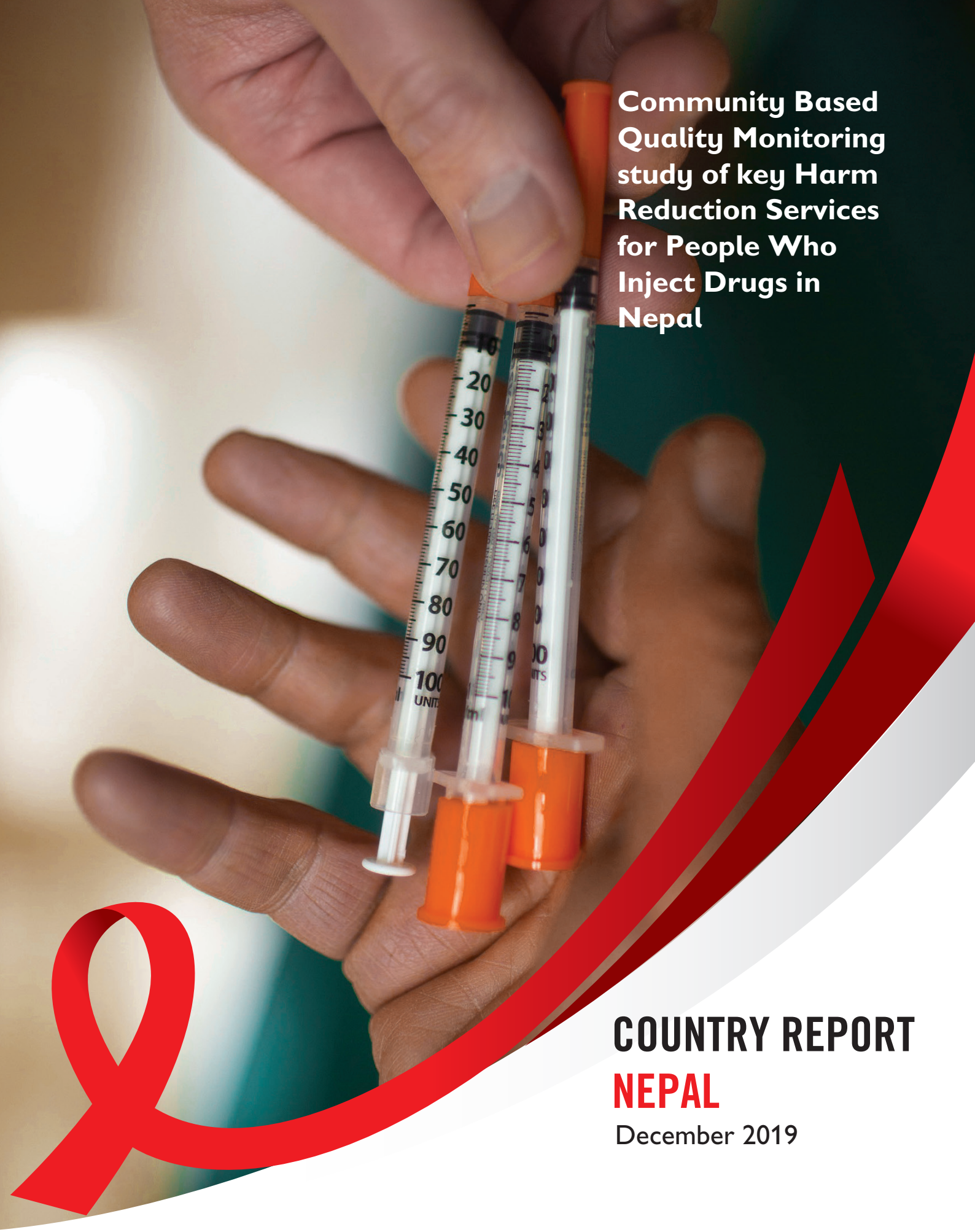

Community Based Quality Monitoring study of key Harm Reduction Services for People Who Inject Drugs in Nepal

COUNTRY REPORT

NEPAL

December 2019

RECOVERING NEPAL

ANPUD 20th Anniversary

KPRA Key Population Research & Advocacy Project

Save the Children

Community Based Quality Monitoring study of key Harm Reduction and other healthcare services for People Who Inject drugs in Nepal.

This report presents a detailed description, methodology, and findings of the Community Based Quality Monitoring study. This study is the first of its kind in the region, designed, implemented, and analyzed in a peer-to-peer approach and model. The study presents information on the q uality of Needle Exchange Services, Opioid Substitution Therapy Services, HIV testing, ART services, and the treatment of Hepatitis C, B, and TB infection. This study has also looked at the current linkage to essential HIV and other healthcare services for people who inject drugs in Nepal.

The study has been designed and conceived by ANPUD with the active participation and the support from our partners in Nepal. ANPUD appreciates the support from the data collectors and the community groups who directly and indirectly supported the implementation of this study.

This study is funded by The Global Fund To Fight AIDS, Tuberculosis, and Malaria under the program title: Key Population Research & Advocacy project and managed by Save the Children International, Nepal as the Principal Recipient.

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This study would not have been completed without support from teams at Recovering Nepal, SPARSHA, Dristi Nepal, Sathi Samuha and Community Support Group.

In solidarity,

Bishnu Fueal Sharma
Executive Director
Recovering Nepal

ABSTRACT

Community Based Quality Monitoring (CBQM) Study of key Harm Reduction services for people who use drugs in Cambodia, Indonesia, Nepal and Vietnam.
Country Report: Nepal

KEY WORDS

Harm Reduction, People Who inject drugs, Needle Syringe Exchange Program (NSP), Opioid Substitution Therapy (OST), HIV

CONTEXT

This study comes in the context of a multi-country grant from the Global Fund to ANPUD and other three regional networks. One of the components of the grant is to conduct a study to monitor the quality of services related to Needle Syringe Exchange Programming (NSP), Opioid Substitution Therapy (OST) and linkage to health care for people who inject drugs (PWID) in Cambodia, Indonesia, Nepal and Vietnam. In this backdrop, the report comes as the country report of Nepal, as a part and partial of the regional study, conducted by ANPUD along with Recovering Nepal, the national network of People who Use Drugs (PUD) in Nepal, with the financial support of a regional grant from the Global Fund, namely: Key Population Research Advocacy Project.

OBJECTIVE

Key specific objective of this study is to improve understanding of the perceived quality of harm reduction services among PWID in Cambodia, Indonesia, Nepal and Vietnam. The broader objective of this study is to build evidence for advocacy for improved quality of Harm Reduction, HIV, HBC, HCV prevention and care services to PWID in Cambodia, Indonesia, Nepal and Vietnam.

RESEARCH DESIGN

A mixed methods research entailing of community survey (CS) using structured interview and focus group discussion (FGD) among service users of NSEP and OST and key informant interview (KII) among service providers in Kathmandu and Pokhara cities of Nepal.

RESULTS

It was found that 92% of service users of NSEP were either very satisfied or satisfied with the overall quality of survey while around 7% were neutral to the overall quality. Less than one percent were found dissatisfied with the overall quality of NSEP. In the context of OST, more than a half of service users (64.10%) agreed — among which a quarter of respondents (25.60%) strongly agreed and more than two-third (38.50%) agreed; that OST services they had been receiving was perfect. In contrast only 17.10 % either strongly disagreed or disagreed that OST services they had been receiving was perfect.

ABBREVIATION

AIDS	Acquired Immuno-Deficiency Syndrome
ANPUD	Asian Network of People who Use Drugs
ART	Anti-Retroviral Therapy
BCC	Behavior Change Communication
CDO	Chief District Officer
COW Scale	Clinical Opiate Withdrawal Scale
CS	Community Survey
DCS	Drug Control Strategy
FGD	Focus Group Discussion
FA	Facility Assessment
FIDU	Female Injecting Drug User
FO	Facility Observation
GAM	Global AIDS Monitoring
GF	Global Fund
HBV	Viral Hepatitis B
HCV	Viral Hepatitis C
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
INGO	Implementing Non-Governmental Organization
IRRTTR	Identify, Reach, Recommend, Test, Treat and Retain
KII	Key Information Interview
KP	Key Population
LR	Literature Review
MSM	Men who have Sex with Men
MU	Medical Unit
NCASC	National Center for AIDS and STD Control
NGO	Non-Government Organization
NHSP	National HIV Strategic Plan
NSEP	Needle Syringe Exchange Program
NSP	Needle and Syringe Programming
OST	Opioid Substitution Therapy
PUD	People who Use Drugs
PWID	People Who Inject Drugs
RN	Recovering Nepal
SOP	Standard Operating Procedure
SSU	Social Support Unit
TB	Tuberculosis
TG	Transgender People
WHO	World Health Organization

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CHAPTER 1
INTRODUCTION

1.1 Background

Due to social and biomedical advances, the responses to HIV have yielded remarkable results. There are better, improved tools for screening, diagnostics, and treatment of HIV. Community responses to HIV are also established as the cornerstone of effective, equitable and sustainable programmes. They play a critical role in demanding and delivering services, supporting health systems and reach those most vulnerable to HIV where state facilities cannot.

Communities are increasingly involved in monitoring access and quality of HIV treatment, care, and support services. They can act as barometers in their watchdog role, tracking what works and what does not, from a local, contextualized perspective. Communities give a voice to those who need services, provide feedback as to whether policies and programmes are working and suggest how they can be improved. As service recipients, they are best positioned to evaluate the programs and provide critical feedback to HIV and health programs.

Asian Network of People who Use Drugs (ANPUD) is a regional network of people who use drugs established to address the obstacles faced by the people who use drugs and their families in Asia. The core belief behind the formation of ANPUD is that, people who use drugs living in countries of the region coming together with a unified voice can have a greater impact in ensuring that the community enjoy equal human rights and opportunities for a better quality of life. ANPUD believes drug use as a health issue (and not a law and order issue) and can work more effectively towards creating a better environment for people who use drugs and their communities, building from within the community.

In 2014, ANPUD along with other three (03) regional networks applied for a multi-country grant to the Global Fund and was subsequently approved. One of the components of the grant is to conduct a study to monitor the quality of services related to Needle Syringe Programming (NSP), Opioid Substitution Therapy (OST), and linkage to care for people who inject drugs in Cambodia, Indonesia, Nepal and Vietnam. With the objective of conducting the study, ANPUD has entered into collaboration with the national networks of People who Use Drugs (PUD) of the abovementioned six countries.

In this backdrop, the report comes as the country report of Nepal, as a part and partial of the regional study, conducted by ANPUD along with Recovering Nepal, the national network of People who Use Drugs (PUD) in Nepal, with the financial support of a regional grant from the Global Fund, namely: Key Population Research Advocacy Project.

1.2 The study rationale

In 2014, ANPUD reached out to its country constituents in the region for meeting in Bangkok Thailand to discuss key gaps in HIV and Drug User program in the countries. Among a few areas identified, during the consultation, the following are the key observations:

1. The community of current and former drug users are required to play more central roles in advocating for the quality of programs being provided to the drug users
2. There is a tendency among service providers to count the number of people reached through the programs and lack of interest in improving comprehensiveness and effectiveness of the services provided
3. The Community of people who use drugs are more capable than ever in designing and implementing simple and grounded studies that will bring about information on the quality of care, as often it is in the best interest of the community to advocate improvement of services being provided for them.

The following are the rationale of the community quality monitoring of key HIV Prevention Services for people who use drugs in Cambodia, Indonesia, Nepal, and Vietnam study:

1. There is a need to better understand the quality of the key HIV prevention services provided to people who use drugs in the study countries. There is an opportunity to encourage programs in the study countries to focus on monitoring and improving the quality of services provided and not limit themselves in only reporting coverage.
2. Communities of people who use drugs feel that services are partially provided and there is a room for improvement in the quality of services provided. They believe that there is too much focus on coverage while often times comprehensiveness and quality of those services are not prioritized.
3. Donors, specifically the Global Fund is increasingly interested in the community-centric monitoring of the quality of programs they fund. The people that are the recipients of the services will be extra eyes and ears on the ground to help ensure that the programs are delivered according to expected standards.

These avenues are new to this region, that is why ANPUD has taken leadership in designing and delivering a quality monitoring study, which will pave a way towards a national and regional level dialogue particularly on the quality of the services provided alongside the improving access

1.3 Objective of the study

The broader objective of this study is to build evidence for advocacy for improved quality of Harm Reduction, HIV, HBC, HCV prevention and care services to PWID in Cambodia, Indonesia, Nepal and Vietnam. The study also aims to expand community-based monitoring in South and South East Asia, moving it out of that which is just related to donor programs and starting to monitor national programs and local services. The evidence generated from the study is expected to help to reshape policy, address bottlenecks and provide an important feedback mechanism for the improvement of the quality of HIV prevention, care, and support programs for the people who inject drugs.

The following are the specific objectives of the study:

- To improve understanding of policy position, program strategies, legal barriers and the stage of implementation of harm reduction services for PWID in Cambodia, Indonesia, Nepal and Vietnam.
- To improve understanding of the perceived quality of harm reduction services among PWID in Cambodia, Indonesia, Nepal and Vietnam.
- To explore the status and the function of referral services, lifesaving care such as provision of ART, management of TB and Treatment of Hepatitis C and B.

The information gathered from this study will be used to advocate for improved quality of harm reduction programs.

