV infection among people who inject drugs from 2000 to 2009 with classification of micro and macro environmental determinants found that the most frequently recorded microphysical determinants included the locations where drugs were injected, homelessness, incarceration, and spatial inequities. It estimated that, during 2010–15, HIV prevalence could be reduced by 41% in Odessa (Ukraine), 43% in Karachi (Pakistan), and 30% in Nairobi (Kenya) through a 60% reduction of the unmet need of programs for opioid substitution, needle exchange, and antiretroviral therapy. Mitigation of patient transition to injecting drugs from non-injecting forms could avert a 98% increase in HIV infections in Karachi; whereas elimination of laws prohibiting opioid substitution with concomitant scale-up could prevent 14% of HIV infections in Nairobi (Strathdee et al., 2010).

Another cross sectional study among 582 HIV positive people in Russia who inject drugs showed an association between arrests for syringe or drug possession and non-fatal overdose and needle sharing among PWIDs. The findings supported the assertion that punitive drug law enforcement practices contribute to the HIV risk environment of Russian PWID, which was also consistent with studies from other countries (Lunze et al., 2014). Similarly, in Mexico, almost a third (32%) of PWID reported that police involvement led them to rush injections and share needles and syringes, and affected drug users' decisions on where to buy and use drugs because of the fear of being arrested and prosecuted (Volkmann et al., 2011).

*2.2.4 Conclusion*

Nepal is one of the countries practicing repressive drug policy. Laid down in the Act, 1976, the master plan designed with the assistance of UNODC primarily focuses on two major strategies-Supply reduction and Demand reduction, including key areas of national drug control administration, legislation, law enforcement, preventive education, treatment and rehabilitation (United Nations Office on Drug and Crime, 2005). The enactment of punitive policy has brought concomitant risk to the health of PWID in Nepal. Though, not properly documented, several issues of barriers to access, human rights violations and compelling situation to practice risky behaviors due to law enforcements have been repeatedly reported and raised by the local organizations and PWID activists. A local online news site of Nepal reported death of a 21 years old young drug user due to inhumane tortures in the police custody after being arrested for his drug use (Dhauligiri Online, November 15, 2015).

The MDG 6 report listed Nepal as one of the countries successful in halting and reversing the new HIV infection by more than 20% during 2000 to 2014

(UNAIDS, 2015). But still the UNAIDS 2014 GAP report depicts a significant treatment coverage gap of 77%, AIDS related death increased by 8% (UNAIDS, 2014a). Furthermore, the country profile on SAARC report (Kathmandu declaration to end the AIDS epidemic by 2030, 2014) also shows substantial gap of more than 50 to 70% in HIV testing depending on different key populations, more than 50% gap in the condom programming, about 40% gap in HIV prevention (SAARC, 2015).

The fact that few studies are available without consideration of multifaceted implications of drug law enforcement on life saving harm reduction programs as well as well-being of PWID, this study is opted to provide a dimensional perspective on the issue. The failure of previous researchers to consider systematic barriers upon the labeling of intrapersonal characteristics has enthused a contrasting question. Therefore, this study sought to investigate the implications of the drug law enforcement in the three major areas - Barriers to access harm reduction services, Human rights violations and Risky behaviors among PWIDs.

# CHAPTER III

# RESEARCH METHODOLOGY

## 3.1 Research Design

The proposed study followed a qualitative research design. Narrative analysis of written text and spoken words gathered through the in-depth interviews was done in order to come up with themes and patterns from the data. Open-ended in-depth interviews, report reading and field note methods were applied in order to collect necessary information from the study population. Four distinct populations were studied. The populations of this study were categorized into four different levels as policy level, National HIV program level, harm reduction service delivery level and community level.

## 3.2 Study Area

This study was conducted in Kathmandu Valley, which is composed of three major districts of Nepal – Lalitpur, Bhaktapur and Kathmandu (also the capital city of Nepal). Kathmandu Valley is the central hub of all the ministries of Government of Nepal, national and international stakeholders, harm reduction service delivery points with highest number of people who use or inject drugs. Central Bureau of Statistics (CBS) Nepal estimated the number of hard drug users to be 91,534 nationally, among which almost half (36998) were reported to be in Kathmandu (MoHA, 2013). Furthermore, the Social Welfare Council (SWC) Nepal reports registration of 98 Non-Governmental organizations (NGO) working to contribute to the drug abuse and HIV response amongst which 56 reside only in Kathmandu (Social Welfare Council,

2015). This diverse dynamics and availability of all categories of study populations in the same area led to selection of Kathmandu Valley as the study area.

### 3.3 Study Population

This study aimed to collate and analyze information from four sets of open-ended in-depth interviews. Four distinct populations under study were further categorized as four different levels based on nature of the organization they work for. The categories comprised Policy level, National HIV program level, Harm reduction service delivery level and Community level.

**Policy level** referred specifically to the Ministry of Home Affairs (MoHA) and Ministry of Health and Population (MoHP), which are the government bodies responsible for formulation and implementation of drug law and health policies respectively in Nepal. It was identified that Narcotics Control Bureau (NCB) is the sole drug law enforcement agency under MoHA and National Centre for AIDS and STI Control (NCASC) is the sub-division under MoHP, which specifically influenced the national policy environment for PWID's access to health services. Therefore, the first study population under this level was all the officials who worked specifically for MoHA and MoHP under the two sub-divisions (NCB and NCASC).

**National HIV program level** referred to the organizations, both national and international, which had nation-wide coverage regarding the issues of PWID, harm reduction program and HIV. It was further sub-categorized as International organizations and national network organizations. To be particular, United Nations Office on Drug and Crime (UNODC), Joint United Nations programme on HIV/AIDS (UNAIDS) and Save the Children (SC) were identified as key international organizations and in the same way under national network organizations, Recovering

Nepal (RN), National Users Network Nepal (NUNN), Federation of Drug Demand Reduction (FDDR), Union C, and Nepal Drug Users prevention Association (NEDUPA) were identified. Therefore, the second study population under this level was all employees working in these 8 organizations.

**Harm reduction service delivery level** referred to the harm reduction service delivery points sited by community based non-governmental organizations (NGO) through which, services were catered to the PWIDs in Kathmandu Valley, Nepal. For the purpose of this study, Needle and Syringe Program (NSP), Oral Substitution Therapy (OST), HIV Testing and Counseling (HTC), Anti-Retroviral Therapy (ART), and Hepatitis C Virus (HCV) Testing were selected as the harm reduction services provided to PWID by the NGOs. Therefore, the third study population under this level was all the employees who were working in the NGOs delivering 5 types of harm reduction services to PWIDs.

**Community level** referred to the entire population of people who inject drug in Kathmandu Valley.



In order to make the population in each category more specific and relevant to the study objective, following inclusion and exclusion criteria were framed:

*3.3.1 Inclusion Criteria:*

The participants of the in-depth interview should be employee in one of the aforementioned sub-divisions or organizations in each category.

- In-depth interview participants must be based in Kathmandu Valley having at least one year of working experience in drug abuse and HIV sector.
- At harm reduction service delivery level, the NGOs should be implementing one of the five harm reduction services for PWIDs.

- At community level, only PWIDs who are above 18 years old and has been practicing injecting at least past 3 months from the date for interview should be recruited in the study.

*3.3.2 Exclusion Criteria:*

- Employees and PWID who do not provide the informed, voluntary and rationale decision to participate for the interview with audio recording.
- Employees and PWID who cannot express their opinions.
- Employees and PWID who withdraws interview session or do not answer to adequate number of questions (*i.e. at least 3 of the numbered questions in the checklist).*
- Employees and PWID whose mental disability is reported by line managers or supervisors.

**3.4 Sampling Technique**

This qualitative study basically applied maximum variance (purposive) sampling technique. This strategy for purposeful sampling aimed at capturing and describing the central themes that cut across a great deal of variation (Patton, 2002). In order to capture as much variation as possible in the study population, I constructed a matrix sample of 4 in which each sample were as different as possible from every other on such characteristics as role in the drug and HIV sector, and purpose and scope of their involvement. Restraining in these characteristics, the samples were drawn from the four heterogeneous population categories -policy, national HIV program, harm reduction service delivery and community level. Further variations within the four categories as law enforcement (NCB) and NCASC under policy level;

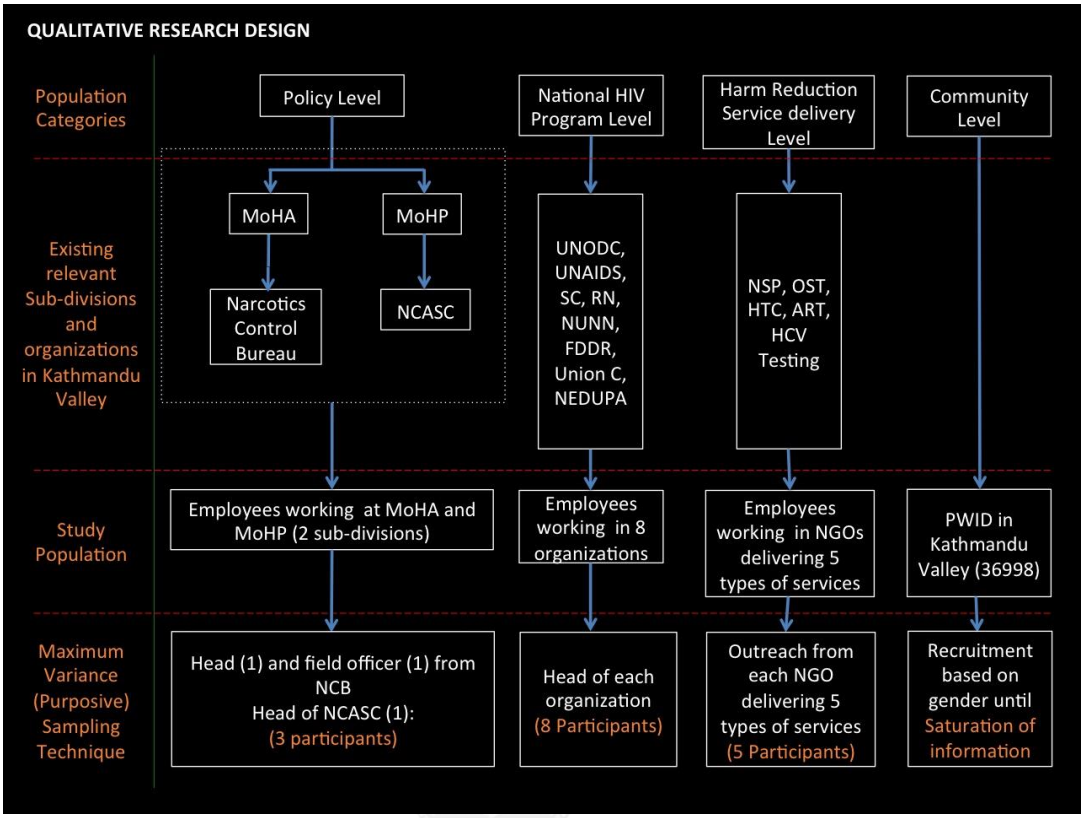
National networks and international organizations under national HIV program level; five different services at harm reduction service delivery level; and gender at community level were considered.

**3.5 Sample and Sample size**

In the beginning of this study, I did not have comprehensive information regarding key actors relevant at all varying levels. Though ambivalent during the proposal writing phase, based on preliminary inquiries and literature reviews, 16 in-depth interviews for policy, national AIDS program and harm reduction service delivery level were targeted. Also, to deal with uncertainty regarding the availability of in-depth interviewees like the head of NCB, NCASC, international organizations, contingency plan of recruiting at least 2 other samples was at place.

At community level, the sample size determination was based on the saturation of the information taking budget and time into consideration. In each of the five harm reduction service delivery sites, PWIDs were purposively selected as per convenience on the basis of their gender. The recruitment of PWIDs was closed when there was repetition of information and no new information came out from the PWIDs in two successive interviews. *Figure 1* represents the illustrative diagram for overall research methodology of this study.

**Figure 1: Schematic Diagram of the Study**




### 3.6 Measurement Tools

The primary measurement tool used in this study was open-ended in-depth interview checklist. It was further supported by the field notes and memos prepared by the researcher during interview.

A translator proficient in both Nepalese and English language translated the checklist into Nepalese language. Since the principal researcher was a native of Nepal, necessary adjustments in the translation were again made directly by him.

In-depth interviews are one of the main methods of data collection used in qualitative research. With an objective to achieve both breadth of coverage across key issues, and depth of coverage within each issues, content mapping and content mining questions were prepared. The content mapping questions were used to open up a

research territory or issues and content mining questions to probe and follow up within the issue (Legard, Keegan, & Ward, n.d.). For each level, separate semi-structured in-depth interview checklists of questions were developed. The questions were open ended and designed to encourage a fulsome response from participants of the study. In addition, the checklists were devised in such a way that participants had equal opportunity to provide their opinion both positive and negative. For instances, if participants were asked how law enforcement authorities deter PWID to access harm reduction services, then they were given equal opportunity to answer by another question on how law enforcement authorities support PWID to access harm reduction services. In this way, both closed ended and leading questions were avoided as much as possible. All the interviews were recorded using a professional audio recorder so that it could be later transcribed for comprehensive analysis and interpretation purpose.

Furthermore, content of the open-ended in-depth interview checklists were constantly consulted with and validated from thesis advisor and other thesis committee members. It was also sent out for review and comments to HIV sector professionals and research assistants for face validity. The in-depth interview checklists are attached in the *ANNEX III*.

**3.7 Data Collection**

Five research assistants were recruited to undertake the data collection. Acknowledging the fact that PWID are hard to reach population as well as do not welcome or open up with any outsiders for interview, locals having previous drug use history were recruited as research assistant. Given the resources, only those whose academic qualification was under-graduate level were available. But as they were

locals with drug use history, they already had a good rapport or trust bond built with the PWID to get a fulsome response, which in most of the cases is hard even for the professional researchers.