1.4 Expected outcome of the study

The approach used for quality monitoring under this study broadly relates to (with limitation specified in the following section) with the model 1: Downward accountability: Services incorporate mechanisms to allow service users to provide feedback and for feedback to be acted upon (e.g. complaint-handling systems) among the four models of community-based monitoring reported in a review commissioned by the Global Fund. The study which is a significant part of this grant aims for the following outcomes.

The following outcomes are expected from the study:

Outcome 1: Consolidated report on HIV prevention and care program, legal environment and types of services provided to PWID in Cambodia, Indonesia, Nepal and Vietnam along with country-specific profile and a regional consolidation on HIV prevention and care program, legal environment and types of services provided to PWID in Cambodia, Indonesia, Nepal and Vietnam. The report will include the perceived quality of harm reduction services among service users (PWID).

Outcome 2: A study report each from each study country which will incorporate the policy position, program strategies, legal barriers and implementation of harm reduction services and perceived quality of harm reduction services among service users (PWID) in Cambodia, Indonesia, Nepal and Vietnam.

CHAPTER 2
HARM REDUCTION PROGRAM IN NEPAL

This chapter deals with the findings of literature reviews that has been done basically to briefly describe the legal, strategic and programmatic backdrops for the harm reduction program in Nepal. .

2.1 Legal Context

Nepal came up with its latest version of Drugs Control Policy in 2006 with one of its objectives to minimize the risk of transmission of HIV, Hepatitis and STI among People Who Use Drugs and their families. Further to this, building upon the plinth of Drugs Control Policy 2006, the Ministry of Home Affairs in its Drug Control Strategy (DCS 2066) with the objective of controlling the transmission of HIV, Viral Hepatis C, and STI has clearly envisaged the expansion of OST programme even within prisons of the country through the execution from government and private hospital as well as NGOs (NGO)s. Similarly, Drug Control Strategy 2066 with the objective of controlling the transmission of HIV, Viral Hepatis C, and STI has also pointedly envisaged the provision of safe needle/ syringes and condoms through comprehensive outreach activities of harm reduction program for PWID.

2.2 Strategic Framework

The National HIV Strategic Plan (NHSP) 2016-2021, sets out strategies to fast-track Nepal's HIV response towards achieving the 90-90-90 treatment targets by 2021 in order to end the AIDS epidemic by 2030. This Strategic Plan adheres to innovative Identify, Reach, Recommend, Test, Treat and Retain (IRRTTR) approach for all of its key populations (KPs) – that includes also PWID - to address the critical gaps in the prevention-treatment continuum by envisaging interventions across the entire HIV cascade, with a focus on case finding and case management.

2.3 Population Size

The latest Size Estimation of PWID was conducted in 2017 under the aegis of National Center of AIDS and STD Control. According to this Size Estimation there are around 30,068 PWID in Nepal of which 89% (27,567) are male, and 11% (3,301)female (1).

2.4 Harm Reduction Program for PWID

Pursuant to its NHSPs, Nepal, over the last two decades, has been running a comprehensive HIV prevention programme for PWID. This is basically a defined package harm reduction services entailing of a) Needle Syringe programming, b) Condom promotion, c) HIV testing d) STI treatment, e) Naloxone distribution, f) Prevention and Management of Co-infections and Co-morbidities. In addition to this, the harm reduction program also includes OST.

2.4.1 Needle Syringe Programming (NSP)

Nepal is one of the first countries in the region of South Asia Association of Regional Cooperation (SAARC) to recognize harm reduction interventions including needle-exchange as a strategy for prevention of HIV transmission among IDU. The first NSP program was reportedly set up as early as 1991 in Kathmandu Valley by LALS (2) .

Currently Needle Syringe Program is being implemented with the abovementioned harm reduction package in 26 districts of the country. Investment Plans for the Implementation of the National HIV Strategic Plan (NHIP) 2016-2021 sets both the coverage of reaching (with needle syringe) and HIV testing of 90% (29,522) PWID by 2021. To this end, a total of 15249 PWID were reached with needle syringes and 11478 PWID were tested for HIV in the period of June 2016 - July 2017 in Nepal (Fact Sheet -8-2017, www.ncasc.org.gov.np). The Needle Syringe Program is being guided by the National Targeted Intervention Operational Guidelines 2010– Injecting Drug Users, published by NCASC.

NHIP 2016-2021 stipulates the distribution of an average 10 needles/syringes per month for every person who injects drugs. However, number of needles and syringes distributed per person among PWID who injects drugs per year has remained low over the years in Nepal as around 61 needles and syringes were distributed per person per year in 2017 - nearly a half of that envisaged by NHIP (Global AIDS Monitoring Report 2017).

2.4.2 Oral Substitution Therapy (OST)

Key informant interview (KII) Methadone and Buprenorphine. OST coverage is targeted at 10% (3280) of the PWID population by 2021. Operation of these sites are guided by the following three frameworks :

- Directives for Operation of OST, Ministry of Home Affairs 2070
- Clinical Guideline for Opioid Substitution Therapy in Nepal, 2015
- Standard Operating Procedure for Social Support unit in Methadone/ Buprenorphine, Nepal

Despite its very long history of OST in Nepal and expansion of service sites, the enrolment andretention of service clients have remained one of the major challenges for the OST intervention (3).

CHAPTER 3
METHODOLOGY

3.1 Study Design

The study was done using a mixed methods research and it employed concurrent triangulation strategy. Thus, during the research, quantitative data using community-based structured interview and qualitative data using: i) Focus Group Discussion (FGD), ii) Key Informants Interview (KII), and iii) Facility Assessment (FA) were obtained simultaneously but independent of each other. Apart from all these, literature review is also one source of information of this study. The primary purpose of adhering to a mixed methods research, in principal, is to subscribe to the concept of confirmation, corroboration or cross-validation within a single study. The data integration took place mainly during data interpretation and during data analysis also.

3.2 Research Location

For the purpose of this study, Kathmandu and Pokhara are the two cities selected in Nepal premising upon the following criteria:

- The cities with the highest concentration of PWID in the country,
- Availability of NSP and OST services, and
- Consideration to available local capacity, available money and geographical access.

3.3 Sampling

The study has adopted a two-tier approach entailing of 1) Facility-based information and 2) User level information. As such, facility-based information was gathered through: a) structured facility-based assessment, b) focus group discussion, and c) key informant interviews. Whilst, a community-based structured interview was used to interview PWID for the obtainment of user level information.

3.3.1 Sampling for qualitative methods

For the collection of data, the study conducted KII, FGD and FA among those NGOs which were delivering services related to NSEP. These NGOs were: i) Sathi Samuha, Kathmandu ii) Dristi Nepal, Kathmandu and Community Support group, Pokhara. These organizations were chosen on purposive basis on their strength of the number of PWID taking NSEP related services from these facilities. Dristi Nepal which delivers NSEP among FIDU, in particular, was selected for ensuring the enrollment of female participants in this study.

Similarly, for the collection of data on OST, two NGOs: i) SPARHSA Nepal of Kathmandu, that runs an OST site and ii) Community Support Group, which also runs Social Support Unit for the delivery of OST in Pokhara, were purposively selected for conducting KII, FGD and FO.

Mangers of these organizations were the participants for the KII, whereas participants of FGD were purposively selected from those current users who were taking services from these organizations with the help of service providers. Since the desired level of data saturation was achieved from visiting three organizations in Kathmandu and Pokhara, other organizations were not required to visit for data collection.

Apart from the KII of key authorities, notably, of National Center of AIDS and STD, Drug and HIV program, and Save the Children, PR of GFATM were also conducted for the study.

3.3.2 Sampling for quantitative method

Community based structured interview was conducted among PWID using chain referral system. Combining 242 participants from Kathmandu and 136 from Pokhara, a total of 378 participants were interviewed in Nepal for this study. The number of participants apportioned to these two cities were on the basis of the proportion of estimated PWID size of these two cities.

For the roll out of the chain referral system in Kathmandu, four seed participants (also commonly referred to as initial participants), comprising one each of i) male under 25 years of age, ii) Male 25 years or above of age, iii) current OST service receiver, and iv) Female Injecting Drug User were selected. Interviews were conducted across four different spots of Kathmandu Valley including in all three districts of the Valley, taking convenience of participants into consideration. Similarly, three seeds, comprising one each i) Male, ii) current OST service receiver, and iii) Female Injecting Drug User were selected in Pokhara, where all the interviews were conducted at one common convenient spot .

3.4 Eligibility criteria for research participants

The following eligibility criteria were used to recruit participants for Quantitative Structured Interview.

1. The respondent had been or was injecting drugs until 12 months prior to the interview. That is, if a person says that he had not injected drugs for more than 12 months (at the time of the interview), the participant was NOT eligible.
2. It is If and only if a participant met are If the first condition is met, the participant has to meet any one of the following two conditions
   Had used NSP from a service center or an outreach within 12 months prior to the interview?
   "OR"
3. Had used OST service within 12 months prior to the interview.
   Apart from all the above, a respondent must have been minimum 18 years of age to take part in the study.

3.5 Instruments and participants of qualitative methods

The following table presents the summary of the research instruments, research participants chosen for this Qualitative Methods:

Qualitative Data Collection for Facility

Technique	Participants	City
KII	1. Manager, Sathi Samuha, NSEP	Kathmandu
	2. Manager, Dristi Nepal, NSEP	Kathmandu
	3. Manager, SPARHSA Nepal, OST	Kathmandu
	4. Manager, Community Support Group, (CSG)NSEP	Pokhara
	5. Manager, Community Support Group,(CSG) OST	Pokhara
FGD	1. Service Receivers, Sathi Samuha, NSEP (all male)	Kathmandu
	2. Service Receivers, Dristi Nepal, NSEP (all female)	Kathmandu
	3. Service Receivers, SPARHSA Nepal, OST	Kathmandu

4. Service Receivers, CSG, NSEP (mixed)	Pokhara
5. Service Receivers, CSG, OST (mixed)	Pokhara

Other that those mentioned above KII with following managers at policy level were taken:

1. Policy Level Manager, NCASC
2. Policy Save the Children, Principle Recipients for the Global Fund

3.6 Ethical consideration

Ethical clearance from National Health Research Council, were obtained on February 26, 2019, prior to conducting the field study. Apart from that, a written approval from each of all those NGOs - which facilitated in the data collection processes, notably of, FGD, FO and KII - was obtained before conducting this research.

All the participants interviewed for FGD, KII or Structured Interview were fully informed, read out consent form and explained about the nature of the study, the research objectives, the confidentiality of the data, potential risk and benefit and their rights to participate or not to participate in the study. An informed consent in Nepali language for their participation in the study was obtained.

No individual data are presented or disseminated here in a way that would lead to identification of respondents. Statements and quotes are presented in the report in such a way that it cannot be linked with individuals who gave the interview.

3.7 Limitations of the study

This study was conducted in Pokhara and Kathmandu in Nepal. The analysis and results presented in this report are, therefore, confined to Kathmandu and Pokhara valley and may not be generalized to other districts or any other parts of the country.

There may be a possibility of biased response. Survey participants are expected to provide honest responses to the survey questions asked. However, in some circumstances, this assumption may be breached due to factors such as social desirability or recall bias.

CHAPTER 4
RESULTS

4.1 Socio-demographic Characters

Respondents of quantitative survey

A total 378 respondents participated in the quantitative survey of which, 242 (64%) were from Kathmandu and 136 (36%) from Pokhara. Out of these 378 respondents interviewed for the quantitative survey, 81.2% were males while 18% were females and the remaining 0.8% considered themselves transgender (Table 26). Similarly of these 378 respondents, 37.9% were married, 1.6% were in living relationship but not married, 56.5% single, 3.4% divorced/separated, and 0.5% widow/widower (Table 27). Only 11 (2.9%) out these 378 were illiterate, whilst 33.3% had completed primary level, 40.2% completed secondary level,19% higher secondary level, and 4.5% college or higher level of education (Table 28). Age group (25-29) is with the highest frequency 26.5%, followed by the age group (20-24) 24.9%, while the age group that older than 44 years is with least frequency (1.3%) (Table 29) .

Respondents of FGD - NSEP

Two FGDs (one each for male only group and female only group) were conducted in Kathmandu, while a FGD (mixed of male and female) was conducted in Pokhara. Altogether a total of 28 participants from these three separate groups took part in FGDs held on the theme of NSEP, of which 13 were females and 15 were males. The age of these participants ranged from 18 years to 32 years.

Respondents of FGD - OST

One each FGD on the theme of OST was held in Pokhara as well as in Kathmandu in which a total of 21 participants comprising of one female and 20 males participated. The age of these participants ranged between 18 yrs to 46 yrs.

4.2. NSEP services

4.2.1 NSEP coverage among PWID population (syringes/PWID/year)

The National HIV Implementation Plan (NHIP) 2016-2021 stipulates the distribution of an average 10 needles/syringes per month (120 needles/syringes per year) for every person who injects drugs (4). However, the Factsheet of 2018 issued by NCASC have shown that a total of 1,459,464 needles/syringes were distributed to 22,201 PWID at the rate of 66 needles/syringes per person for the year 2018 (5). This is a slight increase as compared to that that of 2017 in which 61 needles and syringes were distributed for every person who inject drugs (3). This is, however, too ower than 200 sterile needles and syringes per drug injector per year, that the World Health Organization (WHO) recommends to provide in order to effectively tackle HIV transmission via this route (6)

4.2.2 Provision and quality of drug use equipment and injecting paraphernalia

Provision and quality of drug use equipment and injecting paraphernalia is the second variable for the Needle Syringe Programme (NSP) that is included in this study with the aim to understand the quality, sufficiency and acceptability of injecting equipment provided for PWID through NSP.