In order to schedule an interview with the participants from policy, national HIV program and harm reduction service delivery level, request emails were sent out and further follow-up through phone calls were made. On the other hand, PWID participants under community level were met at each harm reduction service delivery site with permission and support from the site employees. As an attraction as well as appreciation to the time and effort everyone contributed to support this study, all the research assistants were provided with NRs. 500 (approx. US $5) per interview (exclusive of travel expenses) as their stipend. Similarly, all the interview participants under Policy and Harm reduction service delivery level were provided with NRs. 1000 (approx. US $10) and participants under National HIV program and Community level were provided with NRs. 500 (approx. US $5).

*3.7.1 One Day Orientation and Training of Research Assistants*

On April 12, 2016, one-day orientation and training on the study was convened for research assistants in Hotel Manang at Thamel, Kathmandu. One week prior to the orientation date, principal researchers provided all the participants with relevant reading materials like research proposal, in-depth interview papers and checklists in both English and Nepalese language. Altogether 11 participants (5 research assistants, 5 professionals from Drug and HIV sector and 1 principal researcher) attended in the orientation. The 5 professionals from drug and HIV sector were invited in the orientation with an objective to get practical Intel on the ground situation. For instance, which organizations are implementing the 5 types of harm

reduction services, which sites/locations are able to reach maximum number of PWID, who and how to contact in every organizations etc.

In the orientation, principal researcher presented slides on the key information about the study based on the proposal like background, objectives and methodology of the study with particular focus on in-depth interviews. Participatory discussion was held on the methodology and in-depth interview sessions. The orientation also focused on mapping the population with the help of invited participants and assigned research assistants to interview different study populations. The schedule and topic guide of the one-day orientation and training is attached in the ANNEX V.

*3.7.2 Assessment of Research Assistants to undertake in-depth interviews*

Since the research assistants were not professionals, principal researcher scheduled an interview with a participant at National HIV program level, in which all 5 assistants attended as observer (with consent from interview participant) to learn the technique to hold in-depth interview using the provided checklists.

The interview checklists were devised in such a way that it could be easily applied by anyone, including research assistants. Every study population had separate semi-structured checklist with exact statements formulated in the form of questions to be asked to the interview participants. For convenience, the broad issue based *(content mapping)* questions were numbered and detailed two-tired follow-up/probing *(content mining)* questions were bulleted under each numbered questions. Therefore, even if the research assistant lacked the skill to interview and probe *(which is not the case)*, just following the checklists would easily gather adequate amount of information from participants. Unlike quantitative design, entire interview data of this qualitative study were safe in the form of audio recordings.

*3.7.3 Interview Data Transcribing and Translating*

All the interviews were conducted in Nepalese language and therefore needed English translation before moving on to data analysis. An independent translator proficient in both English and Nepalese language was provided with all the interview recordings for transcribing and translating tasks. In the given resources, professional translators could not be hired and principal researcher made all the necessary adjustments to the transcripts submitted by the independent translator.

**3.8 Data Analysis**

Identifying and refining important concepts is a key part of the iterative process of qualitative research ("Qualitative Data Analysis," 2000). This study followed the method of thematic content analysis, adapted from Glaser and Strauss (Glaser & Strauss, 1967). This method used to categorize and codify the interview transcripts (Burnard, 1991) is best described through following stages:

Principal researcher listened to each interview audio recordings and validated the interview transcripts translated by the independent translator. Where losses of any data or its essence during Nepalese to English translation were realized, transcripts were adjusted.

Transcripts were read repeatedly and as many highlights and headings as seen important were written to describe all aspects of the content. Possible categories were freely generated and quotations were put under those categories.

Generated categories were revised again and grouped together under broader themes. Merging of similar categories was done.

Repeated visit to transcripts and generated themes and categories was conducted and necessary adjustments were done.

A matrix with themes and categories on the rows and four study populations on the column was developed in Microsoft Excel sheet and all the highlighted verbatim quotes were copied and pasted into the matrix. This matrix was visited repeatedly and adjusted as necessary. Each theme and category in the rows were given different background color for easy identification and further cross checking.
The draft of the matrix was shared among research assistants and few committee members to review if the quotations fit into the category/theme and necessary adjustments were made again to finalize.

After crosschecking and comparing between all data in the matrix, report-writing process was started.

**3.9 Ethical Consideration**

This study was ethically approved *(Reg.no.117/2016)* by the ethical board of Nepal Health Research Council (NHRC), which serves as main national institution responsible for technical and ethical review of all proposals submitted by individual health scientists, national authorities, NGOs, INGOs and universities. Following the ethical guideline of NHRC, only participants of age above 18 years were recruited. Interview participants were given time to read and enough opportunity to ask questions relating to the content of the informed consent form before proceeding for the interview. All the research assistants and participants of this study were compensated with small amount of remuneration for their time and effort. After the development and approval of thesis report, all the audio recordings as well as interview transcripts were destroyed.

# CHAPTER IV

# RESULTS

Altogether 28 participants were interviewed using the semi-structured open-ended in-depth interview checklist. In detail, among the total participants, 1 represented the policy level; 7 represented the national HIV program level; 5 represented the harm reduction service delivery level and 15 were the people who inject drugs (PWID) at the community level. Among the 15 PWID participants under the community level, 4 female PWID receiving different harm reduction services were interviewed. Initially targeted interviews with 2 officers of Narcotics Control Bureau (NCB) under policy level, some national and international organizations under national HIV program level could not be reached in the given time frame despite regular follow-up to schedule the interview with the concerned organizations. The participants of this study are summarized in *Table 1*.



**Table 1: Summary of total number of participants in the study**

| **Study Population** | **# of participants** |
|---|---|
| Policy level | |
| Narcotics Control Bureau (NCB), MoHA | 0 |
| National Centre for AIDS and STD Control (NCASC), MoHP | 1 |

| | |
|---|---|
| National HIV program level | |
| International Organizations | 2 |
| National Community network organization | 5 |
| Harm Reduction service delivery level | |
| Needle and Syringe Program (NSP) | 1 |
| Oral Substitution Therapy (OST) | 1 |
| HIV Testing and Counseling (HTC) | 1 |
| Hepatitis C Virus (HCV) Testing | 1 |
| Anti-Retroviral Therapy (ART) | 1 |
| Community level | |
| NSP (male, female) | 3 (3,0) |
| OST (male, female) | 3 (2,1) |
| HTC (male, female) | 3 (2,1) |
| HCV (male, female) | 3 (2,1) |
| ART (male, female) | 3 (2,1) |
| **Total participants** | **28** |



Findings emerging from the analysis of the verbatim interview data revealed many key findings. These findings are discussed into seven major themes and further categorized within the themes. The themes under this study findings are – Drug use scenario; How do they perceive Harm Reduction?; Access to harm reduction services; Human rights violations; Risky behaviors; Prison setting; and Joining the dots. Major findings that emerged from the data analysis are summarized in *Table 2*:

**Table 2: Major findings of the study based on themes**

| Themes | Major Findings |
|---|---|
| **Drug use scenario** | There was a rapid increase in juvenile drug use with 13 years as age of initiation; drug cost per dose increased by more than 30 times and was associated with assisting drug dealers to sell drugs for daily dose, formation of group to manage money, use of low quality mixtures, and sharing of syringes among group members, thereby increasing cases of abscess, Deep Vein Thrombosis (DVT) and blood borne infections among PWID. |
| **How do they perceive harm reduction program?** | Participants perceived harm reduction programs to be imperative; proactive implementation could not only avert drug-related harms but would also play vital role in shaping quality life of PWID; Participants associated the presence of harm reduction program to reduction in selling of sex among female PWID and different physical harms and unsafe injection practices; frequent complaints on degrading quality of OST (Methadone) and syringes by PWID. |
| **Access to harm reduction services** | Presence of law enforcement authorities near service delivery sites, their intervention, on-street stopping, searching and interrogations, arrests for carrying a syringe deterred PWID to access harm reduction services; PWID with multiple arrest history |

| | |
|---|---|
| | or disclosed drug using status experienced more obstacles in accessing services compared to other PWID.<br>Law enforcement authorities were mostly unaware about harm reduction services; knowledge of such services resulted in realizable amount of changes in law enforcement activity such as referral and service intake inside custody; generally, law enforcement authorities were personally inclined and more supportive in referring PWID to abstinence based drug rehabs rather than harm reduction services. |
| **Human rights violations** | Human rights violation of PWID was one of the most reported implications of law enforcement. They were in form of stringent scrutiny, threats and arrests, breach of confidentiality, stigma and discrimination, sexual harassment among female PWID, physical punishments and financial hassle.<br>Disclosing of drug use behavior to families by law enforcement authorities was associated with crisis that drove a PWID into the world of isolation and petty crimes.<br>Participants perceived behaviors like calling by slang words *(such as 'tyape', 'addict' or 'drug abuser')*, treating once an addict always an addict and unfair judgments during encounter as stigma and discrimination. There was a likelihood of being stopped and searched wherever encountered or whenever some incident happened in the locality if an individual was previously arrested or |

was known to have drug use history. Such PWID were vulnerable to being convicted for crimes other than their drug use also.

Female PWID were often humiliated and forced to comply with sex demands inside custody. Male PWID partners and drug dealers also created such compelling situations.

The fear of arrest among PWID as a result of criminal law enforcement in Nepal had become an opportunity to a nexus of some of the field level law enforcement authorities and drug rehabs. Brutal tortures and death from such torture happening inside those rehabs were not directly carried out by law enforcement authorities but was one of the implications of drug law enforcement.

Financial hassle practiced by the nexus was one of the worst implications of drug law enforcement. The senior law enforcement authorities were found supportive towards the issues of PWID while, due to lack of awareness and strict/regular field monitoring, some field level law enforcement authorities were trading drug users with rehabs for huge amount of commission.

No proper mechanisms to report human rights violations were identified. But three major parties were held responsible to protect human rights of PWID – Law enforcement authorities, Human rights commission and organizations working for people who use

| | |
|---|---|
| | drugs. PWID either had no awareness or feared to report violations as the law criminalized their drug use behavior. |
| **Risky behavior** | Stringent drug law enforcement was directly associated with high level of risky behavior practices among PWID. Associated risks were syringe exchange practices hasty injection practices; risk of overdose; risky shooting locations and shift in drug administration route from oral to injection. |
| **Prison setting** | Most of the law enforcement authorities, in best-case scenario, referred PWID to abstinence based drug rehabs or at worst sent them to prison on drug offences. Either way PWID suffered through range of human right violations and health-related risks. High availability of drug, financial hassle and far worse risk of syringe exchange were identified inside prison. |
| **Joining the DOTS** | One of the change that most of the participants repeatedly mentioned was increased support from the law enforcement authorities to effective implementation of harm reduction services in Kathmandu Valley; high-ranked law enforcement authorities (Inspector and above) were more receptive and supportive towards issues of PWID.<br>Analysis of data also showed most of the law enforcement related impediments might be occurring due to failure in effective and updated flow of information within government agencies such as between Health Ministry and Home Ministry, between Home |

Ministry and drug law enforcement authorities, and within senior law enforcement authorities to field level authorities.

Gap in coordination between law enforcement authorities and health workers, including service providers and civil society networks was identified. Law enforcement authorities were in need of better education regarding issues of drug use through health and human right lens.

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**4.1 Drug use scenario**

*4.1.1 Using Trend*

Questions related to the drug use scenario were asked with study populations other than community level (PWID). Data from the interviews showed that the situation of drug use in Kathmandu as well as Nepal was increasing rapidly with in a short time span. Participants shared their serious concern on such escalation in number of drug users as estimated in the most recent report of Central Bureau of Statistics (MoHA).

> *Drug use situation is in difficult position. Home ministry had done study in 2013 through central bureau of statistics; it estimated that there are* ***more than 91000 drug users in Nepal. Injection users are alone 50-51 thousand*** *and main thing is we are not able to launch programs like harm reduction in high scale. So the situation is vulnerable* [an official at NCASC, MoHP, Policy Level].

*In last 6-7 years, it has increased and doubled itself. There is* ***annual growth rate of 11%*** *among the drug using population* [a member of national network of people who use drugs].

Some participants representing the national and international organizations were also concerned about the age of initiation of drug use.

*Now… if we see the drug situation in Nepal compared to the past, the use has been increasing, and adding in that, next danger and thoughtful situation is that* ***the average age of the drug user is getting younger****. This is a bit risky and vulnerable situation* [a representative from Save the Children, National HIV program level].

Rapid increase in drug user population was identified as a big problem but increasing drug use among juveniles was identified as even bigger yet unheeded problem. Participants also mentioned the challenge in working with or including these juveniles in studies due to age of consent barriers as per the ethical guidelines and different Standard Operating Procedure (SOP) of services in Nepal.



*Talking about drug use scenario in Kathmandu… there are maximum drug user but hidden. Like in past, they are not found in junctions or in any hunting places (Drug dealing areas). But* ***there are lots of users: boys and girls*** [a female outreach at OST Centre, Harm reduction service delivery level].

*From what I have observed, as I run a drug rehabilitation Centre. People nowadays fall easily into drug use habit at a young age.* ***I have 2-3 patients that are under 15 years who are injecting drug users*** [a member of FDDR, National HIV program level].

*As per the study and various researches, the people of* ***age group 15-18 seem to be using drug more than any other****. But, since* ***our studies do not cover the age below 18****, we do not have sufficient data. So, we talked to other centers and they told us that* ***people start using drugs from the age of 13****. And, the trend of using drug is increasing among the females as well* [a representative from UNODC, National HIV program level].

*4.1.2 Drug Cost, Management and Risk*

Besides the increase in drug users and drug use among younger cohorts, the cost per dosage of drug was also drastically increased by more than 30 times. The situation was further exacerbated by the stringent law enforcement and personal crisis of money in order to take his/her daily dosage. Due to these multi-layered problems, drug users were compelled to manage their drug use through small-scale drug dealing, cost sharing making small group and inject with harmful low quality mixtures.

***A drug user needs at least NRs 3000 per day to meet his dosage.*** *Now, he doesn't always have Rs 3000 with him. So he must know the dealer who might offer him to sell half the drugs in exchange for some dose.* ***He will get his dose so he won't hesitate to sell the drugs although*** *the main dealer is someone else* [a member of Union C, National HIV program level].