Satisfaction on the quality of Injecting Equipment

The quantitative survey of this study depicted that less than one -fifth (18.5%) of the respondents were unsatisfied with the quality of injecting equipment and anther quarter of respondents (25%) neutral. More unsatisfied NSP clients were observed in Kathmandu (20.3%) than in Pokhara (15.7%) (Table 1).

Table 1: Satisfaction on the issue of the quality of needles and syringes

Satisfaction on the issue of the quality of needles and syringes						
	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Very satisfied	55	32.0	43	37.4	98	34.1
Satisfied	78	45.3	33	28.7	111	38.7
Neutral	4	2.3	21	18.3	25	8.7
Unsatisfied	35	20.3	18	15.7	53	18.5
Total	**172**	**100.0**	**115**	**100.0**	**287**	**100.0**

Satisfaction on the quality of needle

On the theme of quality of needles, the quantitative survey of this study noted that among those unsatisfied and neutral, less than one-fourth of respondents (25.3%) said that the size of needle was smaller than they needed and remaining 74.7% said the size of needle was not smaller than they needed. In the same context, among those unsatisfied and neutral, two-third respondents (69.6%) said that the size of needle was bigger than they needed and remaining 30.4% said that the size of needle was not bigger than they needed (Table 30).

Satisfaction on the quality of syringe

The quantitative survey of this study observed that among those unsatisfied and neutral, 16.3% said that the size of syringe was smaller than they needed and remaining 83.7% said the size of syringe was not smaller than they needed. In the same context, among those unsatisfied and neutral, less than one-tenth (8.9%) respondents said that the size of syringe was bigger than they needed and remaining 90.1% said that the size of syringe was not bigger than they needed (Table 30).

Perceived sufficiency of injecting equipment

The quantitative survey observed that overwhelming majority (99%) of respondents perceived that they were supplied with sufficient amount of injecting equipment. This holds true equally for both cities (Table 2).

Table 2: Perceived Sufficiency of injecting equipment received

Perceived Sufficiency of needles and syringes received						
	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Yes	170	98.8	114	99.1	284	99.0
No	0	0.0	1	.9	1	.3
Refused to answer	2	1.2	0	0.0	2	.7
Total	**172**	**100.0**	**115**	**100.0**	**287**	**100.0**

The quantitative study also noted that about two-third (66.5%) respondents received less than 20 needles and syringes in a week whereas only 2% received more than 60 in a week with the median figure being 14 while the average figure around 19 per PWID per week (Table 3).

Table 3: No. of needles and syringes received by person in a week

No. of needles and syringes received by a person who inject in a week						
No. of needles and syringes received	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Less than 20	130	76.5	59	51.8	189.0	66.5
20-40	31	18.2	34	29.8	65.0	22.9
40-60	7	4.1	18	15.8	25.0	8.8
More than 60	2	1.2	3	2.6	5.0	1.8
Total	**170**	**100**	**114**	**100**	**284.0**	**100.0**

Quality of needles

All the three FGDs conducted with NSEP clients observed that service receivers were not satisfied with the quality of needles. During the qualitative survey also noted a variety of complaints on the quality of needles.

Needles are not ok. P1, P3, P5: FGD, Dristi Nepal, Kathmandu

Needles often gets crooked, broken. P1: FGD, Dristi Nepal, Kathmandu

It's useless. P3: FGD, Dristi Nepal, Kathmandu

While loading it gets snapped. P5: FGD, Dristi Nepal, Kathmandu

Similar observations were made in FGDs among service receivers of CSG, Pokhara. The variety of drawbacks of needles as weak, liable to break, flimsy were flagged in the FGD.

There is a complaint on the quality of needle. P1:FGD, CSG, Pokhara

Yes, the needle of 5ml, that came earlier, gets bent. P3:FGD, CSG, Pokhara

This is weak and liable to break. P4: FGD, CSG, Pokhara

Liable to break. P3,P5: FGD, CSG, Pokhara

It does not pull easily. P5: FGD, CSG, Pokhara

FGDs at Sathi Samuha also came up with many issues of needles. One of the interesting among them was that it could create chance of occurring abscess.

Syringe is fine, but the needle is not (appropriate) as for those who do not inject properly, there is a chance of occurring abscess. P4: FGD, Sathi Samuha, Kathmandu

Because needle being very long. P10: FGD, Sathi Samuha, Kathmandu

Tip of the needle gets broken and stuck inside. P4: FGD, Sathi Samuha, Kathmandu

Apart from the service receivers, service providers in KII also triangulating the drawbacks, in terms of the quality of needle, shared their insights on the following manner.

Needle? the complaints on the needles that are coming it is too long. The demand is that the new needle, that is on the use for one month should be changed. P1:KII, Sathi Samuha, Kathmandu

It's get crooked. P1: KII, Drisiti Nepal, Kathmandu

Quality of syringes

The qualitative survey of this research gathered mixed responses as far as the quality of syringe is concerned. Participants of FGD expressed that they were content with the quality of syringe.

…Syringe is fine. P4:FGD, Sathi Samuha, Kathmandu

Syringe is good … P6:FGD, Sathi Samuha, Kathmandu

No problem in syringe. P3: FGD, CSG, Pokhara

Participants among FGD at Dristi Nepal which runs NSEP exclusively for Female Injecting Drugs Users (FIDU), pointed a number of drawbacks for the quality of syringe.

Syringe also comes off when you pumped. P6: FGD, Dristi Nepal, Kathmandu

They, now, are not good quality as of previous time. P2: FGD, Dristi Nepal, Kathmandu

For us who plays with blood some time it is spilled. This is not good as previous lifeline. P5: FGD, Dristi Nepal, Kathmandu

Quality of swab

This study while discussing about the quality of drug use equipment and injecting paraphernalia also during FGD and KII came up with a solo complaint, in particular, from a female participant.

It is not fine, it is a duplicate. In the past, cotton swab used to be soft the cotton swab but at present, it becomes rough after using once. P4: FGD, Dristi Nepal, Kathmandu

Findings of qualitative survey on numbers of needle/syringes received through NSP

Conversations with service receivers in FGDs noted the number of needles/syringes that a service receiver could get vary from a maximum of 3 at a time to as many as many as one can inject. The study further noted that they could take needle/syringes from outreach workers apart from DIC. The study noted 3-4 needles/syringes would become inadequate in the instance when these syringes had to be shared with those friends who had not brought needle/syringes along with them.

They did not give more than 3-4 (needles/syringes) at a time. P5: FGD, Dristi Nepal, Kathmandu

……they would come there and leave 10-15 (needles/syringes) at time I would keep it for a week. If it is not adequate …….then I myself would go there and bring them. P3: FGD, Dristi Nepal, Kathmandu

That is unlimited. As far one demand for it. P6: FGD, Sathi Samuha, Kathmandu

They say, take as per your limit, as many as you inject P5: FGD, Sathi Samuha, Kathmandu

If it is not here we will take from them while they are taking round. P3: FGD, Sathi Samuha, Kathmandu

If we look according to GAM report, the rate of needle distribution is one needle in one week but in practice we can see one (person) is using 6 needles in a day. P1: KII, NCASC

Acceptability of injecting equipment

Only one case in the entire KIIs and FGDs of this study, a couple of female participants said that they did not take at all needles/syringes from DIC. The further probe showed that because of self-stigma, the participant perceived the service of DIC unacceptable.

I do not go to DIC, I will go to the medical. If it is not there, if there is scarcity then I would go to DIC. P2: FGD, Dristi Nepal, Kathmandu

I do not enter to DIC, if I enter DIC, I will get tainted. That is why I do not often go into DIC, rather buy at medical P2: FGD, Dristi Nepal, Kathmandu

4.2.3 Information provided on safer drug use, injecting and safer sex

Information provided on safer drug use, injecting and safer sex is the third variable among a total of 16 variables that this study embraces for assessing the quality of NSP. The purpose of this variable in this study is to: a) understand the quality of HIV prevention information provided to

people who use drug, and b) check if there has been a conscious effort in providing safer sex education to people who inject drugs.

About eight out of ten (79.50%) of NSP clients were either very satisfied or satisfied with information provided on safer drug use and safer sex (Table 4). Only a remarkably low proportion of the clients (1.70%) clients were unsatisfied with information provided on safer drug use and safer sex, while nearly one-fifth of them (18.5%) were found neutral. None of NSP clients were found to be very unsatisfied.

Table 4: Satisfaction among NSP clients on information on safer drug use, safer sex

Satisfaction among NSP clients on information provided on safer drug use and safer sex							
		Kathmandu		Pokhara		Total	
		N	%	N	%	N	%
How satisfied are you with the information provided on safer drug use and safer sex?	Very satisfied	35	20.30%	18	15.70%	53	18.50%
	Satisfied	106	61.60%	69	60.00%	175	61.00%
	Neutral	29	16.90%	24	20.90%	53	18.50%
	Unsatisfied	2	1.20%	3	2.60%	5	1.70%
	Very unsatisfied	0	0.00%	0	0.00%	0	0.00%
	Don't know	0	0.00%	1	0.90%	1	0.30%
		172	**100%**	**115**	**100%**	**287**	**100%**

The quantitative survey also showed that information on HIV, Hepatitis B and C were among the common contents of information, as an overwhelming proportion (96.5%) of respondents said that they had received information on HIV testing through an NSP site or outreach staff or peer educators (Table 5). Similarly, around 90.2% (Table 6) of respondents said that they had received information on Hepatitis B and C through an NSP site or outreach staff or peer educators.

Table 5: Proportion of respondents received information through an NSP site or outreach

Proportion of respondents who received information on HIV testing at an NSP site or by an outreach worker/peer educator						
	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Yes	167	97.1	110	95.7	277	96.5
No	5	2.9	5	4.3	10	3.5
Total	172	100.0	115	100.0	287	100.0

Table 6: Proportion of respondents who received information on Hepatitis B&C at an NSP site or by an outreach worker/peer educator

Proportion of respondents who received information on Hepatitis B & C at an NSP site or by an outreach worker/peer educator						
	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Yes	162	94.2	97	84.3	259	90.2
No	10	5.8	18	15.7	28	9.8
Total	172	100.0	115	100.0	287	100.0

Current practice and strategies

It was observed that for dissemination of information, a two-pronged approach entailing of a) holding group meeting with service receivers and b) out-reach communication had been put in place. The following quotes noted in FGD and KII put forward the proofs for using group meetings with service receivers as a plank for education session. It was also noted that one of the organizations maintained the practice of holding a meeting once in a month.

Our seniors will explain in meeting. They will explain so that messages get to us and through us to other. P1: FGD, CSG, Pokhara

When these are explained in the meeting …… P3: FGD, CSG, Pokhara

As mentioned earlier, once in a month. P3: FGD, CSG, Pokhara

In every PE (Peer Educators) meeting, clients come for this meeting and we conduct sessions, in every PE meeting, on different topics. P2: KII, Dristi Nepal, Kathmandu

Daily logs of outreach workers gathered during FO clearly show the content of information as well as clients code dealt with during client - outreach communication.

Contents of Information

Safer sex, abscess, overdose, harm reduction including HIV, STI were found to be contents of information disseminated to service receivers.

Didi (Seniors at DIC) often tell us about abscess, overdosage and cut in vein, and infection through shared syringe. They also advise us to use own syringe. P5:FGD, Dristi Nepal, Kathmandu

He (DIC in-charge) talked about Hepatitis C, I do not remember in a length. P8: FGD, Sathi Samuha, Kathmandu

HIV, AIDS, STI, Harm Reduction, Injecting and one is other P2: KII Dristi Nepal, Kathmandu

For safer sex, the main thing we provide sessions to in-reach workers for their capacity building. In every PE (Peer Educators) meeting. PE, clients come for this meeting and we conduct sessions, in every PE meeting, on different topics. P2: KII, Dristi Nepal, Kathmandu

Vein management and overdose were found to be a few relevant issues that were not included in contents of information disseminated to service receivers. For illustration, some surprising comments were observed as the participants were not aware of these issues. It was also surprising to note service providers themselves admitting that the issue of overdose had not been included for counselling.

Vein management, I do not know about vein management, because I use 90. P2: FGD, Dristi Nepal, Kathmandu

Rarely 1-2 persons may have come in the span of 2-4 years. That's why we have not given counseling on overdose. P1: KII, Sathi Samuha, Kathmandu

IEC materials provided on safer drug use, injecting and safer sex

Conversations with program managers clarified that these organizations did not receive IEC materials or just received e -copy without any budget for printing. In absence of IEC materials, these organizations were doing away with IEC materials for their part of BCC.

We have not distributed any IEC materials and we have not received IEC materials. Regarding IEC materials we do only talking. P1: KII, CSG, Pokhara

According to the past practice, it should come from Save, they have also sent us e-copy. But I do not think there is budget for (printing) it. P2: FGD, Dristi Nepal, Kathmandu

We gave presentation based on e-copy. P2:FGD, Dristi Nepal, Kathmandu

Training of staff members, outreach workers and peer educators

Out of all three KIIs conducted with three NSEP implementing agencies, it was only the staff members of Sathi Samuha who had received training relevant to BCC.

> *All the staff here are trained by Save the Children, maximum numbers of our staff trained, we do not have any staff untrained. Office management trains on us " how to do outreach" and "how to distribute services". That means they normally give training.* P1: KII, Sathi Samuha Kathmandu

Other two service sites, namely, Dristi Nepal and CSG were found not to have been given any training especially on BCC. KIIs with program managers of CSG clearly revealed there was no training on BCC and PWID. Both of these service sites, however, admitted they had received a number of training including on CLT and Monitoring and Evaluation.

> *After September, once we have (gone) into this partnership, with respect to PWID there has not been any training. In our context, many of our staff recruited have come out of the area (of HIV), and after their recruitment there has not been any training.* P1: KII, CSG, Pokhara

> *There was no training on BCC and PWID.* P1: KII, CSG, Pokhara

Similar responses were obtained from Dristi Nepal to the query " Have you been trained on Hepatitis, Abscess Management, and Counselling?."

> *Not on these, they (IRWs) may have been given (training) on counselling.* P1: KII, Dristi Nepal, Kathmandu

> *IRWs have not got these training. But for us, we have not got training on harm reduction.* P2: KII, Dristi Nepal, Kathmandu

4.2.4 Availability of NSP in the closed setting (prison and judicial custody)

There is no NSP in prison in Nepal.

4.2.5 Modality (specialized NSP, outreach, other, e.g. drug treatment service)

Modality is the fifth variable included to assess the quality of NSP. The study through this variable intends to understand : a) the types of NSP services that they receive, b) If the services are integrated with drug treatment, HIV testing or ARV sites, and c) if the services are provided through stand-alone sites, or through outreach and if there is a differential approach for Female, Transgender and MSM who use drugs.

Modality Practiced

Conversations with key informants clearly showed that In-reach Model, surprisingly, also referred to Outreach Model - that revolved around a fixed station i.e., Drop In Center (DIC) - was found to be put in place by all three agencies surveyed. It was found that the hotspots of PWID were divided into a number of clusters with the assignation of In-reach workers to these clusters for reaching out to PWID.

> *We have adopted in-reach model, in total we have five in-reach workers, three looking after Kathmandu and two looking after Latitpur.* P1: KII, Dristi Nepal, Kathmandu

> *….one in-reach worker provides services to seven to eight clients.* P1: KII, Dristi Nepal, Kathmandu

> *About the model, we are distributing NSP through DIC and NSP through outreach workers all over Kathmandu.* P1: KII, Sathi Samuha Kathmandu

> *We have identified hotspots and divided them into a number of cluster and we assign certain number of in-reach workers for a cluster. We move in-reach workers in that way.* P1: KII, CSG, Pokhara

Comprehensiveness of Services

Service Providers during interviews spelled out Needle Syringes Program (NSP) invariably included: a package for behavioral changes comprising of commodities i.e., needle/syringe and condoms; (HIV) testing and linkage to other services. One among a number of linkage services - these organizations were doing -was referral of those tested positive to ART sites. Though this study also come across the fact that PWID were supported for HCV testing through referral to appropriate sites, but these were not of their regular activities.

We have testing (program) along with behavioral package and we also supply syringe and commodities, and if needed we also do linkage (to other services). P1: KII, CSG, Pokhara

CSG is running a comprehensive program of HIV and CSG itself has a team of community homebased program, we link (the positive case) to this team. Through the CHBC we help positive cases to accessing ART. P1: KII, CSG, Pokhara

Along with that, we also do condom distribution P1: KII, Dristi Nepal, Kathmandu

Now we have come to CLT. P1: KII, Dristi Nepal, Kathmandu

We refer positive cases to Teku. P1: KII, Dristi Nepal, Kathmandu

We accompanied there at ART sites until our clients get all the services when they start ART. P1: KII, Sathi Samuha Kathmandu

Though this study also come across the fact that PWID were supported for HCV testing through referral to appropriate sites, but these were not regular activities.

I tested (HCV) through Sahara Nepal. Yes through Sahara Nepal. P4: FGD, Dristi Nepal, Kathmandu

I have tested for Hepatis C. I have tested for once it was many years back. After that I have not done that. P3: FGD, Dristi Nepal, Kathmandu

Hepatitis …. was conducted earlier but have not done now. Need to do Hepatitis. P1: FGD, CSG, Pokhara

Regarding TB, participants said that they did not get any test for TB.

TB Test I have not done. P1, P3: FGD, CSG, Pokhara

Differential approaches taken to reach out to Female, Transgender and MSM who use drugs

The following conversations at Dristi Nepal, that runs NSEP for exclusively for female injecting drug users (FIDU), with its program managers put forth a number of cogent proofs to show that no differential approach was being taken such as employing TG and female sex workers as IRWs for targeting TG and female sex worker.

…We do not target by employing the specifically same backgrounds (IRW). P2: KII, Dristi Nepal, Kathmandu

We do have not that kind of approach but we are giving openly services to all here. P1: KII, Dristi Nepal, Kathmandu

We are giving openly services to all. P2:KII, Dristi Nepal, Kathmandu

Similar responses were also obtained from CSG Pokhara when asked if there was any differential approach taken targeting MSM and TG. It was evident that no MSM and TG were identified as service receivers.

Strategy is that what do we do for general male we are doing the same but we have not identified any (MSM and TG). P1: KII, CSG, Pokhara

When it comes to targeting female injecting drug users, it appeared that female outlets and female field workers were put in place for enhancing the catchment of FIDU.

For female, we have female outlets that is separate. P1: KII, CSG, Pokhara

For female we have female in-reach workers. P1: KII, CSG, Pokhara

As I am looking after female (PWID); with respect to female, once the clients are identified, our in-reach workers tell them about importance of testing, and we do have counsellor for female, these counsellor do counselling, once our (female) clients are ready for testing, we do not call them to office, we go for testing when she is taking syringe (drugs) for the reason of her convenient, and comfort and maintaining confidentiality, as there is Community led testing we conduct CLT. P2: KII, CSG, Pokhara (female)

4.2.6 Success of referral/utilization of HIV testing

Success of referral/utilization of HIV testing is that variable in this study that aims to understand the access to HIV testing services for people who inject drugs and if the linkages to such services are established and functional.

The quantitative survey of this study noted that eight out of ten (81.9%) respondents utilized HIV testing service while they were in NSP. Among those who utilized more than one-tenth (11.50%) utilized HIV service through referral (Table 7).

Table 7: HIV Testing service utilized in NSP

HIV Testing service utilized in NSP						
	Kathmandu		Pokhara		Total	
Yes	116	67.44	86.00	74.78	202.00	70.40
Yes through referral	14	8.14	19.00	16.52	33.00	11.50
Not	42	24.42	10.00	8.70	52.00	18.10
Total	**172**	**100**	**115**	**100**	**287**	**100**

HIV Screening and testing behavior among PWID

The qualitative survey noted that with the implementation of Community-led HIV testing (CLT), the screening of HIV among PWID were being done at the community i.e. through outreach testing. During the conversations with service receivers in FGDs as well as with service providers in KIIs, the following evidence for these facts were noted.

They conduct HIV test on the spot. P1: FGD, Dristi Nepal, Kathmandu

In-reach workers are conducting the test. P1: KII, Dristi Nepal, Kathmandu

We are only authorized to conduct "Determine" only screening test. P1: KII, Dristi Nepal, Kathmandu

Now we have a new model that is called CLT, I think almost all staff member within Nepal has got the training on it for conducting test. So we conduct HIV tests. P1: KII Sathi Samuha, Kathmandu

It became evident that screening of HIV was being conducted at every six months and many of the participants during FGDs told that they had tested for HIV recently.

On six- six months. P2: FGD, Dristi Nepal, Kathmandu

Yes. Have conducted very recently. P2 & P4: FGD, Dristi Nepal, Kathmandu

Tested for HIV. P3 & P4: FGD, Sathi Samuha Kathmandu

Having said taken, we have tested brining (testing team) here and at different locations. P1: FGD, CSG, Pokhara

It was also observed that some participants were convinced that they need to test for HIV at every six months because of their high-risk behavior.

In the interval of three months or six months, they call for HIV test, we also need that as we are the one who use needles. P1: FGD, Dristi Nepal

I conduct my HIV test at Naulo Ghumti I go to Naulo Ghumit every three months and do HIV testing. P2: FGD, CSG, Pokhara

Confirmatory test of reactive cases through accompanied referrals

The evidence from the qualitative survey showed that accompanied referrals to mostly ART sites for confirmatory test- of all clients with the reactive test result- were taking place at all those three service sites that participated in this study.

They had taken me to Teku. I was pricked at that time I was taken to Teku. P6: FGD, Sathi Samuha Kathmandu.

If the case turns out to be positive, In-reach workers counsel them saying that the case has not been confirmed yet as this is screening only we have to go to hospital to conduct HIV testing for final confirmation of it. Then they (In-reach workers) inform us, then we will make arrangement for other (remaining) tests by buying ticket and consulting with doctor at Teku Hospital. P1: KII, Dristi Nepal, Kathmandu

Anyone who come here if tested positive , we will take them to Teku either on motorcycle or motor, but mostly on motorcycle as most of us are riding motorcycle. But for a few only we take them on car, as we do not have enough resource for Taxi. P1: KII, Sathi Samuha Kathmandu.

The qualitative survey also noted a few challenges of taking those clients who tested positive during screening to an ART site or any other diagnosis center for performing a confirmatory test.

When the case turns out to be positive, even though IRW can do counselling, the In-reach workers bring the positive case to DIC. We, even though try hard to provide counseling to them, it is hard to change their mind sets over the night. Other issue is that we do not have their phone numbers and permanent addresses, for this reason we cannot take them to ART site promptly. For example, if testing happens to be positive today, we cannot immediately rush them (to ART site for further confirmatory testing). Because we go to field for distributing needle syringe and their priority is to take drugs. When we say come along with us (for confirmatory testing now) they give us assurance saying that they will come tomorrow, but after that it is difficult to meet them again. We had encountered two-to- three such cases but we finally managed to take them to the ART site. P1: KII, Dristi Nepal, Kathmandu

Partner Testing

The qualitative survey observed that efforts were put in place for partner testing by all the three NSP service providers that participated in this study. It appeared that commonly it was through PWID that their partners were approached for testing. Dristi Nepal, the FIDU focused organization even maintained the marital status of its clients during the enrollment with the aim of tracking their partners for testing. This was done in consideration of the chance of being involved in unsafe sex when their male partner denies for condom use .

Most of the males have female partners, it is through the male partners we meet female injecting drug users. P1: KII Sathi Samuha, Kathmandu

We conduct that also (partner testing). There are spouses who are mostly living into relationships and when they are new users and men help inject injection for them and teach them how to inject, this bring them into a relationship, when the relationship takes place no one knows the HIV status and because of that unsafe sex happens in a large proportion. When asked for condom use, male partner denies for that. Because of this reason, we conduct test among spouse. P1: KII, Dristi Nepal, Kathmandu

Bringing males for testing is not difficult, clients have to reveal their marital status. And if they are in living relationship, they also tell that. We also take information of partners or spouses, if found they are into risk behaviors or drug users, we call them and counsel them. P2: KII, Dristi Nepal, Kathmandu

It is also noted that CSG of Pokhara rather than conducting partner testing of all the clients only focused only the partners of positive cases.

More than focusing on partner testing, we focus on testing of (our) target group. If there is any reactive case during testing (of our target group) then only we go for partner testing…... P1: KII, CSG, Pokhara

4.2.6 Success of referrals to ART, TB management, diagnosis and treatment of Viral Hepatitis

Success of referrals to ART, TB management, diagnosis and treatment of Hepatitis B & C is the variable that aims to understand access to ART, TB management, diagnosis and treatment of Hepatitis B & C for PWID through NSP and if the linkages to such series are established and functional

Referral for primary care for STI services and abscess

The study got an impression that referral services for treatment of abscess and STI were inadequate. This was evident in the following responses across participants of all the three service sites when asked if they had been referred to other sites, for the treatment of abscess. This was despite the fact, during FGD, the study came across a number of participants with serious abscesses.

No. P1, P10: FGD, Sathi Samuha, Kathmandu

No. P2: FGD, Sathi Samuha, Kathmandu

No. P3: FGD, Dristi Nepal, Kathmandu

No. P3, P2: FGD, CSG, Pokhara

The study got only very few instances where service receivers were referred for treatment of abscesses.

When there was a health camp, I along with Ramesh Dai took him (pointing to one of the participants) there. P3: FGD, Sathi Samuha, Kathmandu

Referral for ART services, CD4 count, Viral load services

The study found strong evidence that PWID when tested positive for HIV they were referred for ART services. The qualitative survey did not probe further into other services such as testing for CD4 count and Viral load.

……..and if needed we also do linkage (to other services). P1: KII, CSG, Pokhara

CSG is running a comprehensive program of HIV and CSG itself has a team of community homebased program, we link (the positive case) to this team. Through the CHBC we help positive cases to accessing ART. P1: KII, CSG, Pokhara

We refer positive cases to Teku. P1: KII, Dristi Nepal, Kathmandu

We accompanied there at ART sites until our clients get all the services when they start ART. P1: KII, Sathi Samuha Kathmandu

Referral for Viral Hepatitis and TB services

This study noted that the treatment of Viral C Hepatitis for PWID for a limited number of those infected with HIV- were being carried out with the support from the Global Fund. In this context,

this study also come across the fact that PWID were supported for HCV testing through referral to appropriate sites. It was also noted PWID did not tested for HCV regularly. Participants in an FGD in Pokhara said they had not tested for TB when asked if they had tested for TB.