*Now, looking at the Kathmandu's scenario, drug use has changed because there is threat of police and crisis of money.* ***Things we used to have in NRs 50-60 per dose, is now costs around NRs 1700-1800****. And it is not possible to afford it alone. So what they do is, make* ***group of 2-3 persons*** [an outreach at NSP Centre, Harm reduction service delivery level].

Their actions to manage their drug use either increased their risk of being arrested by law enforcement as drug trafficker or risk of health-related harms through sharing of drug and needles among their group members. Further, they did not even have access to a quality drug as mentioned by one of the participant.

> *Other problem here is that, one dose need to be shared among their group so, that increased the need of mixture. Now* ***there are many cases of abscess, DVT... due to mixture*** *like stargon, phenergan, other… avil. And all that mixed, made poison* [an outreach at NSP Centre, Harm reduction service delivery level].
>
> *Nowadays they go for street drugs,* ***it is difficult to get pure heroin****, they use street drugs, which is used through injection* [an official at NCASC, MoHP, Policy Level].

**4.2 How do they perceive Harm Reduction programs?**

One thing in which everyone couldn't agree more was the significance of harm reduction program in Nepal. Most of the participants at all levels perceived harm reduction programs as the only essential health services capable of averting risk of blood borne infections among people who inject drugs. Senior officials at policy and National HIV program level said -

> *Harm Reduction is a great program,* ***without this kind of program; there will be a disaster****. We should prevent HIV and Hepatitis C. so it is really good* [an official at NCASC, MoHP, Policy Level].
>
> *I have been working in this harm reduction sector for a long time personally.* ***This program should be taken seriously*** *by government or any other agencies* [a representative from Save the Children, National HIV program level].

At community level, PWID were also satisfied with the services and friendly environment provided by the outreach workers of NSP Centre.

> *No matter where we are whenever we say them- Brothers (NSP outreach workers) I am at this kind of place and I don't have money to buy syringe today, if you don't mind, please help me, then* ***brothers understands our situation and agrees to come****. This is one thing that* ***really makes me happy*** *when thinking about harm reduction programs* [a male PWID receiving NSP service, Community level].

Participants associated the presence of harm reduction program to reduction in selling of sex among female PWID and different physical harms and unsafe injection practices.

> *Harm reduction has done good work. Now, whatever the organization is providing, it has prevented drug user from harm. Like there are female drug users also,* ***they don't need to sell sex for money, there won't be physical harmed*** *and also with male, there used to be problem in the past. There were no methadone offices, there were no options. So they have to inject drug forcefully. So, due to that, there comes physical problem like abscess, DVT, HIV positive, Hepatitis B, C* [a female outreach at OST Centre, Harm reduction service delivery level].

Harm reduction was not limited to prevention of HIV and Hepatitis among PWID only, but it had broader scope in the quality life of PWID. The cases of HIV or HCV infections had negative impact on any career related endeavors among PWID. Therefore, beyond a health perspective, harm reduction was able to play imperative role in preparing PWID for their career opportunity.

*3 years ago I tried to go abroad, at that time* ***during the medical check-up, Hepatitis C was detected and I did not qualify for the opportunity****. When I received harm reduction service, I felt really comfortable because before getting introduced here, I did not know my disease (HCV) status, I was afraid on what will happen, if it may take my life, but after coming here I came to know it is not a very difficult problem.* ***I came to know that we can reduce the problem, it can be treated, and I can improve my health, so I felt very good*** [a male PWID receiving HCV service, Community level].

Representative from Save the Children expressed his serious concern on passive implementation of harm reduction programs in Nepal saying - ***'If harm reduction programs were implemented proactively, 80-90% ID users would not have infected themselves from Hepatitis****. But now due to Hepatitis, they fail to go abroad for work. Hepatitis treatment in other hand is too costly'.*

*Harm reduction is just temporary transitional program. If we see in the part of harm reduction, there is no supplementary activity after harm reduction or post harm reduction.* ***For client what after harm reduction, the second strategy does not exist; the people come but how long they should take syringe, or other form of medicine is not clear. Harm reduction is a very good entry point to break the vicious circle;*** *we come to the new drug users who are not known from harm reduction program. Then after the part of linkage is ours, which is left out. I don't know if it is not understood or it cannot be done.* - He further added.

Some participants did not perceive harm reduction programs as others did. Instead they were concerned about the service hours and negative influences on

PWID who are abstinent from drugs or even to those curious youths who have never experimented drugs.

> *Bad aspects are…* ***we won't get in the night time; it is closed in weekends.*** *It is a bad aspect. We, service receiver would be happy to get 24hrs service like ATM. ATM too does not work at times but we would like to get 24-hour service* [a male PWID receiving NSP service, Community level].
>
> *Harm reduction program (pause).. **For the people who have already quit drugs- it is bad**; for the people who are doing drugs- it is very good. There are chances of relapse among those who has already quit drugs and also **more chances of getting new ones to start drug use.** It seems like easily available, so sometimes I think it is not good* [an outreach at CCC (ART) Centre, Harm reduction service delivery level].

Finally, there was additional concern pertaining to the quality of supplies such as methadone at OST Centre and syringes at NSP Centre provided to PWID. Participant, based on informal but frequent reports from PWID, expressed his aggression for such insensitive procurement that could directly increase harms among PWID.

> *The complaints we have at present is that **methadone is not as strong as it used to be**. The quality has degraded. It is mixed now. And **needle syringe is not as good as the lifeline syringe that we used to get earlier.** The syringes then used to be of 5 and 1 but if you look at the present syringes, the needle gets bent while you try to inject. Many of them break down. Such cases are happening right now. Now we have to look at the procurement committee.*

***Who did the procurement? It is like playing with the health of drug users*** [a member of Union C, National HIV program level].

**4.3 Access to Harm Reduction Services**

*4.3.1 Barriers to access*

Data from interviews showed that the presence of law enforcement authorities in the vicinity had deterring effect among PWID's to access harm reduction services.

*Sometimes, when the police are around,* ***we feel frightened even to go near to the DIC*** [a female PWID receiving both HCV and NSP services, Community level].

*If a police officer is just outside the office or in the vicinity,* ***the drug user will not come to us to get a syringe*** *and will return back* [an outreach at NSP Centre, Harm reduction service delivery level].

*Around DIC, there is always police department. There we held coordination meeting so that in future days our service receivers do not get any type of difficulties. And we want them to cooperate with us but that will be implemented for 2-3 days only. After that, on same area,* ***they arrest even if they find drug users with syringe only****. That is what a wrong thing happening, which is deterring PWID to come to services as per my own experiences* [a female member of NEDUPA, National HIV program level].

In addition to the presence of law enforcement, high cases of police intervention, on-street interrogations, arrests for carrying a syringe were reported. These kinds of activities of law enforcement were keeping PWID away from accessing services.

*Talking about police, after finally getting the drug when I go to get syringe from DIC, they keep watching us secretly. And when I return back. They call me and starts checking.* ***I can't even walk that way to the DIC*** [a male PWID receiving NSP service, Community level].

***We are really facing problems while going to or returning from DIC.*** *DIC provide needles for the drug users' safety while the police department catches that and punish them. In many cases, drugs belong to one person, that pity guy who just brings syringe from DIC becomes the victim* [a male PWID receiving ART service, Community level].

*Methadone and buprenorphine is distributed by the organizations but the* ***police administration's scrutiny on drug users, intervening, searching and ragging service receivers, these cases are up and complaints are high*** *due to which they do not want to come to service center* [an outreach at CCC (ART) Centre, Harm reduction service delivery level].

The situation was far worse among the PWID who have been arrested multiple times by the law enforcement authorities in the past. For such cases, service providers were found really supportive in ensuring the PWID gets his/her medicine in time wherever they are.

*Drug user clients that we have are arrested by police for two three times. They want to change but they fear police scrutiny.* ***I have to take their ART for them where they are.*** *Some of them come hiding their face with mask* [an outreach at CCC (ART) Centre, Harm reduction service delivery level].

Harm reduction service providers did not experience support from law enforcement, rather identified negative perception among law enforcement towards

existing services. Since law enforcement envisions drug free society, they were more inclined and supportive towards abstinence based drug rehabs.

> *I don't think Nepal government or police has done anything because saying about drug use, they don't do anything except arresting and punishing them. If we provide medicine,* ***they think we should not distribute it,*** *they create obstacles, they say it's better not to provide them.* ***They don't understand what happens if they won't have it, don't know how much lives it is saving*** [a female outreach at OST Centre, Harm reduction service delivery level].

> *In some places,* ***police arrests drug users under methadone treatment and refers them to a abstinence based rehabilitation Centre*** *without any consent and even without informing their parents* [a male PWID receiving OST and ART services, Community level].

Many existing harm reduction services tailored to PWID in general inadvertently exclude females, and punitive laws, discriminatory policies and social stigma drive female PWID from care and expose them to human rights abuses. Besides barriers from law enforcement, female PWID had their unique issues while accessing services as they are subject to double stigma and discrimination resulting in far less accessibility.

> ***We had to go to male-targeted DIC for services.*** *It was hard on us. Despite being looked down upon as female drug user, I went. I needed needles, syringes and such. I registered my name, had my code and used the services infrequently. I felt odd and asked for 3-4 days stock at once.* ***They denied me saying it wasn't possible and asked me to come back later*** *though sometimes*

*female employee used to sympathize and give me more needle* [a female PWID receiving ART service, Community level].

*4.3.2 Enablers to access*

Interview data also identified that barriers to access created by the law enforcement might be a result of lack of awareness on such services among law enforcement authorities. Changes in law enforcement activity were realized after effective communication and interactions with law enforcement authorities. But level of their support depended on their personal attitude towards services and repeated cases of misuse of service enrollment status by PWID.

*Police give more priority to rehab. But senior level officers said,* ***they did not know about harm reduction earlier****, but now we are involving them and having interaction and they are also committed to support these problems. But* ***they must be worried that it will be misused*** [an official at NCASC, MoHP, Policy Level].

*When arrested for the first time,* ***if the person is young, then they try to take commitment from the person on quitting the drug and never using again and take them to rehabs****. On personal basis they refer to such harm reduction program and make linkage* [a representative from Save the Children, National HIV program level].

One of the PWID also expressed his agreement that PWID should stop using drug after getting enrolled in OST, if they wish no trouble from law enforcement authorities.

*The police don't have much knowledge and experience about the services.* ***They don't harass those coming for OST at the center****. I think they treat you*

*fine once you get enrolled in the services. If you take drugs out on the streets, no one respects you. That's given.* ***If you take illegal substances and don't act civil in the society, for sure you will be in trouble with the police*** [a male PWID receiving ART service, Community level].

Some participants at community level mentioned that they experienced support from law enforcement to access services of their need. Even when they were arrested, they were provided access to services inside the custody.

*I was once caught doing drugs at Teku. At that time, a male officer asked me why such a nice person would use drugs? There was an organization providing harm reduction services at Sanepa, nearby.* ***He informed me about the location and asked me to go and get help.*** *The organization was for people like me, he said* [a female PWID receiving ART service, Community level].

*If I am taken in custody and craving methadone then, I can simply call at the office and take it.* ***They allow you to take methadone even inside custody*** [a female PWID receiving OST service, Community level].

*What I have seen is that there was a friend of mine who used to take methadone and he was in police custody. Now I am telling you what I have seen and the* ***police allowed his family to administer the required dosage of methadone to him, which is a very positive aspect*** [a female PWID receiving HCV and NSP services, Community level].

## 4.4 Human Rights Violations

### *4.4.1 Police scrutiny, threats and arrests*

Human rights violation of PWID was one of the most reported implications of law enforcement. Almost all the participants from the community level had experienced some form of violations of their rights from the field level law enforcement authorities.

Stringent police scrutiny, unnecessary on-street interrogations, threats of imprisonment, body search and ragging while going to or coming back from harm reduction service Centre was experienced by most of the participants. Even though it is the duty of law enforcement authorities to enforce and maintain law on street, participants expressed their frustration on the harassment they face just because of carrying the very syringe provided by Drop-in-Centre (DIC) with approval from Home and Health Ministry. Outreach worker at NSP Centre also pointed out role of law enforcement to arrest drug traffickers at Nepal-India borders rather than harassing an impotent PWID.

> ***We face ragging from narcotics department police.*** *We are not the suppliers; we are the ones addicted. We just buy it for regular use but the police confront asking "who is selling? What are you doing? What do you have in your pocket?"* [a male PWID receiving NSP service, Community level].
>
> *DIC suggests using new syringe and does not recommend using old syringe. That very* ***DIC provides syringe to control risks of using old syringe, but when we are carrying that very syringe with us, say while walking somewhere, if police catches, they harass us*** [a male PWID receiving NSP service, Community level].

> *As a PWID, I have no such feeling of rights being violated, but yes,* ***activities of police like interrogating unnecessarily, interrogating while walking in the street, threats and thrashing, making us fearful to walk freely, threating to convict and send us to jail, harassing by saying they will leave if we provide money.*** *I feel these activities they do to us are wrong* [a male PWID receiving HCV service, Community level].
>
> *No one supports drug use', isn't it? But the main supplier is not caught and apprehending one person using one or two doses of drugs is not of any use. If the police want to apprehend the real culprits,* ***border areas must be tightened.*** *Drugs are being imported freely from the ports and* ***apprehending a user here isn't a good idea.*** *Isn't it so?* [an outreach at NSP Centre, Harm reduction service delivery level]

Having arrested and harassed just for carrying two syringes in the past, one of the PWID participant felt being treated more disrespectful than a dog by the law enforcement authorities. He recounted – *'During the Dog Tihar (one of the biggest Hindu festival) even they worship stray dogs at least once a year. Drug user is still a human but are being harassed the whole 365 days in a year,* ***they are treated even lower than dogs.***

Participant, representing Save the Children, Principal Recipient (PR) of The Global Fund (which is the largest investor of harm reduction program) in Nepal appreciated the performance of law enforcement and also mentioned some risk to PWID.

> *When we see from their (police's) perspective,* ***they are very effective.*** *But when we see from* ***the part of human rights of drug users and harm***

***reduction part, they have the risk*** *in some part* [a representative of Save the Children, National HIV program level].

*4.4.2 Breach of confidentiality*

Two participants from the community level also experienced their rights being violated through breach of confidentiality by law enforcement authorities. As per them, the crisis that drives a drug user into the world of isolation and petty crimes starts when their drug use behavior is disclosed to their family.

***I feel my rights are violated*** *(Pause)... while walking with my family,* ***one police called me and searched my pocket in front of my family.*** *How have I felt that time? What can be bigger violation of human right than this?* [a male PWID receiving NSP service, Community level].

*You have to experience either small or large hassles, like* ***mostly the users do not notify their family and due to them the family gets to know,*** *after family society comes to know,* ***fear of seclusion, fear of being hated, these are experienced*** [a male PWID receiving HCV service, Community level].

*4.4.3 Stigma and Discrimination*

Most of the participants identified stigmatization and discriminative behavior towards PWID as one of the most common ways of violating rights. Participants perceived behaviors like calling by slang words, treating once an addict always an addict and unfair judgments during encounter as stigma and discrimination.

***They insult us by calling us 'tyape'*** *(Slang for addict) and other indecent terms* [a member of Union C, National HIV program level].

*These police administration always looks at us from negative perspective, even though we say them, we want to be good and do good, they treat us once*

*an addict always an addict.* ***They always look at us from the same angle*** [a male PWID receiving NSP service, Community level].

*...even when they meet us randomly, say at hospital,* ***they call upon us a "Drug user" and suggest the doctor to touch us wearing multiple gloves.*** *We are also human, we fall sick, have to go hospital but they mistreat us everywhere. They would be coming for other purpose but upon seeing us, always judge us unfairly. The police treat us with such behavior* [a female PWID receiving ART service, Community level].

Data also showed a likelihood of being stopped and searched wherever encountered or whenever some incident happened in the locality if an individual was previously arrested or was known to have drug use history. Such PWID were vulnerable to being convicted for crimes other than their drug use.

***Police also know me as a drug user now, and wherever they see me, they call me and check my body.*** *If I carry branded mobile phone, they suspect I have stolen it from someone. So there are lot of problems* [a male PWID receiving NSP service, Community level].

*Most of them treat us like criminal. There is the record at Police bit about my wrong doings. So,* ***whenever there is the incident related to drugs, they come to our junction and arrest us and even harass us sexually*** [a female PWID receiving OST service, Community level].

One participant, during his times in custody in the past, raised the issue of a murderer being bailed out within 30 days while a drug user, despite his/her health condition, being left to suffer in the dark cold room for 90 days. An on-duty police replied him – ***'It is our right to keep drug users like that'.*** Participants also spoke of

some police talking disrespectfully even with harm reduction service providers because of their drug use history.

> *There have been many incidents when the drug users have been apprehended and taken into custody. When we went to bail them out and take them to rehabs,* ***police personnel looked down upon us.*** *Even when we voiced that treatment in rehabs is required rather than punishment, they call us out on our past drug user identity and demean us.* ***When people like us, with organizational identity, with responsibility are looked down then they surely discriminate the drug user*** [a member of FDDR, National HIV program level].

It was a shocking fact to know how even some doctors, who swore to treat their patient, were discriminating on the basis of drug use history in hospital. Participant expressed his despair saying:

> *There is no human right for drug users. For example: many of drug users have HIV or Hepatitis.* ***Even doctors would hesitate to check our body, unless provided them with gloves.*** *One drug user died and we had to buy gloves for 5 doctors to see him. So when a person like doctor doesn't treat drug users with care and respect, how will normal people respect them?* [a member of Recovering Nepal, National HIV program level]

*4.4.4 Sexual harassment among female PWID*

Female who inject drugs are the most vulnerable and marginalized population within the criminalized PWID population. Due to intense social stigma towards female PWID they were hidden and had to rely on male counterparts for managing daily dose.

*Every drug user especially the females have dealt with it. Whether it's by the police administration or even by fellow drug users.* ***It difficult for us we have to ask help from boys'.*** *They try to take advantage of it. They suggest to stay with them saying they will provide the drugs free of cost* [a female PWID receiving ART service, Community level].

Female PWID are often compelled to provide sex in exchange for housing, sustenance and protection, suffer violence from sexual partners and practice unsafe sex (Pinkham & Malinowska-Sempruch, 2008). One female participant mentioned how female PWID were humiliated and forced to comply with sex demands inside custody.

*When they catch you, they call you various names.* ***"Junkie", "Addict".*** *Especially if female, they further degrade you. They act the good cop/bad cop part. One comes to you and say why such a good person was taking drugs then another comes and calls by various names and says -'they are drug users. They are like that' and such. Another cop comes in, whispers to others and then asks us to do as they say- sleep with them at night to be free. You get easily scared. Being a drug user, you are afraid of police as matter of fact. Uhh… Then I thought and asked them to let me free, I also told them I wasn't well enough. They said that they will let me free through back doors but I have to meet with them at said room. In fact,* ***2-3 cops took me. They offered me the drug stash they had busted. I even took some. They again asked me to sleep with them. I had to get out and take some drugs, so I accepted the offer.*** *They took me to the room and allowed me to take some more of the drugs. They had brought liquor too for later. When I was done with drugs, I*

*boldly told them that I HIV positive. They were confused and asked me for proof. I told them to have blood test. They faltered and let me leave* [a female PWID receiving ART service, Community level].

*4.4.5 Physical punishments*

Physical punishments beyond body search and thrashing were reported by some of the participants. These punishments were experienced on-street as well as inside the custody when arrested.

*Some times I forget pen (syringe) in pocket, sometimes the syringe cap is in my ear. Then* ***they find it, slap me and take me to custody*** [a male PWID receiving NSP service, Community level]

*Obviously we get sick when we don't have access to drugs for long hours, and we may not even be able to stand up.* ***In such weak condition, inside custody, when we ask help with police they scold us, and make us clean toilets.*** *They should have given us medicine in such situation, but* ***they humiliate us saying we are addicts and useless and start torturing us*** [a male PWID receiving NSP service, Community level].

This study was able to identify how law enforcement implicates to human rights violations from ways other than regular physical punishment by law enforcement authorities as mentioned above. The fear of arrest among PWID as a result of criminal law enforcement in Nepal had become an opportunity to a some of the field level law enforcement authorities and drug rehabs. This nexus of police and rehabs easily took advantage of the fact that PWID lives in fear, are vulnerable and cannot deal with any hostile situation as they do not have any door to knock for support and on the other hand, government and higher ranked police officers were

also not able to strictly monitor the streets regularly. The brutal tortures and even death of drug users due to such torture inside rehabs as described by the participant were not directly carried out by law enforcement authorities but was one of the implications of drug law enforcement.

> *There must be more than 100 rehabs in Kathmandu alone.* ***There is a nexus between the rehabs and some police.*** *Neither has the government fixed the price for treatment nor has the network come up with a certain amount for treatment. They charge whatever amount they like. Those from a well-to-do family are charged high amount and those who cannot afford are sent back from rehabs the other day.* ***The rehabs and police work together to curtail our rights.*** *They forcefully take away people just like in cases of kidnapping. They torture people inside the rehab.* ***Some of our friends have died and those cases haven't come out*** [a member of Union C, National HIV program level].

*4.4.6 Financial Hassle*

Not all, but some of the referral of PWID to rehabs made by law enforcement authorities were found to have vested financial interest. These apparently good impression giving referrals happening between some of the field level law enforcement authorities and some rehabs that were registered as not-for-profit non-government organizations but commenced solely to gain profit. Participants expressed their disgrace on such human trading being practiced by the nexus of police and rehabs.

> *They refer the arrested drug users to the rehabilitation centers which is really a good thing but* ***some referral taking place for commission is not a good***

***thing.*** *It feels like* ***they are trading drug users.*** *Drug users' right to choose appropriate health services is violated here* [an outreach at ART Centre, Harm reduction service delivery level].

*They demean us by saying* ***"JUNKIE"*** *and before agreeing to refer a drug user to rehabilitation Centre,* ***they ask for commission.*** *The process is all corrupted. They charge you 20,000 and divide the money among themselves. Also, they* ***demand things such as mobile balance (recharge card) or the latest iPhone as bribes*** [a member of FDDR, National HIV program level].

*Sadly,* ***some police are corrupted and there are rehabilitation Centre for demand reduction, which are opened solely for monetary gain.*** *With these two coming forward, harm is done to the drug user only. It violates the human rights of the patients* [a member of FDDR, National HIV program level].

Ongoing financial hassle practiced by the nexus was one of the worst implications of drug law enforcement. This was not only affecting human rights of PWID but was also extended to emotional blackmailing to their families for money, as one participant recounted. The senior law enforcement authorities were found supportive towards the issues of PWID while due to lack of awareness and strict field monitoring, some field level law enforcement authorities were trading drug users for huge amount of commission.

*There is prior deal between some field level police and rehabs.* ***These two – rehab and police – together catch the drug user and blackmail his family.*** *They inform their family that they have arrested their son and gives them option whether to send him to jail or to rehab. Nobody wishes their children to go to jail so they prefer rehab. Even if they don't have money, they manage it*

*by taking loan. The police then get commission. What I feel is* ***higher rank police such as Inspector attends our meetings and are supportive*** *but they hardly monitor their field officers who have less knowledge about our issue* [a member of Union C, National HIV program level].

*4.4.7 Reporting mechanism and correctional efforts*

After identifying such level of human right abuses among male and female PWID, participants were asked if there were any mechanisms to report such abuses or any efforts made to rectify such practices. No proper mechanisms were identified even when talking to service providers, representative from national/international organizations and policy level participants. Analysis of data identified that participants were holding three major parties responsible to protect human rights of PWID – Law enforcement authorities, Human rights commission and organizations working for people who use drugs. First, PWID were mostly unaware about reporting mechanisms and second, as PWID have already developed fear and negative perception towards police activities they were not able to go to report at station and human rights commission was a long shot.

***There is no place to report human right violations for drug users.*** *Let's say there is, and how would he go? First he is drug user, he is running away from police. I am ex-drug user and currently a service provider, but still when I am walking in my way and* ***I see group of police in regular check, I have that fear till today*** [an outreach at CCC (ART) Centre, Harm reduction service delivery level].

*There is **no proper department to file the complaints** against these violations and unfortunate incidents. S/he should go to **human rights commission** (laughs)* [a representative from UNODC, National HIV program level].

***There is a human right commission but that's a waste of time and effort.** That place is also ripe with corruption. Even we don't go to many places as they are only a hassle* [a member of FDDR, National HIV program level].

*Till date, **I have not heard of any place where drug user can file case saying** he is tortured and his human rights is violated. Generally **he can go to police station,** but (Pause).. For drug users there is no authorized place to file complaints for human rights violation* [a representative from Save the Children, National HIV program level].

One of the female participants also showed her concern on how those who are supposed to protect human rights could abuse their power. She further added – *'Police already know that drug users are humans not animals and have human rights still they are doing wrong'.* While representative of NCASC tried to justify doings of law enforcement authorities saying:

*Human right means, if he says he wants to die, that may be his right, but we may have policy of county, whether or not to let them die. In some countries there are, but not in our country. It is the same thing about drug use* [NCASC].

As per information shared by representative of UNODC, the issues of human rights violations were previously discussed in NCASC and as solution, placing human rights desk in different localities was discussed, which was also included in the current strategy as well. But there were no efforts towards implementation of the

solution. She further described how situation was changing compared to the past approaches within police system by saying:

> ***The police have become much more aware*** *because the way they are groomed and trained have changed. We need to understand the human resource approaches they have been using and explain their responsibilities to them* [a representative of UNODC, National HIV program level Binija, UNODC].

The other parties who were held responsible to voice out issues of drug users and protect their rights were national networks of people who use drugs. Service providers had realized that these networks of drug users were not as active as it used to be previously. But issues around mushrooming of rehabs and violations inside those rehabs were raised frequently with the concerned government agencies, which were not entertained yet.

> *Talking about my experience of four years in FDDR, the effort has been one sided only. We have laid down all our problems with the government.* ***In the past, there were only 20 rehabs, while today we have about 160 rehabs.*** *In these 5 years, the numbers of rehabs have increased so much.* ***The government should at least monitor these rehabs.*** *They should be concerned about whether there have been human rights violations or not. But* ***the government has shown no interest at all*** [a member of FDDR, National HIV program level].

**4.5 Risky behaviors**

*4.5.1 Syringe exchange practices*

Most of the participants under every level (community to policy level) directly associated stringent law enforcement with high level of risky behavior practices among PWID. Law enforcement would first deter PWID from getting access to services and compel them to share syringe on one desperate day with no money to buy a syringe even from medical stores. Most importantly, PWID were detached from the very information, education and counseling which could prevent them from practicing risky behavior.

> ***If we suppress too much, there might be risky behavior practices.*** *But if we create friendly environment, they won't practice risk behavior. They can easily use drugs in DIC (dope in Centre) where they get syringes. So if environment is suppressive, risky behavior will be high. Police administration should also be aware regarding this* [an official at NCASC, Policy level].
>
> *The possibility of risk behavior is high. Like sometimes someone goes to take syringe, the police are around him, which deters drug users to come for services. If they have money to buy its fine but* ***if they do not have money, they will share syringe.*** *The other thing is* ***when our partners gives syringe, they get extra support, information and awareness which they will miss when they decide not to come for services due to fear of police*** [a representative from Save the Children, National HIV program level].
>
> *Users have drugs in their pocket while coming to get a syringe, and if they see the police they will fear for being caught.* ***Some of those clients will not come back for couple of days or even a month; they will find or borrow an old***

***syringe from some of their contacts*** [an outreach at NSP Centre, Harm reduction service delivery level].

***Due to police department, the risky behavior has increased.*** *There is no sign to decrease. How to say it is decreasing? Police will arrest or harass us even if we are found carrying a syringe. If we get to carry 3-4 syringe, then only that will reduce risk* [a male PWID receiving NSP service, Community level].