I tested (HCV) through Sahara Nepal. Yes through Sahara Nepal. P4: FGD, Dristi Nepal, Kathmandu

I have tested for Hepatis C. I have tested for once it was many years back. After that I have not done that. P3: FGD, Dristi Nepal, Kathmandu

Tested for Hepatitis earlier but have not done now. Need to do Hepatitis P1: FGD, CSG, Pokhara

TB, Test I have not done. P1, P3: FGD, CSG, Pokhara

Referral with social welfare and legal aid services

The study found no evidence for the referral for social welfare and legal aid services, when asked if they had been referred for social welfare and legal aid services.

No. P3: FGD, Dristi Nepal, Kathmandu

No. P3, P2: FGD, CSG, Pokhara

4.2.7 Availability of Naloxone at the service provision sites and provision of the take-away Naloxone

Availability of Naloxone at the service provision sites and provision of the take-away Naloxone is the variable in this study that intends to understand if programs provide education on overdose prevention and provides take-away Naloxone.

Among the entire 378 PWID who participated in the quantitative survey, less than one third (31%) experienced overdose on any drugs to the point they lost consciousness (Table 8).

Table 8: Proportion of PWID who experienced overdose on any drugs to the point of losing consciousness

Proportion of PWID who experienced overdose on any drugs to the point of losing consciousness		
	N	%
Yes	117	31
No	261	69
Total	**378**	**100**

Despite this, more than three-fourth of respondents (79.9 %) did not know about Naloxone and about 16.1% considered that Naloxone was provided in the area they lived (Table 9).

Table 9: Knowledge about Naloxone and its availability among PWID

Proportion of PWID who experienced overdose on any drugs to the point of losing consciousness		
Knowledge about Naloxone and its availability	N	%
Can get it from an outreach worker	7	1.9
Can get it from service center/hospital/OST/NSP site	4	1.1
Take-away naloxone available	4	1.1
Naloxone available in area	61	16.1
Do not know what naloxone is	302	79.9
Total	**378**	**100**

Corroborating these findings, the qualitative survey also pointedly noted: a) poor management of over-dosage among PWID, b) lack of knowledge of Naloxone and c) use of availability of Naloxone.

Poor over-dosage management among PWID

The study observed that a common practice, among PWID, of commonly putting a spoon into mouth and hitting/patting on feet or chin when over dosage happened to their mates.

One of friend had once gone into overdose, after taking tablet, formula. We put a spoon into his mouth in order to prevent two sets of teeth coming together. P5: FGD, Drisiti Nepal, Kathmandu

If a friend gets overdose, we should put spoon into his mouth. In order to wake him up, (we) should hit gently him on feet or we should him hit on chin. P8: FGD, CSG, Pokhara

Lack of knowledge of Naloxone among PWID

Participants across all three service sites during the FGDs said they were unaware of Naloxone, let alone its use for the treatment of over dosage.

We do not know (about Naloxone). P2, P3, P4: FGD, Drisiti Nepal, Kathmandu

I do not know about that. P6,P4, and P2:FGD, Sathi Samuha, Kathmandu

This is the first time I am hearing it. P5: FGD, Sathi Samuha, Kathmandu

Use of Naloxone

The KII with service providers clearly showed there had not been any use of Naloxone. Reasons appeared in this survey for not using Naloxone were: there were no cases of overdose and no had asked for.

So far we have not used it as there have not been any case of overdose. P1: KII, Dristi Nepal, Kathmandu

No one has asked (for it). P1: KII, Dristi Nepal, Kathmandu

No we have not distributed it …… P1: FGD Sathi Samuha, Kathmandu

Take Away of Naloxone

During the study it was evident none of these organizations adopted the practice of giving take away of Naloxone. This is in context that the Program Implementation Guideline nowhere mentions Naloxone in it.

We do not have any such thing on take away dosage of Naloxone. P1: KII, Dristi Nepal, Kathmandu

No there is nothing like that (of take away Naloxone). P1: KII, CSG, Pokhara

During the KII with service providers of Dristi Nepal raised the issue of difficulty of the distributing injection form of Naloxone as they perceived only trained person should give the injection of Naloxone.

If (Naloxone) that is available it will be better. P2: KII, CSG, Pokhara

One should look whether that person is trained or not and whether that person is capable of taking or not. P2: KII, Dristi Nepal, Kathmandu

4.2.8 Stockout of NSP supplies

Stock out NSP is the variable included in this study that aims to understand if stockout of supplies (including condoms) are frequent and problematic at the NSP site

Less than one-fifth of service users (18.9%) in the quantitative survey experienced refusal of clean needles/syringe because of a shortage of needles/syringes whereas more-than (81.9%) did not experience any refusal (Table 10).

Table 10: Refusal of clean needles/syringes because of a shortage of needles/syringes by experienced service users at the NSP site

Refusal of clean needles/syringes because of a shortage of needles/syringes by experienced service users at the NSP site						
	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Treated with respect and dignity	170	98.8	110	95.7	280	97.6
Not Treated with respect and dignity	2	1.2	5	4.3	7	2.4
Total	**172**	**100.0**	**115**	**100.0**	**287**	**100.0**

Both KIIs and FGDs showed that stock out of NSP supplies in Kathmandu and Pokhara was rare in occurrence. The FO at the service sites showed well maintained records showing daily details of quantity issued, received in and the balance of stock at hand.

Participants in Kathmandu Valley, when asked had ever been returned empty handed because of stock out of commodities, responded in an overwhelming "no" in both service sites.

No. That has never happened here. P1, P2, P3, P4 & P6: FGD, Dristi Nepal

No. P2 and P6: FGD, Sathi Samuha,

Similarly, conversations with service providers during KII in Kathmandu Valley also confirmed that the stock out NSP supplies had never happened at these sites.

That has not happened till this day. P1: KII, Sathi Samuha Kathmandu

No stock out. P1: KII, Dristi Nepal, Kathmandu

Conversations at CSG showed that this service site faced one event of stock out of two commodities, notably of; alcohol swab and 5 ml syringe. The conversation also showed that they however had managed this problem ensuring that its clients did not return empty handed from the service site. The conversation showed that the problem of stock out took place because of delayed procurement process at the central level, but managed by the service site through local procurement.

We had faced the problem of stock out last time. Especially we had (stock out) on the alcohol swab and we had also on 5 ml syringe also. Stock out of alcohol was of the national level and for 5 ml syringe that can be substituted by 1 ml 2 ml or 10 ml. But there was complete shortage of alcohol swab. P1: KII, CSG, Pokhara

We purchased at the local level taking approval. There was shortage at the source because of delayed in procurement process. P1: KII, CSG, Pokhara

4.2.9 Service-based stigma, perceived confidentiality, behavior of service providers

Service-based stigma, perceived confidentiality, behavior of service providers is that variable in this study which intends to understand the experiences of service-based discrimination, perceived confidentiality, and other social stigma among NSP users.

It was noted that more four-fifth (84.7) of the respondents did not felt any experience of insult by the health workers while visiting NSP service centers, while only 2.9% of the respondents felt they were insulted by the health workers (Table 11) in the last 6 months.

Table 11: Experience of ever insulted by the health workers while visiting NSP site

Experience of ever insulted by the health workers while visiting NSP site		
	N	%
Yes, in the last 6 months	11	2.9
Yes, but not in the last 6 months	2	0.5
No	320	84.7
Don't know	45	11.9
Total	378	100

Probing on the behaviors of service providers, the quantitative survey recorded that an overwhelming proportion 97.6% of respondents felt they were treated with respect and dignity by the health workers/staff at NSP site (Table 12).

Table 12: Perception among PWID on behavior of service providers at NSP site

Perception among PWID on behavior of service providers at NSP site						
	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Treated with respect and dignity	170	98.8	110	95.7	280	97.6
Not Treated with respect and dignity	2	1.2	5	4.3	7	2.4
Total	**172**	**100.0**	**115**	**100.0**	**287**	**100.0**

Stigma and perceived confidentiality

Regarding the stigma and perceived confidentiality, the qualitative study came across mixed responses i.e., positive from the male and negative from the female service receivers. The negative responses, came, in particular, from FIDU. Among the positive responses recorded were that service receivers found that services provided were of confidential, secured, well treated and loving. Most importantly, they perceived DIC secured from the police.

Our is confidential. P1: FGD, Dristi Nepal, Kathmandu

It is secured and plus there are sharing also. Lot of issues are shared there. P5: FGD, Dristi Nepal, Kathmandu

Police do not come inside the DIC. P2: FGD, Dristi Nepal, Kathmandu

They are friendly so far. I feel friendly that is why I come here. P2: FGD, Dristi Nepal, Kathmandu

They treat well. P5: FGD, Dristi Nepal, Kathmandu

Loving care is there. P4: FGD, Dristi Nepal, Kathmandu

They love us. P1, P5, P6: FGD, Sathi Samuha,

We have all things confidential. P1: KII, Dristi Nepal, Kathmandu

This study also came across some pieces of evidence showing services being provided were discrimination free. The following verbatim is one of them.

We drug users are fighting for there should not be discrimination against us. Thus discrimination is a

very old fight for us. We ourselves never discriminate and we do not allow our staff to discriminate. We have not received any such complaints (on discrimination). P1: KII, Sathi Samuha, Kathmandu

There is no such case of discrimination. P2:KII, Dristi Nepal, Kathmandu

As mentioned there were some concerns regarding self-stigma, and perceived lack of confidentiality particularly from FIDU. The following conversations brought forward why service receivers at Dristi Nepal were reluctant to visit the DIC.

I do not enter to DIC, if I enter DIC, I will get tainted. That why I do not often go into DIC, rather buy at medical. P2: FGD, Dristi Nepal, Kathmandu

It is not only me all (FIDU) feel hesitancy to go to DIC. P3: FGD, Dristi Nepal, Kathmandu

If this is DIC, and it is known pen (syringe), lifeline is available, and I enter here then no one would think positively of me. P2: FGD, Dristi Nepal, Kathmandu

Not only service receivers, the service providers also shared the same concerned.

Main issue is that if they go into DIC or service delivery center then everybody will know that's she is user, why do not want to go to DIC. P1: KII, Dristi Nepal, Kathmandu

Training to service providers

Regarding training to service providers - with the contents on "sensitivities" while providing services to people who use drugs to service providers, the study during KII found the following two kinds of responses: a) no training was given in this regard, and b) orientations to newly recruited staff was given.

After September, once we went into partnership, with respect to PWID there has not been training. In our context, many of our staff recruited have come out of the area (of HIV), and after their recruitment there has not been any training. P1: KII, CSG, Pokhara

Mostly when staff entered in this field they were oriented that one should not have judgmental view on anyone. P1: KII, Dristi Nepal, Kathmandu

4.2.10 The system of referral to external social and legal services and collaboration with them

The system of referral to external social and legal services and collaboration with them is that variable which intends to understand if there is a systematic approach to refer clients to relevant services: social and legal services for the service users of NSP.

Programme Implementation Guideline has also inter alia prescribed for linkages to social welfare schemes and legal aid (7). In this context, this study has not found any substantial evidence for linkages to social welfare schemes and legal aid being put in place.

4.2.11 Collaboration and support from law enforcement agencies

Collaboration and support from law enforcement agencies is the variable that intends to understand if there is a systematic approach to engage with local law enforcement agencies and if it has been successful.

Police harassment faced by PWID

The study through the FGDs with has come with two different observations; a) FIDU at Dristi Nepal that they were not harassed by police, whereas; b) PWID at CSG as well as Sathi Samuha said that police harassment to them is a common problem. The following quotes of a FGD recorded at Dristi Nepal clearly police harassment was not problem for FIDU.

When one say we are people from DIC, Police do not touch it. The police do not care syringe addict.

P4: FGD, Dristi Nepal, Kathmandu

KII at Dristi Nepal showed that the occurrence of arrest to its clients was of relatively low intensity.

Till now there were two of clients arrested in the cases of possession of syringe. P1: KII, Dristi Nepal, Kathmandu

In contrast, police arrests seemed to be common incidents for service receivers of Sathi Samuha and CSG. During FGDs at Sathi Samuha it was observed all of the eight participants had been arrested by the police. This was revealed by the following quotes of the participants in response to the query of how many of them you had been arrested. Further it was found that some participants were even detained for 25 days for the needle/syringe.

All of yes. P3, P4 and P8: FGD, Sathi Samuha, Kathmandu

(We) all have been to detention. P1&P5: FGD, CSG, Pokhara

For the case of pen (needle syringe) I had been in detention for 25 days. P3: FGD, CSG, Pokhara,

(For) 25 days. P5: FGD, CSG, Pokhara

It was found that these service receivers had been arrested for the possession of syringe in the pocket.

They even follow us and if needle/syringe is found in pocket (they will take us) P8: FGD, Sathi Samuha, Kathmandu

Even not found in pocket, they will pick it from the ground and they will take (us). P6: FGD, Sathi Samuha, Kathmandu

Coordination meeting with law enforcement

The study observed that service providers has adopted the practice of holding periodic meeting with law enforcement agencies. Further, it was also noted that Dristi Nepal has adopted the practice of coordinating with female police.