A fear of being stopped and searched or arrested by the law enforcement authorities exacerbated PWIDs' concerns about the risk of carrying injecting equipment and this led to a situation of syringe sharing. The worst part was that these sharing took place without following proper process of cleaning the syringes.

*Talking about situation, we will get only one drug for our group, sometime we won't even get it till 7-8 PM.* ***I can't take risk to carry syringe whole day without finding drug.*** *There will be only one syringe with one of us.* ***First one friend will use it and then clean it with saliva and then turn-by-turn we all use it cleaning in same way.*** *Sometime, it happens* [a male PWID receiving NSP service, Community level].

*I used to exchange syringe. The syringes were not readily available. At that time,* ***I knew that exchanging syringe is dangerous but I used to do it anyway*** *because I wanted to have the drug. Even though, I thought of exchanging it only once, it happened a lot of time. On top of that,* ***there was always the risk of getting caught by the Police*** [a female PWID receiving OST service, Community level]

Participants mentioned about the frequent complaints on degrading quality of OST (Methadone) and distributed syringes as one of the negative aspect of harm

reduction program. Though not connected directly, but procurement without quality assurance of the harm reduction medicines and equipment were found one of the factors contributing to the vulnerable environment already created by law enforcement authorities, thus compelling PWID to practice risky behavior. One of the female PWID living with HIV shared her story on how she got infected with HIV:

> *Once, late at night we scored some drugs. At that time, there was shortage of drug. Among the three of us, one was tested for HIV positive though we didn't know at that time. We had stock of two syringes. One immediately broke off so we had only one left.* ***It was night and we couldn't risk going out to buy new syringes because police easily spot us at night. Therefore, we shared a single needle among us, it was risky. After 3-4 months later, I was tested HIV positive*** [a female PWID receiving ART service, Community level].

*4.5.2 Hasty injection practices*

Due to the fear of police, PWID had to inject drug as fast as possible to avoid any interruptions. Participant associated these hasty injecting practices with increase in abscess cases.

> *We cannot use drug freely. They come and interrupt us while using in the places where we hide and use drugs. So due to that disturbances,* ***injecting the drugs in haste sometimes goes out of track, due to which abscess happens*** [a male PWID receiving HCV service, Community level].

*4.5.3 Risk of overdose*

One of the PWID participants shared his story of arrest and torture inside custody. He was physically tortured during his withdrawal period. Such situation

actually developed psychological distress on him, which was one of the indications of getting overdosed. He said:

> *Because of the humiliation and torture while inside custody,* ***I use even more stuffs than my normal dose*** *as soon as I get out from there* [a male PWID receiving NSP service, Community level].

*4.5.4 Risky shooting locations*

Law enforcement and fear of police also drove the decision of PWID in choosing a shooting location. Having a new syringe was important but it did not provide desired level of reduction in harm since PWID were injecting in risky places like bushes, toilets and even sewage under bridges.

> ***I have injected in many risky places*** *but I always carry stock of syringes with me. If a needle doesn't work, I immediately use another one. I take needles form DIC* [a female PWID receiving OST service, Community level].
>
> *I used to inject it along with a friend. As we cannot use it in proper place, mostly,* ***two of us used to stay in a small toilet and inject drugs.*** *One day we were doing the same thing in a toilet and I thought he had finished injecting but he was still injecting it while standing. He had a habit of filling the syringe with his saliva. While filling the syringe with saliva,* ***he slipped the syringe and fell accidentally into my thigh. May be I got infected with HCV then*** [a female PWID receiving HCV and NSP services, Community level].

One of the service providers emphasized a need for shooting gallery under care of health personnel or doctor if possible. He further added:

> *Everyone nowadays is thinking about this matter, in such case* ***they actually will be safe from diseases and if there are doctors or nurses, the overdose***

***case will be promptly responded to and the user will not die*** [an outreach at NSP Centre, Harm reduction service delivery level].

*4.5.5 Shift in drug administration route*

Another risk associated with law enforcement was shift in drug administration route. Injecting drugs were less time consuming and comparatively difficult for law enforcement authorities to detect. HIV infection among PWID was directly associated with number of PWID in the Valley and this number was associated with law enforcement as described by one of the participant representing drug users national network.

*During the starting of 90s, the banning of then used drugs, the users switch to syringes, which led to the drastic increment in HIV patients. Within the Kathmandu valley alone the number of HIV patients increased from 2% to 68% as shown by the statistics. It shows that the* ***banning of drugs and suppression of drug users by enforcing the law shows a direct effect upon the impact on drug users.***



**4.6 Prison Setting**

*4.6.1 Availability of drug*

Depending on the personal attitude of a law enforcement authority, in best-case scenario PWID were referred to abstinence based drug rehabs or at worst sent to prison on drug offences. Either way they suffered through range of human right violations and health-related risks. Some of the participants who had experiences of times spent inside prison were asked questions for availability of drugs inside the prison. Financial hassle existed in prison too and inmates were able to access marijuana and hashish while their imprisonment term.

*If one can provide money,* ***marijuana and hashish was accessible*** *and also in some cases if you can make contacts one could also drink alcohol* [a male PWID receiving NSP service, Community level].

***If you have money you can get anything.*** *Drug is such that it is a Hero of a English movie (both laugh) can arrive anywhere at any time. Foreigners are in jail in drug case, do u think they are staying there without using? They don't eat meal; Hashish cake comes in. how would police know what hashish cake is. There is hashish inside a cake. He is in trip by using the hashish cake. There is no smell, does not have to prepare it, no smoke as well* [a male PWID receiving NSP service, Community level].

*Obviously when I have to tell without lying, the people who has money,* ***he can bribe police and they bring the drug and make the person use in separate room, I have seen this trend.*** *I have also experienced when I was in the jail. The in-charge of the jail after bribing him some money he brings the drug, he brings it inside jail and allows taking it inside jail* [a male PWID receiving HCV service, Community level].

***If you have money, you will get to use anything you want.*** *But if you are poor, and even your family don't support you, for such person it does not matter if he dies or not* [a male PWID receiving NSP service, Community level].

*4.6.2 Risk in prison*

Participants also mentioned occasional availability of injecting drugs inside prison, which was a disastrous situation. The participants identified a closed setting like prison even more risky for drug use. They had to manage with available syringe

among the group and same syringe was shared many times a day for weeks until the drug was finished.

> *Inside prison, there was big situation.* ***There was the situation of using same syringe for weeks.*** *There we need to adjust among a group of people with single syringe for weeks. That means you think yourself, how many times it is used in a day? So, the situation there was critical* [a male PWID receiving OST and ART services, Community level].

**4.7 Joining the DOTS**

*4.7.1 Implementation gap*

One of the changes that most of the participants repeatedly mentioned was increased support from the law enforcement authorities to effective implementation of harm reduction services in Kathmandu Valley. Participants felt senior or high ranked officers like Inspector and above were more receptive and supportive towards issues of PWID.

> *Nowadays* ***police also don't punish drug users, they take them to rehab Centre or harm reduction programs.*** *Police administration is also becoming much friendlier* [an official at NCASC, Policy level].
>
> *During the meeting with higher rank police administration, they create good environment.* ***They assure their help if we have any problem, we can just contact them and they are ready anytime to help us*** [an outreach at CCC (ART) Centre, Harm reduction service delivery level].

As per participants, several meetings and orientations were held with law enforcement authorities to harmonize the situation on the streets. Mostly senior authorities attended the meetings and committed to creating an enabling environment

for PWID but a sense of frustration was felt among participants regarding their efforts going futile at implementation level.

> *We have coordination and stakeholders meeting with DIC, other associated service provider of harm reduction and police administration so that, in coming days PWID don't face any problem, they don't face any obstacle in getting services. Police department (Pause)…* ***they also provide positive response for it but they don't implement it*** [a female member of NEDUPA, National HIV program level].

> *We have organized program like police orientation for police. There, high rank police officers come to attend the program. They know about the harassment of drug user, they know drug users have rights, etc. but* ***lower rank police at field don't know about anything.*** *They arrest if found with syringe also, and punish them. And if requested to higher rank officer, then they release them. That means, the lower rank police are needed to give information because they are the persons responsible for field work* [an outreach at NSP Centre, Harm reduction service delivery level].

4.*7.2 Awareness among law enforcement authorities*

During interviews with policy level and National HIV program level participants, it became apparent that drug use is undoubtedly a health issue and they should be catered with services that are based on welfare of their health and human rights. Representative from NCASC said – *'I am person of health and I think drug use is health issue'.* Representative from UNODC also recounted:

> *We work based on human right and health. Because of the drug addiction, law enforcement agencies are our Line partners. So,* ***our duty is to make the***

> ***agencies aware that drug addiction is a public health issue and you can not just control it by taking drug users into custody.*** *Their role is to control the supply of drug. And, there should be a balance between drug user's human right and health right* [a representative from UNODC, National HIV program level].

To some extent, law enforcement authorities were accepting this fact and also trying their best to support PWID to access health promoting harm reduction services. As per representative from UNODC, police were contributing and were more aware on the issue compared to past. She said – *'Now, they also represent in different forums regarding HIV and drug usage. Civil society also encourages them and help them'.* In the course of educating and sensitizing law enforcement authorities, participants had realized less awareness among field level police personnel. Analysis of data also showed most of the law enforcement related impediments might be occurring due to failure in effective and updated flow of information within government agencies such as between Ministry of Health and Home, between Ministry of Home and drug law enforcement authorities.

> *The government has approved harm Reduction Program. So, NCB can only assist it. Maybe the police have not been made aware of the government's approval or maybe because of lack of flow of information in the system.* ***The policies and regulations are made and signed in the higher level of the system but the makings of such policies and regulations are not communicated well throughout the system*** [a representative from UNODC, National HIV program level].

*If a police from the narcotics bureau catches a person with HIV positive with drugs, and* ***if the user asks for his medicine, say ART. The police will not understand what ART is*** *and will instead ask in which medical store it is found. It is something the government distributes; they don't even know such a thing. So you can see how the system is and must be changed* [an outreach at NSP Centre, Harm reduction service delivery level].

Agreeing to the reality of awareness level among police, one of the participants also expressed his doubt that wrong doings of some field level police might be driven solely by the game of commission within the police and rehab nexus.

> ***It is mostly because of commission that people are caught while they are found carrying needles and syringe.*** *I also think that it is due to the* ***lack of coordination.*** *I think Police are not aware regarding it or there might be the chances that upper levels were only invited in the seminars regarding such issues* [an outreach at ART Centre, Harm reduction service delivery level].

*4.4.3 Coordination gap*

From the interview data, gap in coordination between law enforcement authorities and health workers, including service providers and civil society networks was identified. In some areas law enforcement authorities had better role to play while in others health workers were accountable. Polar views on defining and dealing with the same issue of drug use among these key players was leading into a blame game where consistent coordination effort was critical.

> *Strategy of Nepal government is like this… in my opinion, what I think is* ***methadone, brupre norphine which are endorsed by government; in this part***

> ***the coordination with police administration is lacking,*** *the environment is not conducive* [an outreach at CCC (ART) Centre, Community level]
>
> *Generally, if we watch the drug users' community, we do not have genuine compassion and genuine what you call genuine common understanding between the stakeholders.* ***We have fragmented opinions, we do not have coherent thoughts, still today some people are against the methadone and OST while some are positive,*** *there is no clear understanding about the working principle of drug addiction and meaning of drug addiction. These are creating obstacles in working with drug users* [a representative from Save the Children, National HIV program level].

Besides law enforcement authorities, there were many other organizations working in silo to bring change in the scenario of drug use.

> *We should bring the programs with a view of "Joining the Dots" as different organizations like* ***Home ministry, Health ministry, Nepal Police department, Army Officers' Wives Association, and communities are working on their own way.*** *All these organizations should come at a place and work jointly, then only we can address these problems. There should be a* ***balanced approach*** *on harm reduction, demand reduction and supply reduction* [a representative from national network of people who use drugs].

Law enforcement authorities were in need of better education regarding issues of drug use through health and human right lens. Despite some obstacles in delivering harm reduction services to PWID, one of the service provider said – *'Just because one or two police did bad does not necessarily mean we have to blame the whole police'.* Similarly, other representative of national network of people who use drugs also said:

*There is an increase in the awareness level of these organizations, as we need political education.* ***They cannot be blamed,*** *as Drug Control Act formulated several years ago is the major hurdle since they are the people who can only enforce the law but cannot change the law. They say that it is a disease and you bring a document in written that it is a disease and we will send you to the health Centre* [a member of national network of people who use drugs].

In addition, representative from UNODC also emphasized the role of civil society in coordinating and working with law enforcement authorities instead of blaming and exacerbating the situation.

*It is not that the deployment of police will reduce this behavior of addiction. But undoubtedly, the police have helped in control of drug addiction. I believe the police works according to the mandate they receive so it is not appropriate to blame them for some unfortunate incidents of arresting a victim. We need to understand their limitations and* ***it is our duty as civilians to aware them about such government approved Needle Syringe Exchange program*** [a representative from UNODC, National HIV program level].