As far as coordination we do conduct meeting with police and media persons, including sensitization meeting and we have introductory meeting in earlier stage and lately in order to enhance harmonization with them - coordination meeting.

Coordination at individual level is always remains there. P1: KII, CSG, Pokhara

We have police coordination meeting. During that meeting we brief them about our program and introduce all of us (staff) to them. P1: KII, Dristi Nepal, Kathmandu

In each four month we have police coordination meeting inviting DSPs of our hotspot areas of Kathmandu. If possible DSPs themselves comes, otherwise they send other in the meeting. P1: KII, Sathi Samuha, Kathmandu

No we mostly coordinate with ground level than top level. Even If you coordinate with top level of police they will disseminate information. Thus we have mixed. Plus, we also coordinate with female (police) at the lower level, because we are comfortable with female. P1: KII, Dristi Nepal, Kathmandu

4.2.12 Involvement of PWID in planning, management, implementation and monitoring of NSP

This variable aims to understand if there is a systematic approach to engage people who inject or have used drugs in NSP.

This study observed no involvement of PWID in management, and monitoring of NSP. Their involvement, in implementation was also found to be of limited one – to the extent that peer educators were involved in the service delivery of NSP. The following sequences of conversation

recorded during KII provide proof for that.

No. There is no role of service recipients in management. Only in implementation level, as I have said earlier, peer educators as well as current users are involved in implementation. P1: KII, CSG, Pokhara

No role (in quality monitoring). P1, P2: CSG, Pokhara

4.2.13 Monitoring and evaluation of the quality of NSP services

Monitoring and evaluation of the quality of NSP services is that variable that aims to understand if there is a regular monitoring of services provided with equal importance to quality along with coverage of NSP programs.

Mechanism for receiving complaints, grievances from service receivers

The study found that these service sites had no provision of complaints box.

There is no formal mechanism (for direct communication). Nothing at all. P1: KII, CSG, Pokhara

There is no such thing like complaints box. P1: KII, Sathi Samuha, Kathmandu

But service providers of these service sites claimed that they however collect feedbacks through their peer educators and In-reach Workers.

Yes, there is. We have peer educator and they collect feedback and they add their own feedback to it. They give it to manager. P1: KII, Sathi Samuha, Kathmandu

(But clients) share it to IRW and (we have) what come through IRW. P1: KII, CSG, Pokhara

One of the service sites however claimed that it conducted questionnaire survey among its service receivers with contents including the number of services taken, behaviors of staff member. P1: KII Sathi Samuha, Kathmandu

For that we have prepared service analysis questionnaire with the contents of how many times they have taken our services, and , behaviors of in-reach workers and staff behaviors. P1: KII Dristi Nepal, Kathmandu

4.2.14 Time, cost and other burdens among those who access the NSP services

Time, cost and other burdens among those who access the NSP services is the variable that intends to understand if there are time and cost-related barriers to NSP services.

The quantitative survey of this study showed that more than two-third respondents (71.1%) did not spend any money at all in a day for buying needle syringes from a pharmacy. It also noted that not more than 2% spent NRS 100 to NRS 200 in a day. More than a quarter (27.3%) spent in NRS 1 to NRS 100 for buying needle syringes from a pharmacy .

Table 13: Money spent buying new needles/syringes from a pharmacy in a day by a PWID

Money spent buying new needles/syringes from a pharmacy in a day by a PWID						
Money Spent in (NRS)	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
0	134	88.2	48	46.2	182	71.1
1-50	13	8.6	26	25.0	39	15.2
51-100	5	3.3	26	25.0	31	12.1
101-150	0	0.0	1	1.0	1	0.4
More than 151	0	0.0	3	2.9	3	1.2
Total	**152**	**100**	**104**	**100**	**256**	**100**

Appropriateness opening and closing hours of NSP services

The FGDs at service sites recorded two versions of opinion on the issue of appropriateness opening and closing hours of NSP services. For the first version, some service receivers said that current business hours of NSP services were appropriate for them.

The 10-5 opening hours is appropriate for us. P8: FGD, Drisiti Nepal, Kathmandu

It is fine for us. P5 & P6: FGD, Sathi Samuha, Kathmandu

The (present opening time) is fine as it is continuing like this. P2, P5: FGD, CSG Pokhara

The study also noted a contrary voice from service receivers in which they demanded the expansion of current business hours of NSP services.

Sometime you want to take drugs early in the morning and you have to wait till 10:00 am to open this place. P4: FGD, CSG Pokhara

(But) Sometime you need early (earlier than 10:00) and sometimes you need later (than closing hour 5:00 pm) P1: FGD, CSG Pokhara

Out of pocket expenses incurred while utilizing NSP services

However, qualitative survey, in particular, FGDs with service receivers revealed they needed to buy needle/syringes especially due to holiday only occasionally but not normally.

Not in a week, but one or two times in month or every two - three months in case of Saturday (which is official) holiday. P3: FGD, CSG, Pokhara

In the case of holiday sometime. P3: FGD, CSG, Pokhara

The study probed on the cost paid by service receivers buying needles/syringes

Yes, 5 Rs for a thing that costs 100. P1: FGD, Drisiti Nepal, Kathmandu

Thing that should cost 5 Rs is costing 100. When we ask for needle, medical vendors say us to pay 100 Rs and we must pay it. P1: FGD, Drisiti Nepal, Kathmandu

Service receivers also expressed their difficulty while buying needle syringe from pharmacy.

No they do not sell. P2, P3: FGD, Sathi Samuha, Kathmandu

If asked, the shopkeeper says "I will call the police". P5: FGD, Sathi Samuha, Kathmandu

During FGDs, many service receivers said that they did not need to travel while utilizing NSP services for: a) most of them were from nearby from the DIC sites, b) outreach workers brought to them, c) kept stocks of needles/syringes.

Yes, we all are from around here. P1, P2, P3 & P7: FGD, Sathi Samuha, Kathmandu

It will take 5 minutes if you walk. P7: FGD, Sathi Samuha, Kathmandu

They (outreach workers) will bring (to us). P1: FGD, CSG, Pokhara

In many cases we keep stock of needle syringe for Saturday knowing that this day the office will be closed. P4: FGD, CSG, Pokhara

4.2.15 Overall satisfaction of quality of NSP

Overall satisfaction of quality of NSEP is that variable that aims to understand if the clients who have used NSP services are satisfied with the overall quality of services.

Table 14: Satisfaction Level of overall quality of NSP services

Satisfaction Level of overall quality of NSP services						
Money Spent in (NRS)	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Very satisfied	97	56.7	62	53.9	159	55.6
Satisfied	57	33.3	47	40.9	104	36.4
Neutral	17	9.9	5	4.3	22	7.7
Unsatisfied	0	0	1	0.9	1	0.3
Very unsatisfied	0	0	0	0.0	0	0.0
Don't know	0	0	0	0.0	0	0.0
Refused to answer	0	0	0	0.0	0	0.0
Total	**171**	**100**	**115**	**100**	**286**	**100**

Overwhelmingly proportion (92%) of respondents said that they were either very satisfied or satisfied with the overall quality of NSP services. Moreover, around 7% were neutral to the overall quality. Less than one percent were unsatisfied.

The study got a variety of answers from research participants in response to the question of "how satisfied are you with the overall quality of the NSP services that you receive?". A few participants said that they were totally satisfied.

Totally satisfied. P1 & P3: FGD, CSG, Pokhara

We have do not complaints whatsoever. P3: FGD, CSG, Pokhara

There were some participants put forward many demands in response to the question of "how satisfied are you with the overall quality of the NSP services that you receive?"

There should be some medicines especially of abscess and dressing. P7: FGD, Sathi Samuha, Kathmandu

At DIC the junky needs diet first of all. You should include the provision of diet at the DIC P7: FGD, Drisiti Nepal, Kathmandu

4.3. OST services

4.3.1 Coverage of OST Program

Despite its very long history of OST in Nepal and expansion of service sites, the enrolment and retention of service clients have remained one of the major challenges for the OST intervention (3). The Fact Sheet from NCASC revealed that in July 2018, a total of 740 were on Methadone, decreasing that of 909 in July 2017. In contrast, the Year 2018 saw an increase of the number of PWID on Buprenorphine from the total of 145 PWID in 2017 to 176 in July 2018 (5) .

4.3.2 Waiting time to first treatment admission

Waiting time to first treatment admission is the second variable included in this study with the intent of understanding if and why patients have to wait for OST initiation. Moreover, this variable also aims to understand issues around expulsion from OST and re-admission into OST program.

The quantitative survey revealed that more than a two-third (70%) of respondents did not have to wait at all i.e. 0 days for their first treatment, around more than one-tenth of the respondents (11%) waited for one day. The study found that only 8% of clients had to wait for more than 4 or more days. Apart from this, the study also recorded that only 3 clients waited for more than a month (Table 15).

Table 15: Waiting time to first treatment admission experienced by OST service receivers

Waiting time to first treatment admission in days experienced by OST service receivers		
Day	Frequency	Percent
0	135	70%
1	21	11%
2	12	6%
3	14	7%
4	2	1%
5	2	1%
6	1	1%
7	2	1%
9	1	1%
12	1	1%
14	1	1%
20	1	1%
Total	**193**	**100%**

No waiting list because of unavailability of slots

The qualitative survey did not find any case in which clients were kept in the waiting list because of the unavailability of the slots at the OST sites.

> *Not Yet. Clients do not have to remain in the waiting list because of overcapacity of the sites.* P1: KII, SPARHSA, Kathmandu

Delay in OST initiation

The qualitative method came across proofs for delay in OST initiation. The KII at the service sites further revealed that documents required and difficulty in getting appointment of psychiatric doctor were the reasons for delayed OST initiation.

> *Usually document (requirement) creates the major hinderance (for initiation of OST). And there is provision of that clients, at first, must be checked by psychiatrist (Medical Doctor) and as you know (un) availability of doctor time because of that timing cannot be arranged with doctor and the clients may not come on the given time.* P1: KII, SPARHSA, Kathmandu

Simple, easy free enrollment process

During the qualitative survey, OST clients revealed that the enrollment process was simple, easy without any cost, this is despite the procedural requirements need to submit a copy of citizenship. This is well reflected in the quote of captured below .

> *While getting admission (in the OST site), citizenship and a member of family were needed but it is not difficult and it was simple.* P3: FGD, CSG, Pokhara

In the case of failure to produce of citizenship, other identity cards of clients can be the substitute of the citizenship.

> *We must have a document that clearly shows identity of clients in absence of citizenship.* P1: KII, SPARHSA, Kathmandu

When asked about was money required for getting enrolled, participants said that enrollment in OST program was free. During KII it was also noted that the costs of routine diagnosis for PWID such as Hepatitis and Liver Function were provided by the Program

(Money) Not needed. P2, P3: FGD,CSG, Pokhara

Usually we do Hepatitis and Liver Function Tests for PWID.….Global Fund provides these costs but it is very minimum it is NRs 500 clients. P1: KII, SPARHSA, Kathmandu

When asked about the implementing provision of SOP that bars a person with history of legal accusations or a history of crime or imprisoned in past to access the treatment, the service providers during KII said that it was not practical to implement this provision.

In order to find out whether one has criminal record, we need to go for further verification. For further verification we need to search national documents and sources, we do have not this verification process. Therefore, it is not possible to verify criminal records thus it is not practical (to implement this provision) P1: KII, SPARHSA, Kathmandu

Expulsion from the OST service

The qualitative study did not come across any client expelled from OST.

I have not heard any one expelled from OST. P3: FGD, CSG, Pokhara Discussion

4.3.3 Appropriateness of Methadone/Buprenorphine dosage

Appropriateness of Methadone/Buprenorphine dosage is the third variable that this study entails for the assessment of quality of OST services. The objective of this variable is to understand appropriateness and acceptance of the dosage.

Assessing the satisfaction of dosage received during OST, the quantitative survey showed out of 117 respondents the overwhelming proportion 114 (97.4%) were satisfied with Methadone/ Buprenorphine dosage they were taking (Table 16). Moreover, only 2.56 % of respondents were unsatisfied for receiving lower than needed dosage.

Table 16: Satisfaction with Methadone/Buprenorphine dosage received during OST

Satisfaction with the Methadone/ Buprenorphine dosage received during the treatment						
	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Satisfied	75	98.68	39	95.12	114	97.44
Received lower than needed	1	1.32	2	4.88	3	2.56
Received higher than needed	0	0	0	0	0	0
Total	**76**	**100**	**41**	**100**	**117**	**100**

Initial Dosages on the basis of history of drugs used including nature and quantity of drugs

The qualitative study found the doctor at OST sites prescribed the initial dosage after taking accounts of history of drugs used including nature and quantity of drugs. The doctor at closely followed their clients in the beginning so as to make adjustment on dosage.

For the calculation of first dosage, Doctor gave me an appointment. P6: FGD, SPARHSA, Kathmandu

Doctor asked me " what (drugs) you taking earlier what chemical, substitute you were taking? I answered such and such. Doctor instructed me "now take this amount". P2: FGD, CSG, Pokhara,

Doctor of this site closely followed me personally during my initially days after that he added another 5 mg to my original dosage. P6: FGD, SPARHSA, Kathmandu

The other approach that appeared prominently in this study was that the OST sites commonly started with an initial dosage usually 20 mg of Methadone (less commonly also of 10 mg) for their

newly enrolled service receivers. The following quotes recorded in FGD held with service receivers at CSG, Pokhara distinctly highlight this approach.

At start we were given 20, we were given 20 at first and according to that, if 20 works or not on the body, If it does not work we can increase to more than 20. If it has worked well on him, he can start from 20. P6: FGD, CSG, Pokhara

If 20 is felt more (than adequate) it can be reduced. P3: FGD, CSG, Pokhara

It can be reduced and it can be increased also. P4: FGD, CSG, Pokhara

But we are doing all these under the monitoring of our doctor. P4,P5: FGD, CSG, Pokhara

Similarly, the practice of starting with an initial dosage of 20 mg of Methadone among the newly enrolled service receivers was also startlingly prominent in Key Informants Interview (KII).

Though the standard dosage is 40 mg, but in practice, here we start from 20 mg, 10 mg. In case (the patient) is given 20 mg, and tomorrow the patient experiences high withdrawal or a bit of over (dosage), and its symptoms are vomiting and skin rashness, if these start appearing, then we can either taper the dosage or increase. P2: KII, CSG, Pokhara

Low starting dosage and inadequate adherence to the Clinical Guideline

A Service provider at an OST site raised the concerns of the low starting dosage of methadone as well as inadequate adherence to the Clinical Guideline. This service provider also opined the case management approach should be applied for better retention of clients.

We start with low starting dosage. P1: KII, SPARHSA, Kathmandu

We have medical guidelines that say we can easily give a dosage starting minimum 10-15 up to 30 mg. If dosages higher than that needed, there are certain precautions that must be taken. But these (provisions) are not being followed. P1: KII, SPARHSA, Kathmandu

Observation should be evaluated by the application of COWS score. We do not see any OST site following COWS score. P1: KII, SPARHSA, Kathmandu

Because of failing to apply case management approach, the problem of retention is there. P1: KII, SPARHSA, Kathmandu

Unavailability of Doctor Time

The qualitative study also noted a difficulty, for the service receivers at one of the study sites, in changing their dosages, resulting from unavailability of doctors at that OST site.

I found difficulty in reducing my dosage as I am not able to get appointment with doctor because, doctor is not regular here. P5: FGD, SPARHSA, Kathmandu

4.3.4 OST availability (including new initiation) in prisons

OST availability (including new initiation) in prisons is that variable that aims to understand access to treatment for people who use drugs and are in prison or in judicial custodies.

The monthly reports of the year 2018 showed that two OST patients in Pokhara had received custody dose. This fact, was also captured in quotes of Programme Manager of CSG, has revealed that custody dosage had been dispensed to some PWID during their stay in custody but not in Prison.

In Prison, there has not been (delivery), in custody there has been (delivery of OST). P1: KII, CSG, Pokhara

4.3.5 OST costs including transportation to and from the site

This variable is meant to understand out of pocket expenses spent by clients for utilizing OST services.

Proportion of OST clients who paid out of pocket expenses while accessing OST

The quantitative survey observed that 77% respondents were paying out-of-pocket expenses (Table 17). The categories of out-of-pocket costs include expenses such as registration/ enrollment, laboratory and diagnostics, hospitalization, transportation, accommodation and food (Table 31).

Table 17: Proportion of OST clients who paid out-of-pocket expenses while receiving OST.

Proportion of OST clients who paid out of pocket expenses while accessing OST		
	N	%
Paid	91	77.1
Not Paid	27	22.9
Total	**118**	**100**

Source of payment of out-of-pocket expenditures

Among those who paid out-of-pocket expenses, an overwhelming proportion of 97.8% paid these out-of-pocket expenditures on their own (or by their family) as it is noted that more than two-third respondents 68.1 % for themselves and, for 29.7% , these expenses were paid by their family (Table 18). It is for only negligible proportion (1.1%) that their expenses were paid by insurance, government and other sources.

Table 18: Source of payment of out-of-pocket expenditures for receiving OST services

Source of payment of out-of-pocket expenditures						
Source	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Individual pocket	40	70.2	22	64.7	62	68.1
Family	15	26.3	12	35.3	27	29.7
Insurance/government/Global fund support	1	1.8	0	0.0	1	1.1
Subsidy from other sources	0	0.0	0	0.0	0	0.0
Don't know	1	1.8	0	0.0	1	1.1
Total	**57**	**100.0**	**34**	**100.0**	**91**	**100.0**

Other costs for utilizing OST service

The qualitative study however noted that enrollment in OST program was free. During KII it was also noted that the costs of routine diagnosis for PWID such as Hepatitis and Liver Function were provided by the Program.

(Money) Not needed. P2, P3: FGD, CSG, Pokhara

Usually we do Hepatis and Liver Function Tests for PWID. Global Fund provides these costs but it is very minimum it is NRs 500 clients. P1: KII, SPARHSA, Kathmandu

4.3.6 Diagnosis or detailed assessment of current substance use, individualized therapy planning

Diagnosis or detailed assessment of current substance use, individualized therapy planning is another important variable of this study that aims to understand: a) about the enrollment

procedure and, b) if that is comprehensive so that a tailored treatment plan can be developed and used.

An overwhelming proportion of respondents (95.70 %) opined that health workers at OST site took a detailed assessment on substance use prior to their enrollment into OST Program. This invariably came as compelling evidence that showed the practice of conducting a detailed assessment of substance among clients before enrolling them into OST program.

Table 19: Perceptions of OST clients on the assessment of substance use before the enrollment into OST Program

Perceptions of OST clients on the assessment of substance use before the enrollment into OST Program							
		Kathmandu		Pokhara		Total	
		N	%	N	%	N	%
Did the health worker take detailed assessment of current substance use before enrolling you into OST program?	Yes	72	94.70%	40	97.60%	112	95.70%
	No	4	5.30%	1	2.40%	5	4.30%
	Total	**76**	**100%**	**41**	**100**	**117**	**100%**

Assessments followed by enrollment

The study observed that the OST sites conducted two rounds of assessment before enrolling a client into OST service. The first round of assessment was done by the Social Support Unit (SSU), which was followed by the second round of assessment that was to be done by the Medical Unit (MU). The following quote of a staff member of an OST site provides evidence for this.

……..Once s/he comes, we assess his/ her drug-use history, what drugs he was taking in the past for how long and also about prison or detention case. Along with that we assess about if there is any such disease. After being is eligible, the patient meets the doctor. The doctor also conducts a medical test, after that test, the doctor prescribes medicine (for patient), after that the patient starts taking medicine from that day. P2: KII, CSG, Pokhara

Similarly, the FGD among service users found that the doctor at OST sites prescribed the initial dosage after taking accounts of history of drugs used including nature and quantity of drugs.

For the calculation of first dosage, Doctor gave me an appointment. P6: FGD, SPARHSA, Kathmandu

Doctor asked me " what (drugs) you taking earlier what chemical, substitute you were taking? I answered such and such. Doctor instructed me "now take this amount". P2: FGD, CSG, Pokhara

It is also found that the doctors at OST were monitoring their clients in person.

Doctor of this site closely followed me personally during my initially days after that he added another 5 mg to my original dosage. P6: FGD, SPARHSA, Kathmandu

Maintenance of medical records

The study, through Facility Observation (FO) come across medical records maintained for the purpose of medical assessment. Both of these assessments are also the normative requirements of the SOP for OST Programme.

Inadequate availability of Doctor

The qualitative study also noted unavailability of doctors at that OST site which hosted a challenge on a developing a tailored treatment plan and furthering use it.

I found difficulty. I am not able to get appointment with doctor because, doctor is not regular here. P5: FGD, SPARHSA, Kathmandu

Lack of understanding on clinical guideline

It appeared that one potential reason was lack of understanding of clinical guideline among OST service providers that could hinder conducting detailed assessment of substance abuse. Conversation with managers of OST site at Pokhara provides further a proof for lack of understanding of the Clinical Guideline prepared by NCASC.

Now there may be stipulation (of dosage) in clinical guideline but we have not understood and no idea. P2: KII, CSG, Pokhara

4.3.7 Take-home OST available/required/desired

Take-home OST available/required/desired is that variable that, in the context of this study, which aims to understand if coming to a center every day for a dose of OST medication is practical, especially for those who have been adherent to the therapy and are using the services for a long time.

The study found a strong preference of take- home dosage among OST users as two-thirds, (67.6%) respondents preferred take-home dosage (Table 20). It is interesting to note that only remarkably low proportion, 2.6% of respondents reported that the take-home dosage was already in practice.

Table 20: Preference of take-home dosage among OST users

Preference of take-home dosage among OST users						
Source	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Should be allowed	46	60.5	30	73.2	76	65.0
Yes, it is already allowed	2	2.6	1	2.4	3	2.6
Should not be allowed	28	36.8	10	24.4	38	32.5
Total	**76**	**100.0**	**41**	**100.0**	**117**	**100.0**

Current practice of take-away dosage

FGDs as well as KII observed that dosages for three or more days were dispensed to OST patients in practice. It was also noted that those OST patients who wanted to take away dosage for the reason of travelling out of the country they needed to show documentary evidence such as plane tickets or bus tickets.

For the take away dosage we are given for three days. P4: FGD, CSG, Pokhara

When I needed to go out of the city, they told me to take approval from Medical Superintend and they said me to bring evidence (to show that I am going out), as evidence I showed a plane ticket (Kathmandu to Hongkong, and Hongkong to Kathmandu) they said ok. P3: FGD, CSG, Pokhara

We give the dosages for two to three days on the supervision of family. P1: KII, SPARHSA, Kathmandu

Preference of take-home dosage among OST users

Two categorical demands from service receivers were noted in FGD and these were: a) advance dosage, and b) take-home dosage for a longer period. Apart from these two demands, participants of FGD also raised an issue of governance associated with take home dosage. Moreover, service receivers were also concerned about the misuse of take-home dosage.

Considering inconvenience caused by strikes and bandhs for accessing OST sites, service receivers demanded for the advance dosage especially of anticipated bandhs or strikes. This demand was very prominent in Kathmandu.

Coming here during strike and Bandh is also barrier. P6: FGD, SPARHSA, Kathmandu

I have to come from Tika Bhairav. It is far from here, it is not possible to walk such a long distance and we have to frequently face strike and Nepal Bandh. Thus in such a situation, for me the advance dosage of take home dosage is very appropriate. P1: FGD, SPARHSA, Kathmandu

The study also noted a prominent demand of take-home dosage for a longer period (than the current practice of three days). The demand for the length of take-home dosage was in a range between three weeks to one week.

For the take away dosage we are given for three days. As we need to go far, to our village or other work where this (service) is not available, if there is at least of dosage of one to two weeks or up to three weeks for take-away it will be good for us. P4: FGD, CSG, Pokhara

As mentioned earlier, many participants opined that three weeks was an unreasonably long period for take home dosage. They were of the opinion that the maximum of two weeks dosage should be dispensed for the take home dosage.

I will put forward one thing, three weeks is very long time. P6: FGD, CSG, Pokhara

Its long. P1, P2: FGD, CSG, Pokhara

When someone (his/her relative) dies, the most one needs is for thirteen days meaning two weeks. it should not be longer than two weeks but it (takeaway dosage) should be of two-weeks. P6: FGD, CSG, Pokhara

Yes, two weeks. P1: FGD, CSG, Pokhara

Attaching a conditionality of mourning to the take away dosage for two weeks, one participant mentioned that the take away dosage for two weeks should only be given only during mourning period and for the normal period, the take home dosage should be for one week.

As you said (earlier), considering the case, normally (take away) for one week and in the death case it (take away dosage) should be of two weeks. P2: FGD, CSG, Pokhara

This study also noted that some of service receivers were also concerned about the misuse of take-home dosage once is taken out of the service site.

But there is chance of misuse once drug is taken out of this site. P5: FGD, SPARHSA, Kathmandu

The study came across the complaints stemmed from the issue of partiality while giving take home dosage. The following verbatim clearly illustrates that.

And another issue is here they act differently to different persons. Some are getting take away dosage for 16-17 days, and for some, they are reluctant to give take-away dosage of 4-5 days. Some get take away in absence of doctor they have managed their (take away) dosage by phone call. There are many cases like these. Therefore, the doctor should treat all in a same manner. P4: FGD, CSG, Pokhara

The perception of service providers on take home dosage

The service providers were of the opinion that the take home dosage could be helpful in preventing the service receivers from taking other than prescribed drugs (side consumption) as well as retaining them in OST services. The following two verbatims clearly show the importance of take-home dosage on the reduction of side consumption and drop out.

We call it take away dosage, rather than take home dosage. There should be (provision of) take away dosage, as there are many circumstances for a person, in those circumstances if he/she cannot use

dosage then he/she can misuse outside, and it may be difficult to come to retention (OST). That's why understanding his/her situation, there should be provision of this (take away dosage). P1: KII, CSG, Pokhara.

Last time, one of the patients had to go to India with the dosages for three days only, but he remained there for 12 days, thus for 9 days he was under full withdrawals. When he came here he was having extreme difficulty. That can create maximum chance of drop out. P2: KII, CSG, Pokhara.

The service providers as well as policy makers were in favor of take away dosage policy. However, service providers did not agree to the notion of the stipulation of fixed number of days for the take away dosage. They were of the opinion that the number of days for take away dosage should be on the case by case basis after conducting a need assessment for each case in which the family members have to be involved.