Data analysis also showed good examples where law enforcement authorities helped PWID to access harm reduction services, PWID were allowed to take OST (methadone) in custody, and PWID were released from custody after law enforcement authorities were properly oriented *(See 'Enablers to access' section for quotes)*. But time after time, participants experienced obstacles from law enforcement authorities. Representative from Save the Children attempted to elucidate such situation by saying:

***The issues of arrest for carrying a syringe depend upon how our partner friends remain in coordination with the local level police.*** *The problem is, after some months the police who receives orientation are transferred from that area, and when it happens, the new transferred do not have the concept of the work we are doing, at that time there are some restrictions, but they do not make hurdles much frequent just for the syringe. When we had budget, we had frequent police orientation but now it has reduced due to budget constraint* [SC]

# CHAPTER V

# DISCUSSION AND RECOMMENDATIONS

To my knowledge, this qualitative investigation is one of the first empirical studies that have explored the implications of drug law enforcement on harm reduction programs and people who inject drugs in in Kathmandu Valley, Nepal. To be specific, this study sought to investigate the implications of the drug law enforcement in the three major areas - Barriers to access harm reduction services, Human rights violations and Risky behaviors among PWIDs. It was also open to any other kind of implications beyond the focused areas. After an exhaustive analysis of the verbatim transcript data produced from 28 in-depth interviews, there were several findings based on seven major themes that emerged during the analysis *(see Table 4.2).* In order to be consistent with the objectives of this study, four major implications of drug law enforcement are discussed below:



**5.1 Implications on Drug use scenario**

Participants interviewed in this study were concerned about the increasing drug use trend among adolescents who stays mostly hidden and are not reported in any studies. The 2013 drug survey in Nepal reported, among 91534 drug users in Nepal, 1.4 percent of drug users below 15 years and 19.9 percent between 15 to 19 years (MoHA, 2013). Rapid increase in juvenile drug use with age of initiation as early as 13 years can be indication of high risk due to the gap between age of initiation of drug use and age at which harm reduction services are accessible. Most of

the harm reduction program, including OST (methadone) service requires parental consent for those who are below 18 years old in Nepal. Besides, National ethical guidelines for health research in Nepal and Standard Operating Procedures 2011 required extra processes to be carried out in order to include children or adolescent participants due to which they are left behind most of the times (Nepal Health Research Council, 2011).

This study identified increase in price of drug per dose by more than 30 times during past decade. Participants mentioned a PWID needs around NRs. 3000 (approx. US $28/per day) to take his daily dosage, which when compared to wage and salary rates in Nepal, is 9 times higher than per day minimum wage rate in Nepal (NRs. 318) and one-third of per month minimum salary rate in Nepal (NRs. 8000) (grs.com.np, 2013). Juveniles who use or inject drugs do not have income sources other than their families. There are some evidences to suggest that law enforcement initiatives are positively associated with price of drugs. In fact, higher level of enforcement affects primarily price, not the availability due to which PWID are further impoverished (Caulkins, 1993; Zimmer, 1990) and compelled to finance their habit through property crime (White & Luksetich, 1983) and different situational cost management strategies. Some of the strategies associated by participants with increase in drug price were assisting drug dealers to sell drugs to get free daily dose, formation of group to manage money, use of low quality mixtures to redress the amount of drug they lost due to sharing drug among group members, and sharing of syringes among group members when new syringes were inaccessible. This kind of situation was further associated by participants to increase in cases of abscess, DVT and blood borne infections among PWID. On the contrary, other studies showed there is no

relationship between arrest and price or quality of drug (Rose, 2016; Weatherburn & Lind, 1997). As per their discussion, their findings might be contrasting due to arrest and seizure of low quantity of drug; import of sufficient quantities of drug to compensate such expected loses due to law enforcement; and time aggregation of data that is likely to mask the short run impacts on price.

**5.2 Implications on Barriers to access harm reduction services**

Analysis of interview data established how presence of law enforcement authorities near service delivery sites, their intervention, on-street stopping, searching and interrogations, arrests for carrying a syringe deterred PWID to access harm reduction services. Participants mostly experienced such barrier to access while accessing NSP or OST services. Regardless of the fact that some participants were receiving other services like HCV, HTC and ART during data collection, most of them shared their experiences of barriers to access NSP and OST services from their past. This finding is consistent with many previous studies in different parts of the world that have suggested law enforcement efforts ranging from regular scrutiny to brutal tortures may create a barrier to access harm reduction services, in particular sterile syringe acquisition when placed in proximity to service delivery points (Dutta et al., 2013; Hayashi et al., 2013; Wood et al., 2003). This situation was even exacerbated among the PWID with multiple arrest history or disclosed drug using status as argued by a study in Russia (Rhodes et al., 2003). Law enforcement negatively influenced PWID to access harm reduction program and their willingness to carry syringes. In addition, it also made the task of outreach to reach PWID difficult by displacing the PWID (Maher & Dixon, 1999a; Small et al., 2006). Some of the participants attributed their service inaccessibility to factors other than law

enforcement, such as limited opening hours, degrading quality of medicines (methadone) and syringes that were distributed through harm reduction services and lack of gender-sensitive services for female PWID. However, those findings of this study are not discussed comprehensively since the objective of this study is limited only to the implications of drug law enforcement. It is just mentioned as findings in order to recommend as issue for future empirical studies.

**5.3 Implications on Human rights violations**

Human rights violation of PWID was one of the most reported implications of drug law enforcement. They were in form of stringent scrutiny, threats and arrests; breach of confidentiality; stigma and discrimination; sexual harassment to female; physical punishments; and financial hassle. Most of the participants perceived behavior of law enforcement authorities to be stigmatizing and discriminative. For instances, calling by slang words such as *'tyape', 'junkie', 'addict' or 'drug abuser'* in public spaces like streets and hospitals; treating once an addict always an addict when they tried to quit illegal drug and enrolled themselves in harm reduction services like OST; and unfair judgment during encounter with the authorities. There was a likelihood of being stopped and searched wherever encountered or whenever some incident happened in the locality if an individual was previously arrested or was known to have drug use history. Such PWID were vulnerable to being convicted for crimes other than their drug use also. Use of discriminative slang words and stopping and searching activity in street led to disclosure of their drug use behavior to their families, which was associated by participants with crisis that drove PWID into seclusion and crime. Labeling PWID in a stigmatized and discriminative way in presence of criminal justice system leads to an increased delinquent self-identity,

decreased pro-social expectations, and an increased association with delinquent peers, which then lead to an increased likelihood of engaging in subsequent delinquency (Restivo & Lanier, 2015). There are arguments on the need of positive identity as a central to helping drug users through alternatives. Only then can a drug user exert upon the decision to choose safer and better paths in future (J. M. McKeganey, Neil, 2001).

Women who use drugs often face discrimination on the basis of both drug use and gender. They are portrayed as so-called fallen or bad women and unfit mothers (Jürgens, Csete, Amon, Baral, & Beyrer, 2010). Violation of human rights among female PWID was more likely to occur than male PWID and more severe as they had to go through all forms of human rights violation with an addition of sexual harassment. They were subject to be sexually exploited by their male PWID partners, drug dealers and law enforcement authorities. They were often humiliated and forced to comply with sex demands inside custody by the authorities. Law enforcement authorities were indulgent to offer drugs to female PWID during their withdrawal in custody forcing them to provide sex in return. There are evidences that sexual violence highly occur in closed settings, may it be a detention Centre or prison. Serious human rights abuses by guards, including severe beatings and sexual assault, have been reported in most of the compulsory detention centres in South-East Asian countries (Jürgens et al., 2010).

It is obvious that criminal law reinforce fear. This fear among PWID had become an opportunity to a nexus of some of the field level law enforcement authorities and drug rehabs. PWID were referred to drug rehabs where brutal tortures and unreported deaths from such torture were happening. These brutal physical and

mental tortures inside drug rehabs were not directly carried out by the law enforcement authorities but were one of the implications of law enforcement. The so-called drug rehabs are supposedly a treatment and rehabilitation Centre to help drug users through abstinence process but they have rather turned into a form of compulsory detention Centre even though it is run by drug user community themselves. Although drug rehabs in Nepal have some differences with the detention centres practiced in South-East Asian countries, there are some similarities in terms of its coercive nature and human rights abuses during the detention. Through studies around such centres in countries like Myanmar, Cambodia, China, Indonesia, Laos, Malaysia, Thailand and Vietnam, it is evident that people who use drugs face coerced treatment and rehabilitation, resulting in many human rights abuses. Most of these centres provide services of poor quality and do not accord with either human rights or scientific principles, and rather implements ill therapies with high rate of relapse (Jürgens et al., 2010; World Health Organization, 2009).

Financial hassle practiced by the nexus was one of the worst implications of law enforcement. The nexus, in this study, refers to a group of some of the corrupted field level law enforcement authorities and some rehabs that are registered as not-for-profit non-government organizations (NGO) but commenced solely to gain profit. The nexus was initiated with a vested financial interest, as such, these authorities and rehabs worked together to arrest drug users and blackmail their family giving a choice between rehab and prison. Once the family decides to go for rehab, then rehabs would get treatment fees, involved field authorities would get huge commission and the exploitation was documented and would appear as good referral practices in the eyes of everyone. This process would be repeated again after the newly referred PWID

spell out some potential names and addresses of other PWID during tortures. However, senior level law enforcement authorities were found supportive towards the issues of PWID, the nexus was easily operating due to lack of awareness and strict and regular field monitoring from senior authorities and government. Maher and Dixon has argued that enforcement of law does not suppress illegal activity, but the threat to the victim encourages development of a level of organizations that protects the victims and increases the potential police corruption (Maher & Dixon, 1999a). Another study has categorized these kind of drug-related corruption of law enforcement authorities as illegitimate goals which are abuse of power for personal gain (Carter, 1990). No proper mechanisms to report human rights violations were identified. But three major parties were held responsible to protect human rights of PWID – Law enforcement authorities, Human rights commission and organizations born to serve people who use drugs. PWID either had no awareness on such mechanisms or feared to report violations as the law criminalized their drug use behavior.



**5.4 Implications on Risky behavior among PWID**

Stringent law enforcement was directly associated with high level of risky behavior practices among PWID. Associated risks were syringe exchange practices, hasty injection practices, risk of overdose, risky shooting locations and shift in drug administration route from oral to injection. Participants were reluctant to carrying a syringe as stock for their next dose but were more comfortable in deciding to share syringe just by cleaning it with saliva due to fear of being harassed or arrested by the law enforcement authorities. Previous studies also discussed that arrest for possession of syringes was associated independently with syringe sharing (Jürgens et al., 2010;

Rhodes et al., 2003). Similarly, presence of law enforcement was considered to be a legal vulnerability while purchasing and consuming drugs which affected behavior of PWID. In order to avoid interruption by law enforcement authorities before confiscation, PWID had to rush during the injection process, further putting themselves into risk of abscess and DVT (Kim Dovey, John Fitzgerald, & Youngju Choi, 2001; Kerr, Small, & Wood, 2005b; Maher & Dixon, 1999a). Rushing to injection sometimes puts them into risk of overdose as they do not take time to learn their dosage (Small et al., 2006). A meta-analysis also demonstrated high risk of overdose among the PWID during the first 2 weeks after their release from any form of detentions like compulsory drug rehabs and prison (Merrall et al., 2010). This study also had limitations and could not further assess potential psychological distress identified in one of the PWID after being tortured by the law enforcement authorities inside custody as one of the determinants of risk behavior that could lead to overdose, which was not discussed in almost all the cited papers. But a comparative investigation of psychological effects of torture showed that those who were tortured had significantly more symptoms of long term anxiety/depression compared to non-tortured participants (Basoglu et al., 1994), which might justify such self-harming decision of PWID. In terms of risky behavior, law enforcement implicated the decision in choosing shooting locations both indoor and outdoor. PWID chose settings that were more likely to be unhygienic, poorly lit, ill-ventilated and congested in size (Maher & Dixon, 1999a). A shooting gallery space where PWID could safely inject drugs and gets assisted by professional doctor or a health worker to mitigate any form of health-risk was desirable for some of the participants. Finally, HIV infection rate among PWID was directly associated with number of PWID in the Valley and this

number was associated with law enforcement as described by one of the participant representing national network of people who use drugs. Banning of drugs and suppression of drug users by law enforcement had a direct effect on the decision of a drug user to select between orally or intravenously administered drug. Previous study in Nepal had tried to explain how enforcement of law facilitated the shift in drug from smoking or chasing to psychoactive substances followed by injecting drug, as they were comparatively difficult to be detected by the law enforcement authorities (Shrestha, 2011).

**5.5 Joining the DOTS**

One of the changes that some participants repeatedly mentioned was increased support from the law enforcement authorities to effectively implement harm reduction services in Kathmandu Valley. On contrary to the discussion above, Law enforcement authorities were also found to be supportive in many instances as described by the participants. Authorities who were aware of drug-related services and health issues of PWID had helped PWID to access services. Especially, senior law enforcement authorities (Inspector and above) were more receptive and supportive towards issues of PWID. In some cases, PWID were allowed to take methadone when they were inside the custody regardless of the nature of their offence, which is not a usual event in Nepal. This kind of contributing change practiced by the law enforcement authorities mostly remained unappreciated and instead whole law enforcement system was blamed for misconduct of few field level authorities.

Gap in coordination between law enforcement authorities and health workers, including service providers and civil society networks was identified. In a recent online news, Deputy Inspector General of Police, NCB explained that organizations in

Kathmandu do not coordinate with them and instead of coordinating beforehand, they only visits them when any of their staffs or recovering users are arrested (Republica, April 29, 2016) and the converse is recounted by participants in this study. In absence of consistent coordination and partnership, it is obvious that law enforcement authorities are left with no choice other than enforcing law and filling courts and prison with drug users (Maher & Dixon, 1999a). In addition, analysis of data also showed most of the law enforcement related impediments were occurring due to lack of awareness and failure in effective and updated flow of information within government agencies such as between Health Ministry and Home Ministry, between Home Ministry and drug law enforcement authorities, and within senior law enforcement authorities to field level authorities. For instance, Government of Nepal, Ministry of Health and population, Department of Drug Administration DDA identified Methadone Buprenorphine (Narcotics and Psychotropic Substances) for Import and Use and listed under essential drug list. Since it comes under Schedule A of the Drug Act, 2035 B.S, it requires the approval of Ministry of Home Affairs for importation into the country (Government of Nepal, 1978). This entails that the MoHP endorsed implemented OST services like methadone buprenorphine treatment in Nepal only after receiving approval from MoHA. But due to the lack of awareness, field level law enforcement authorities still create barriers to access such essential medicines. Upon holding meetings, orientations and interactions with the law enforcement authorities, participants of this study realized changes in their activity, yet their personal inclination towards abstinence based compulsory drug rehabs and resistance to harm reduction programs were also identified. As per one of the study in Vietnam, law enforcement authorities perceive conflicting responsibilities, but

overwhelmingly see their responsibility as enforcing drug law, identifying and knowing drug users, and selecting those for compulsory detention despite harm reduction trainings were provided to them (Jardine, Crofts, Monaghan, & Morrow, 2012). An assessment report of policies on harm reduction in Nepal also reported lack of proper implementation of available policy and program and lack of conceptual clarity among key actors in drug use sector as major gaps that impede the issue of PWID in Nepal (Sharma & Pun, n.d.).

Most of the law enforcement authorities, in best-case scenario, referred PWID to abstinence based compulsory drug rehabs or at worst sent them to prison on drug offence. Either way PWID had to suffer through range of human right abuses and health-related risks. Preceding sections have already discussed the ill-environment of drug rehabs. Similarly, high availability of orally and few intravenously administered drug, financial hassle by guards to provide drug and far worse risk of syringe exchange were identified inside prison. Numerous studies have proved that drug users mostly continue to use drug while imprisoned and often prison is also a place to initiate drug use as a means to cope with overcrowded and violent environments (Jürgens, Ball, & Verster, 2009; Jürgens et al., 2010). Because of a closed setting with no legal access to syringes, inmate PWID are more likely to share syringes than PWID outside prison (Huby, 2000).

### 5.6 Limitations and Strengths

This study has several important limitations. First, the scope of the current study is limited by the fact that the perspectives of law enforcement authorities (NCB representatives) could not be included. Second, there are also chances of recall bias as most of the interviews were based on experiences of participants from their past.

Third, resource limitations have affected in recruitment of competent research assistants and ended up the orientation/training of research assistants into just one day. However, the impact of this limitation was mitigated to least through different ways as described in the *Chapter III*. Finally, the present study is also limited in that it was not able to further assess in depth, the psychological distress of tortures among PWID; barriers to access due to limited opening hours, degrading quality of medicines (methadone) and syringes that were distributed through harm reduction services and lack of gender-sensitive services for female PWID; financial hassle and risk in prison setting that were mentioned by the participants.

Notwithstanding the limitations, the findings of the study are consistent with many previous studies as cited in the discussions. Similar methodologies have been used in prior studies in other countries and region that were focused on impact of intensified police on PWID and harm reduction, factors influencing barriers to access to services, and attitudes towards syringe access. The qualitative method of this study was integral technique to capture participants' perspectives in an under researched area, which can be further used to develop quantitative studies in the future. This study has raised issues that, hitherto, have been peripheral and mostly unheeded.

**5.7 Conclusion**

This study highlights the critical implications of drug law enforcement on drug use scenario, particularly price of drug and its consequences; barriers to access harm reduction services; human rights violations, with emphasis on physical tortures and financial hassle; and risky behavior practices among PWID in Nepal.

Drug law provided ultimate power to law enforcement authorities and concomitant fear to PWID. Abuse of such power resulted in range of human rights violations,

including formation of nexus for financial hassle and increased barriers to access harm reduction services as well as increased risky behavior practices among PWID. A harm reduction approach requires cooperation with every level of stakeholders, especially police-based and non-police based organizations committed to demand reduction and public health. Law enforcement authorities were in need of better education regarding conceptual clarity on existing harm reduction policies and services, new alternatives based on scientific evidences and issues of drug use through health and human right perspective.

**5.8 Recommendations**

*5.8.1 For immediate response* (Short-term impact programs)

As an immediate response to improve the dire situation of PWID in Nepal, following actionable programs are recommended.

Consistent coordination with law enforcement authorities and government agencies vis-à-vis drug use control. Both international as well as domestic funding to drug and HIV sector should be more focused towards holding regular coordination and interaction meetings with the stakeholders, including media for parallel public awareness.

These funding should also be directed towards the short course education and training events for both senior and field level law enforcement authorities so that the information gap between those levels of authorities is mitigated.

Participant mentioned previous discussion in NCASC about placing a human rights desk in different localities, which was also included in the current strategy of Nepal. Such available strategies should be immediately implemented.

Since knowledge had some impact on activities of law enforcement authorities and the real problem was frequent transfers of trained authorities, it is recommended to keep track of all the trained authorities and duly follow up in programs as guest speakers.

Education and awareness to families of PWID should also be prioritized.

*5.8.2 For policy reform* (Long-term impact programs)

Long-term health development of PWID cannot be envisaged without favorable policy and law reform through meaningful involvement of all the key actors, specially the community.

The age of consent guidelines/SOP was identified as one of the barrier that was keeping juveniles away from service access as well as different empirical studies. Such threshold of age need to be reduced so that the issues of drug use among adolescents and young people are better translated into programs.

Education and training module for law enforcement authorities should be endorsed in the curricula of Police academy so that new recruits in the law enforcement system are capable of taking wise decisions during their encounter with drug users.

In long run, it is almost impossible or excessively costly to train and educate each and every law enforcement authorities. The Narcotics Drug Control Act 2033 (1976) that was formulated almost 40 years ago guides the actions of authorities. Therefore, NDC Act should be revisited and amended through the perspective of public health based on human rights and evidence-based harm reduction approaches.

*5.8.3 For further research*

This study explored the situation that was peripheral or unheeded in Nepal. The findings of this study will be beneficial in developing questionnaire for researchers who want to pursue a quantitative research. In the *'Limitations and Strengths'* section above, issues that were not covered by this study are well articulated, which can also be a subject to future researchers. This study also highly recommends further researches exclusively focused on the issues pertaining to juveniles and female who use or inject drugs in Nepal.

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# APPENDIX

**Annex I: Work Schedule (Timeline)**

| Month/Year | Activities |
|---|---|
| **October, 2015** | - Initial meeting with Advisor on topic<br>- Literature Review |
| **November, 2015** | - Literature Review<br>- Concept submission to Advisor |
| **December, 2015** | - Thesis Proposal development |
| **January, 2016** | - Thesis Proposal development and submission<br>- Apply for thesis proposal exam |
| **February, 2016** | - Thesis proposal examination |
| **March, 2016** | - Finalize Thesis Proposal as per feedback from Examiners<br>- Prepare Ethical approval documents |
| **April-May, 2016** | - Ethical Approval process<br>- Data collection and field work |
| **June, 2016** | - Data analysis and thesis report development |
| **July, 2016** | - Thesis submission and application for Journal Publish |

**Annex II: Budget**

| SN | Particulars | Measuring Unit | Unit | Unit cost | Total in NRs | Total in Thai Baht |
|---|---|---|---|---|---|---|
| **1** | **Travel and accommodation** | | | | | |
| | Round trip air ticket (BKK-KTM-BKK) | # of person | 1 | 60000 | 60000 | 20000 |
| | Local transportation | # of days | 10 | 500 | 5000 | 1667 |
| | Accommodation in KTM | # of days | 10 | 1500 | 15000 | 5000 |
| **2** | **Training to research assistants** | | | | | |
| | Venue charge | # of days | 1 | 1000 | 1000 | 333 |
| | Projector charge | # of days | 1 | 1500 | 1500 | 500 |
| | Lunch and snacks to participants (5 research assistants, principal researcher and few experts of the drug and HIV sector) | # of participants | 11 | 1100 | 12100 | 4033 |
| **3** | **Stipend to research assistants** | # of interviews | 31 | 500 | 15500 | 5167 |
| **4** | **Benefits to interviewee** | | | | | |
| | Remuneration to policy level interviewee | # of interviewee | 3 | 1000 | 3000 | 1000 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Remuneration to National HIV program level interviewee | # of interviewee | 8 | 500 | 4000 | 1333 |
| | Remuneration to HR service delivery level interviewee | # of interviewee | 6 | 1000 | 6000 | 2000 |
| | Remuneration to community level interviewee (PWIDs) | # of interviewee | 20 | 500 | 10000 | 3333 |
| | Refreshment to interviewees | # of interviewee | 31 | 150 | 4650 | 1550 |
| **5** | **Transcribing and Translation fees** | # of interviews | 31 | 1500 | 46500 | 15500 |
| **6** | **Rent for audio recorder** | # of recorder | 5 | 1000 | 5000 | 1667 |
| **5** | **Publication of Thesis** | Lump sum | 1 | 5000 | 5000 | 1667 |
| **6** | **Dissemination meeting (refreshment to participant, travel allowance, venue charge, projector charge etc)** | Lump sum | 1 | 20000 | 20000 | 6667 |
| **7** | **Stationeries** | Lump sum | 1 | 5000 | 5000 | 1667 |
| **8** | **Ethical Approval Fees** | Lump sum | 1 | 10700 | 10700 | 3567 |
| **9** | **Miscellaneous** | Lump sum | 1 | 10000 | 10000 | 3333 |
| | **Grand Total** | | | | **239950** | **79983** |

## Annex III: In-depth interview checklists

### Checklists' use

The researcher asks the numbered broad questions first. If the interviewee does not respond with the issues in bullet points, under each numbered questions, the researcher will prompt the issues with further questioning followed by sub-bullet guides.

### A. Policy Level - Narcotics Control Bureau (Police (NCB)) under Ministry of Home Affairs (MoHA)

**1.** What is the current drug use scenario in Nepal and Kathmandu?
- How many users? Kind of drugs? Availability and trafficking routes? Cost and age group? Specific in Kathmandu?
- How has it changed compared to last 5 year/a decade?
- In your opinion, what is drug use?

**2.** What strategies/approaches does Nepal Government employ to respond drug use problem in Nepal?
- Ask about supply reduction and demand reduction (if not responded as answer)
- What are the existing structures to implement the strategy in Nepal?
  - ✓ How many police deployed in Kathmandu only and Nepal?
  - ✓ How do they operate?
- What is the annual budget of Nepal for drug control and how is the fund utilized?
  - ✓ What are its sources?

**3.** What are the activities conducted by Police (NCB) to combat drug use?
- How do you collect information? How is it managed and disseminated?
- What are the procedures of investigation, arrest and prosecution?
- What is done for development of Police (NCB) human resource?
- Any human rights trainings?
- Research and development
- Support system

4. How do you evaluate the effectiveness of the existing strategies and activities?
    - What are the major achievements? (shifts in drug scenario)
    - What are the major challenges?
    - What are the flaws/weakness of current drug control law and strategy (if any)?
5. What do you think about harm reduction program?
    - What are the things that you like about harm reduction program?
    - What are the things that you don't like about harm reduction program?
        - ✓ How about other colleagues in Police (NCB)?
    - How does Police (NCB) help facilitate harm reduction program in Nepal (Kathmandu)?
        - ✓ How does Police (NCB) support PWIDs to access harm reduction services?
    - What kind of differences, if any, does Police (NCB) strategies and harm reduction program have?
        - ✓ Contradiction between health and home ministry?
        - ✓ How do they impede to achieve the objectives of Police (NCB)?
        - ✓ What do you think should be done?
6. What do you think about relation between law enforcement (Police (NCB)) and human rights of PWID?
    - How does Police (NCB) ensure that human rights of PWID is respected and protected?
        - ✓ What are some examples of human rights being protected for PWIDs?
    - Based on your experience, what would you say are the implications of law enforcement to human rights violations of PWID?
        - ✓ What are some examples of human rights violations (if any)?
    - How well do the Police (NCB) team acknowledge these implications?
7. What do you think about relation between law enforcement (Police (NCB)) and risky behavior among PWID?
    - Based on your experience, what would you say are the implications of law enforcement to risky behavior among PWID?

- Literatures shows that implications are sharing of syringes, unsafe injecting attempts, repeated use of same syringes, shift from oral to injecting drugs, overdose.. What do you think about these findings?

**8.** What are other implications of law enforcement to drug use scenario and PWID (if any)?

**9.** What do you like to see happen in coming years regarding drug use scenario?

- How do you think that can be achieved?
- What is your opinion about the concept that drug use is more public health issue rather than criminal issue?

**B. Policy Level -National Centre for AIDS and STI Control (NCASC) under Ministry of Health and Population (MoHP)**

**1.** What is the current drug use scenario in Nepal and Kathmandu?
- How has it changed compared to last 5 year/a decade?
- In your opinion, what is drug use?

**2.** What strategies/approaches does Nepal Government employ to reduce drug use problem in Nepal?
- What are the key policies and guidelines driving programs related to HIV and drug use in Nepal?
  - ✓ How and when were they introduced?
- What is your opinion about the importance of supply reduction and demand reduction?
- What is the current national spending on drug use and HIV sector?
  - ✓ What are the major sources of fund?
  - ✓ What is the proportion expended solely by government of Nepal?
  - ✓ How much is expended only for harm reduction programs?

**3.** What do you think about harm reduction program?
- What are the harm reduction programs implemented in Nepal (and Kathmandu only)? (by NCASC only)
- What are the things that you like about harm reduction program?
- What are the things that you don't like about harm reduction program?
  - ✓ How about other colleagues in NCASC?
- How does Police (NCB) help facilitate harm reduction program in Kathmandu?
  - ✓ How does Police (NCB) support PWIDs to access harm reduction services (if any with examples)?
  - ✓ How does Police (NCB) obstruct PWID's access to harm reduction programs (if any with examples)?
- What kind of differences, if any, does Police (NCB) strategies and existing harm reduction program have?
  - ✓ How do they impede to achieve the objectives of harm reduction program?
  - ✓ What do you think should be done?

4. What do you think about relation between law enforcement (Police (NCB)) and human rights of PWID?
    - What is being done to ensure that human rights of PWID is respected and protected?
        - ✓ What are some examples of human rights being protected for PWIDs?
        - ✓ What is the mechanism for PWID to report any human rights violation issue? How is the report taken forward?
    - Based on your experience, what would you say are the implications of law enforcement to human rights violations of PWID?
        - ✓ What are some examples of human rights violations (if any)?
5. What do you think about relation between law enforcement (Police (NCB)) and risky behavior among PWID?
    - Based on your experience, what would you say are the implications of law enforcement to risky behavior among PWID?
        - ✓ What are the examples (if any)?
    - Literatures shows that implications are sharing of syringes, unsafe injecting attempts, repeated use of same syringes, shift from oral to injecting drugs, overdose.. What do you think about these findings?
6. What are other implications of law enforcement to drug use scenario and PWID (if any)?
7. How do you evaluate the effectiveness of the law enforcement strategies (supply and demand) in Nepal?
    - What would you say about the vision of creating drug free society?
    - What positive aspects do you see?
    - What negative impacts do you see?
    - What are the flaws/weakness of current drug control law and strategy (if any)?
8. What do you like to see happen in coming years regarding drug use?
    - How do you think that can be achieved?
    - What is your opinion about the concept that drug use is more public health issue rather than criminal issue?
    - How National stakeholders perceive importance of management of drug use on the basis of human right as well as public health approach.

**9.** What efforts have been made to resolve the issues faced by national HIV program due to drug law enforcement?

**C. National HIV program Level (INGOs and National networks)**

**1.** What is the current drug use scenario in Nepal and Kathmandu?
   - How has it changed compared to last 5 year/a decade?
   - In your opinion, what is drug use?

**2.** As organization, what are your roles in national drug and HIV programs?
   - How do you collect information? How is it managed and disseminated?
   - How are service providers benefited?
   - How are PWIDs benefited?

**3.** What strategies/approaches does Nepal Government employ to reduce drug use problem in Nepal?
   - What is your opinion about the importance of supply reduction and demand reduction?
   - What is your opinion about the importance of harm reduction program?
   - What is the current spending on drug use and HIV sector by or through your organization?
     - ✓ How much is expended only for harm reduction programs?

**4.** What do you think about harm reduction program?
   - What are the harm reduction programs implemented in Nepal (only in Kathmandu)?
   - What are the things that you like about harm reduction program?
   - What are the things that you don't like about harm reduction program?
     - ✓ How about other colleagues in your organization?
   - How does Police (NCB) help facilitate harm reduction program in Kathmandu?
     - ✓ How does Police (NCB) support PWIDs to access harm reduction services (if any with examples)?
     - ✓ How does Police (NCB) obstruct PWID's access to harm reduction programs (if any with examples)?
   - What kind of differences, if any, does Police (NCB) strategies and harm reduction program have?
     - ✓ How do they impede to achieve the objectives of harm reduction program?
     - ✓ What do you think should be done?

5. What do you think about relation between law enforcement (Police (NCB)) and human rights of PWID?
    - What is being done to ensure that human rights of PWID is respected and protected?
        - ✓ What are some examples of human rights being protected for PWIDs?
        - ✓ What is the mechanism for PWID to report any human rights violation issue? How is the report taken forward?
    - Based on your experience, what would you say are the implications of law enforcement to human rights violations of PWID?
        - ✓ What are some examples of human rights violations (if any)?
6. What do you think about relation between law enforcement (Police (NCB)) and risky behavior among PWID?
    - Based on your experience, what would you say are the implications of law enforcement to risky behavior among PWID?
        - ✓ What are the examples (if any)?
7. What are other implications of law enforcement to drug use scenario and PWID (if any)?
8. How do you evaluate the effectiveness of the law enforcement strategies (supply and demand) in Nepal?
    - What would you say about the vision of creating drug free society?
    - What positive aspects do you see?
    - What negative impacts do you see?
    - What are the flaws/weakness of current drug control law and strategy (if any)?
9. What do you like to see happen in coming years regarding drug use?
    - How do you think that can be achieved?
    - What is your opinion about the concept that drug use is more public health issue rather than criminal issue?
    - How National stakeholders perceive importance of management of drug use on the basis of human right as well as public health approach.
10. What efforts have been made to resolve the issues faced by national HIV program due to drug law enforcement?

**D. Harm reduction service delivery level (CBOs)**

1. What is the current drug use scenario in Kathmandu?
   - How has it changed compared to last 5 year/a decade?
   - In your opinion, what is drug use?
2. As organization, what are your roles in national drug and HIV programs?
   - How do you collect information? How is it managed and disseminated?
   - How are PWIDs benefited?
3. What strategies/approaches does Nepal Government employ to reduce drug use problem in Nepal?
   - What is your opinion about the importance of supply reduction and demand reduction?
   - What is your opinion about the importance of harm reduction program?
4. What do you think about harm reduction program?
   - What harm reduction programs do your organization implement?
   - What are the things that you like about harm reduction program?
   - What are the things that you don't like about harm reduction program?
     - ✓ How about other colleagues in your organization?
   - How does Police (NCB) help facilitate harm reduction program in Kathmandu?
     - ✓ How does Police (NCB) support PWIDs to access harm reduction services (if any with examples)?
     - ✓ How does Police (NCB) obstruct PWID's access to harm reduction programs (if any with examples)?
     - ✓ How does Police (NCB) influence your service delivery role?
   - What kind of differences, if any, does Police (NCB) strategies and harm reduction program have?
     - ✓ How do they impede to achieve the objectives of harm reduction program?
     - ✓ What do you think should be done?
5. What do you think about relation between law enforcement (Police (Police (NCB))) and human rights of PWID?
   - What is being done to ensure that human rights of PWID is respected and protected?

- ✓ What are some examples of human rights being protected for PWIDs?
- ✓ What is the mechanism for PWID to report any human rights violation issue? How is the report taken forward?

- o Based on your experience, what would you say are the implications of law enforcement to human rights violations of PWID?
  - ✓ What are some examples of human rights violations (if any)?

**6.** What do you think about relation between law enforcement (Police (Police (NCB))) and risky behavior among PWID?

- o Based on your experience, what would you say are the implications of law enforcement to risky behavior among PWID?
  - ✓ What are the examples (if any)?

**7.** What are other implications of law enforcement to drug use scenario and PWID (if any)?

**8.** How do you evaluate the effectiveness of the law enforcement strategies (supply and demand) in Nepal?

- o What would you say about the vision of creating drug free society?
- o What positive aspects do you see?
- o What negative impacts do you see?
- o What are the flaws/weakness of current drug control law and strategy (if any)?

**9.** What do you like to see happen in coming years regarding drug use?

- o How do you think that can be achieved?
- o What is your opinion about the concept that drug use is more public health issue rather than criminal issue?
- o How National stakeholders perceive importance of management of drug use on the basis of human right as well as public health approach.

**10.** What efforts have been made to resolve the issues faced during delivery of services due to drug law enforcement?

**E. Community Level - People who use Drugs (PWID)**

**1.** What are your experiences on receiving harm reduction programs?
   - What harm reduction programs have you received?
   - How do you feel about going to a harm reduction service delivery site?
   - How, where and by whom do you receive services of your need (Eg NSP/OST/ART/HCV/HTC)?
   - What are the things that you like about harm reduction program?
   - What are the things that you don't like about harm reduction program?

- How does Police (Police (NCB)) help facilitate harm reduction program in Nepal (Kathmandu)?
   - How does Police (Police (NCB)) support you to access harm reduction services?
   - How does Police (Police (NCB)) obstruct your access to harm reduction programs (if any with examples)?

**2.** As a PWID, what are your experiences when you felt your human rights are violated?
   - How did the violations happen?
   - What were the agents of your rights violation?
   - What is the mechanism to report violation of your rights? How is it taken forward?
   - Based on your experience, what would you say are the implications of law enforcement to human rights violations of PWID?
      - ✓ What are some examples of human rights violations that you experienced (if any)?

**3.** As a PWID, what are your experiences when you acted risky behavior during drug use?
   - Based on your experience, what would you say are the implications of law enforcement to risky behavior among PWID?
      - ✓ What are the examples (if any)?
      - ✓ How does it lead to committing a risky behavior?

**4.** What other consequences have you experienced as a PWID due to law enforcement (if any)?

**5.** What do you like to see happen in coming years regarding your lives of PWIDs?

- How do you think that can be achieved?
- How can government play role in achieving it?
- How can National stakeholders play role in achieving it?

Also please verify if the PWID respondent has been incarcerated before. If yes, then please ask about his experiences, drug availability and using practice inside prison.

**Annex IV: Informed Consent Form**

Informed Consent Form

Interviewee ID (See format[1]):

**Background and Purpose of the study**

Mr. Bikas Gurung, inhabitant of Pokhara, Nepal, student at College of Public Health in Chulalongkorn University in Bangkok, Thailand is undertaking a research as thesis of his Masters of Public Health (MPH) program. The research (thesis) topic -

*'In the name of creating drug free society': A qualitative investigation on implications of drug law enforcement on harm reduction programs and people who inject drugs (PWIDs) in Kathmandu Valley, Nepal*

approved by the university is in the phase of data collection in the proposed study area. As the topic clearly illuminates, the purpose of this study is to review current law enforcement and determine its implications on barriers to access harm reduction services, violations of human rights and high-risk behavior practices among people who inject drugs (PWIDs) in Kathmandu district in Nepal. Well-oriented research assistants are assisting Mr. Gurung for his data collection and analysis process.

**Participation**

Your participation is required for a direct in-depth interview (IDI) for about 1 hour and 30 minutes at maximum. The interview is based on a semi-structured IDI

[1] Policy Level: Organization/Designation/Code no. (Eg. NCASC/PC/001) or (NCB/DIG/001)
National HIV program level: Organization/Designation/Code no. (Eg. SC/ED/001) or (FDDR/Chair/001)
Harm Reduction level: Organization/service/Designation/Code no. (eg. Saathi Samuha/NSP/Outreach/001)
Community level: Organization/service/Gender/Intake status (Lost or Active)/Code no. (Eg. Sparsha/OST/M/L/001)

checklist that objects to help you express your personal/professional experiences and learning in order to aid the study with valuable information. Since, the study can contribute as recommendations to national drug policy and programs, your honest expression/sharing is requested. Participating in this interview will not affect on either of your personal and professional life. Your participation is voluntary and you can choose to leave the interview at any time, without needing to give any reason.

**Audio recording**

The interview will be audio recorded to make sure that we are capturing all the ideas expressed during the session. The recordings will be stored in a safe space and only members of the project team will have access to them. All recordings will be destroyed once key themes emerging from the conversations have been adequately captured and analyzed.

**Benefits to interviewee**

The time and effort contributed by the interviewee to the development of this study will be remunerated. We will never be able to commensurate your valuable contribution but still an amount of NRs. _____ (In words: _____ only) as thank you will be delivered at the end of interview session. Still it would be our pleasure to acknowledge your contribution in the final report and publications (only if authorized).

**Risk in participation**

Though the questions are geared towards collecting information on the law enforcement and its implications on harm reduction programs and PWIDs, you may reflect upon tough personal experiences that might trigger your stress or emotions.

Sufficient time and effort has been invested in devising the IDI questions in order to avoid any leading or biased questions that might challenge the opinion of the interviewee. You are free to express your own opinion on every question.

**Questions**

If you have any questions or concerns about the study or would like to see a copy of the results after we have completed the analysis, you can write to the Principal Investigator, Mr. Bikas Gurung at biksgurung@gmail.com.

**Confidentiality and consent**

All the information collected during the interview will be solely used for the analysis and development of the thesis report. Any critical information disclosed relating your personal life, not relevant to the development of this document will be destroyed as soon as the information is analyzed.

**I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study and use the information for the development of the study report.**

**Signature of interviewee:** .....

**Date:**.....

**Please sign below to verify that you have received the aforementioned amount of NRs. _____ as your remuneration to your valuable contribution.**

**Signature of interviewee:** .....

**Date:**.....

**Please sign below to authorize us to mention your name in the acknowledgement of the final report and publications only if you wish to.**

**Full Name:** .....

**Designation:** .....

**Organization:** .....

**Signature of interviewee:** .....

**Date:**.....

**Statement by the Principal Investigator/Research assistants taking the consent**

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done: I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

I, as the Principal Investigator/Research assistant, understand the ethical principles of research and duly sign to abide myself with the principles.

**Signature of Principal Investigator/Research Assistant:** .....

**Date:**.....

**Annex V: One-day schedule for training of research assistants**

| **One-day training of Research Assistants** | |
|---|---|
| **Schedule (Topic Guide)** | |
| **Time** | **Activity Description** |
| **10:00 AM** | Welcome and objective sharing |
| | Presentation on key information about the Study |
| | - Background, objectives of the study |
| | - Rationale |
| | - Some literature reviews |
| | - Q&A |
| **Tea Break** | |
| | Discussion on methodology of the study |
| | - Research design |
| | - Better understanding of study population |
| | - Inclusion and exclusion criteria |
| | - Sampling technique and size |
| | - Method of data collection and tools |
| | - Q&A |
| **Lunch Break (1 hour)** | |
| | Study population mapping |
| | - Identifying major sources to reach study population |
| | - Assigning research assistants (RA) |
| | - Q&A |

| |
|---|
| Discussion of in-depth interview (IDI) checklists<br>- Do's and don'ts while conducting IDI<br>- How to use the checklists<br>- Extensive Q&A requested during this discussion |
| **Tea Break (Later served with day snacks during the session)** |
| Ethical considerations<br>- Intro to Nepal Health Research Council<br>- Discussion on the informed consent form<br>- Remuneration to the interviewee<br>- Q&A |
| Letter of Agreement with Research Assistants<br>- Assistances required<br>- Mandatory deliverables<br>- Q&A |
| **Final remarks by anyone interested and wrap up** |

# VITA

Bikas Gurung

Permanent Address : Pokhara-11, Phoolbari, Kaski, Nepal

Current Address : 55/46 Soi Kolit, Phayathai, Bangkok -10400

Date of Birth : 16th December, 1986

Mobile No : +66 99 189 2286 | +977 9808916786

E-mail : bikas@anpud.org | biksgurung@gmail.com

Summary of Expertise:

• Eight years of extensive experience in both the planning, development and management of the programs and project pertaining to people who use drugs at national level.

• More than one year of regional experience working, at Asia Pacific level, supporting the regional network of young key populations and People who use drugs with website management, reports and newsletter design, social marketing, proposal development, communication and network development.

Academic Qualification:

Masters of Public Health (2015)

Major in Health Policy and Management

Chulalongkorn University, Bangkok, Thailand