There are many social events. For illustration, a parental death ritual is different context, but if he/she also has to go to native place for 12-13 days in case of death of other (other than father and mother) relatives. How to manage this? Thus, there are many such instances therefore even if criteria are made, it may be complicating (difficult). Thus, it should be on the basis of a need (of a situation), after doing assessment, in presence of family. But it should be in presence of family. P1: KII, CSG, Pokhara

For the control of (misuse) there should be involvement of immediate family. P1: KII, CSG, Pokhara

That's why if it is possible we should deliver one-month dosage, or 10- 15 days or for one week. P1: KII, NCASC

4.3.8 Availability of adherence counseling and encouraging positive behaviors

Availability of adherence counseling and encouraging positive behaviors is that variable in this study which aims to understand if motivational counselling is provided on site for adherence and other behavior change outcomes.

The quantitative survey of this study showed that three out of ten respondents (29.06%) had not received adherence counselling and behavior change communication. As it was found that among 117 respondents more than two-third (70.94%) received the adherence counselling and behavior communication (Table 21). Not much variations were observed between Kathmandu and Pokhara as 69.7% in Kathmandu valley received adherence counselling and behavior communication whilst 73.2% in Pokhara.

Table 21: Proportion of OST clients who received adherence counselling on OST program

Proportion of OST clients who received adherence counselling and behavior change communication received while on OST program						
	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Received	53	69.7	30	73.2	83	70.94
Not Received	23	30.3	11	26.8	34	29.06
Total	**76**	**100**	**41**	**100**	**117**	**100**

Three-pronged approach of counseling Service

The qualitative survey of this study, through KII with program managers, found that a three-pronged approach was adopted for the adherence to and encouraging positive behaviors. Two of the three prongs are: i) individual counseling, and ii) education session. Calling for an important role also from the family members, the third prong approach put a thrust upon consultation with family members highlighting their role on bringing about and behavioral changes in OST patients.

First one is an educational session and other is periodical counselling. There is a role of family members on adherence, apart from the patient as a person. That's why consultation with family is also a part because there should be someone at home to make (appropriate) environment for him inside his house. These kinds of approaches are there. P1: KII, CSG, Pokhara

Satisfaction with counseling service

The qualitative survey of this study collected a wide range of responses from service receivers. There were participants who expressed their dissatisfactions for lack of content in counselling, inadequate counselling sessions as well as inadequate time, background of counselor on the ground of not coming from drug use, and attitude of counsellors.

Counselling here is not satisfying (in its contents). Counsellor does not talk about behavior change here. P5: FGD, SPARHSA, Kathmandu

Similarly, the issues of counselling sessions as well as inadequate time given during counselling were noted in FGD. These issues were captured in FGD only in Kathmandu.

In the course of 4-5 months, I got only two sessions of counselling. P3: FGD, SPARHSA, Kathmandu

It lasts only for one or two minutes. P5: FGD, SPARHSA, Kathmandu

Participants of FGD, particularly, in Pokhara expressed their dissatisfactions over the background of counsellor on the ground of not coming from drug use. They opined that a counsellor not having drug use background could lack the understanding (of drug).

Counsellor is fine, and good counselling but as the counsellor is not from drug using background, hence there is a lack of understanding. P6: FGD, CSG, Pokhara

The main thing is that she has not understood the issue (of drug) and she has not practically involved in this and she does not know this issue. P1: FGD, CSG, Pokhara

The reports also observed that some participants in FGD also in Pokhara as well as in Kathmandu were not satisfied with the attitude of counsellors. This problem was also echoed by service providers.

Now having listen to this talk, the issue of attitude also came here. Since the last two to three days I did not find her attitude appropriate. P6: FGD, CSG, Pokhara

There are different views among our friends but the problem in attitude is an experienced reality. P3: FGD, CSG, Pokhara

Counsellor did not show any empathy although I did not ask for his sympathy. P5: FGD, SPARHSA, Kathmandu

A policy maker also raised the concern of quality of counsellor.

We do not have good counsellor. P1: KII, NCASC

Apart from the dissatisfactions on the counseling service, the study also noted some participants in FGD were satisfied with counseling service.

I felt I have been given (enough) time (during counselling). P4: FGD, CSG, Pokhara

4.3.9 Time, cost and the other burdens among those who access services

Time, cost and the other burdens among those who access services is one of the important variables that this study includes with of the objective of understanding if there are time and cost-related barriers to OST services

The quantitative survey of this study revealed that a little less than one-fifth (19.5)% of respondents did not have to spend any cost for travelling to and from OST site, while one percent paid up to

NRS 400 (). Taking average of both cities, an average one-time cost for traveling to and from OST site comes around NRS 77. It is interesting to note that 46.7% respondents in Pokhara reported that they did not have to pay for travel cost in comparison to 5.3% that of Kathmandu.

Table 22: Transportation Cost to and from the OST site

Transportation Cost to and from the site (one time)						
	Kathmandu		Pokhara		Total	
NPR (RS)	N	%	N	%	N	%
0	3	5.3	14	46.7	17	19.5
15	0	0.0	1	3.3	1	1.1
30	7	12.3	2	6.7	9	10.3
40	2	3.5	4	13.3	6	6.9
50	13	22.8	0	0.0	13	14.9
60	9	15.8	2	6.7	11	12.6
70	2	3.5	1	3.3	3	3.4
75	1	1.8	0	0.0	1	1.1
80	1	1.8	0	0.0	1	1.1
85	1	1.8	0	0.0	1	1.1
90	1	1.8	0	0.0	1	1.1
100	9	15.8	4	13.3	13	14.9
150	3	5.3	1	3.3	4	4.6
200	3	5.3	0	0.0	3	3.4
300	2	3.5	0	0.0	2	2.3
400	0	0.0	1	3.3	1	1.1

Costs of travelling to and from OST sites

During the conversation about travel cost incurred for the assessing OST service, participants at FGDs expressed their costs for travelling to and from OST sites mostly in the liters of petrol consumed while travelling by their motorcycles, in only a few occasions the costs in term of cash were mentioned. Travel costs ranging from a minimum of a liter of petrol for four days to a maximum of a liter of petrol for a day were noted in this study.

……it takes a liter of petrol to come (and go) here as it is around 12 KM from my place. P1: FGD, SPARHSA, Kathmandu

One liter of petrol lasts for four days. P4: FGD, CSG, Pokhara

Transportation Cost as a Barrier to OST sites

The qualitative survey has come across two sets of responses while dealing the issue of transportation cost as a barrier to the uptake of OST service. In a relatively big metropolitan like Kathmandu, where service receivers have to travel from its outskirts to OST sites, travel cost seems to a barrier in the uptake of OST services.

People from distance Chobar and Machhegaon come here for them daily Transportation is a barrier. P3: FGD, SPARHSA, Kathmandu

Transportation is a barrier for here. P3: FGD, SPARHSA, Kathmandu

People come here from places that we do no thought of. Some come from Lele, some come from village adjacent to Kirtipur. P1: KII, SPARHSA, Kathmandu

Clients comes here riding here but they do not have money for fuel. P1: KII, SPARHSA, Kathmandu

For a relatively small city like Pokhara, travel cost is not a barrier for the uptake of OST service.

On account of distance it is not (barrier). There were patients who used to come from 14 KM or 15 KM away but the reasons for their drop out were other reasons (than distance). For the majority (of patients), (travel cost) is not barrier. P2: KII, CSG, Pokhara

For a majority the (travel) cost is not barrier. P2: KII, CSG, Pokhara

It is a form of practice, in which we give transportation cost on the basis of needs after conducting the assessment. As per the assessment, whoever is selected a minimum of transportation cost for traveling on bus is given. P1: KII, CSG, Pokhara

Those who got (travel cost), they got only NRs 600. P4: FGD, CSG, Pokhara

Governance issue arising out of travel cost

The study noted that complaints of some service receivers; according to them that those who needed to travel farer distant daily were not getting travel costs but some of those who were residing near to OST sites were getting travel cost.

Let me say, travel cost yes it takes some travel cost (to come to OST site). Some are from far and some are from near. But what is happening here, irrespective of distance being near or far, travel costs were given to some. We heard that there is provision of travel cost, but some are getting it and some are not getting. P6: FGD, CSG, Pokhara

Another point is that some persons come from very near are also getting travel cost. P6: FGD, CSG, Pokhara

…..supporting transportation cost also depends on resources and we should dole out whatever resources available to us. While doling out the traveling cost some time the most needed may have missed out (from getting travel cost). P1: KII, CSG, Pokhara

4.3.10 Stockout of medicines and supplies

Stockout of medicines and supplies is that variable which aims to understand if stockout of medicines and supplies are frequent and problematic.

The quantitative survey reported that out of 117 respondents around only 4 (3.4%) missed their dosages because of the stockout of medicine. Furthermore, only 3.9% and 2.4% missed their dosages in Kathmandu and Pokhara because of stockout respectively (Table 23).

Table 23: Proportions of OST clients who missed of dose because of a stockout/ shortage of the OST medicine

Proportions of clients who missed of dose because of a stockout/ shortage of the OST medicine						
	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Missed	3	3.9	1	2.4	4	3.4
Not Missed	73	96.1	40	97.6	113	96.6
Total	**76**	**100**	**41**	**100**	**117**	**100**

Stock out of OST medicines

The qualitative survey also noted only few rare occurrences of stock out of OST medicines that took place long time ago.

I have been taking OST for ten years but I am not aware any such case. P1: FGD, CSG, Pokhara

Once so happened only the expired drugs (Methadone) were remaining here, they were saying "(fresh methadone) was coming". I could not wait till then and took the expired drugs. We would have to wait one to two hours. And I took the expired one. P6: FGD, CSG, Pokhara

There was stock out in 2009 or 2011 when handover was taking place. There has been not (any) stock out recently. Now stock is well maintained. P2: KII, CSG, Pokhara

In some occasion medicines did not come on time and staff from here (OST sites) so we went there (NCASC) to bring the stocks. …..that is not because of running out of supplies because they (NCASC) did not have their vehicle to ferry the stocks. P2: KII, SPARSHA, Kathmandu

Logistics Management of OST Medical Supplies

The qualitative survey of this study has collected some proofs showing a system of a bimonthly requisition along with a forecast of consumptions for the period of four months has been put in place.

They make a request on the bimonthly basis along with the assumption (forecast) of four months (consumption). P1: KII, CSG, Pokhara

We make a bimonthly requisition following the Nepali fiscal year. We make forecast of four months but make request of two months. P2: KII, SPARSHA, Kathmandu

4.3.11 Service-based stigma, perceived confidentiality and behavior of service providers

Service-based stigma, perceived confidentiality and behavior of service providers is the variable, in this context of this study, that aims to understand the experiences of service-based discrimination, perceived confidentiality, and other social stigma.

Majority of OST clients (52.10%) perceived that their medical records were not kept confidentially at the OST site. Moreover, a quarter (28.80%) responded that they did not know about. Only 14.30% of clients perceived that their medical records were maintained confidentially in the last six months (Table 24).

Table 24: Perceptions of OST clients on maintenance of confidentiality at OST site

Perceptions of OST clients on maintenance of confidentiality at OST site							
		Kathmandu		Pokhara		Total	
		N	%	N	%	N	%
Have you ever felt that your medical records are not kept confidentially at the OST site?	Yes, in the last 6 months	25	10.30%	29	21.30%	54	14.30%
	Yes, but not in the last 6 months	8	3.30%	10	7.40%	18	4.80%
	No	115	47.50%	82	60.30%	197	52.10%
	Don't know	94	38.80%	15	11.00%	109	28.80%

Training of staff members on "sensitivities" towards PWID

The study during the KII with the program mangers found that four out five staff members of CSG, Pokhara were trained - including on "sensitivities" towards people who inject drugs by GIZ, i.e., before the Global Funds took over these sites. One that had not been trained was recently recruited, but had taken all of these training in her previous job. Further to this, providing a piece of cogent evidence to the finding of KII, literature review also threw light upon the fact that GIZ conducted training to staff member of OST sites according to a standard curriculum, provided continuous on-the-job coaching and also supported in management of integrated patient

documentation systems at each OST site (8). Apart from that, it appeared from the Facility Observation (FO) that the both of OST sites had maintained a computerized data base with the system of coded client identity.

Maximum of our staff have already got training form GIZ. P2: KII, CSG, Pokhara

Service-based stigma and perceived confidentiality

Insofar as on the issue of privacy and confidentiality, the study got two diametrically different responses from FGDs in two different cities. The participants in SPARHSA, Kathmandu expressed they were satisfied with the issue of privacy and confidentiality at the OST site, while the participants in Pokhara clearly showed their grievances.

I do not have any issue with confidentiality. P4,P5: FGD, SPARHSA, Kathmandu

……here otherwise we feel safe and confidential. P1: FGD, SPARHSA, Kathmandu

As mention earlier, responses obtained in Pokhara were in a sharp contrast to that obtained in Kathmandu, as participants perceived privacy and confidentiality completely inadequate. The sequences of the following quotes put forward evidence for that.

(Privacy and confidentiality) Not here. P4: FGD, CSG, Pokhara

Not here. P5: FGD, CSG, Pokhara

The is no such thing as confidentiality here. P6: FGD, CSG, Pokhara

Similarly, in another reference, the FGD noted a majority of participants agreed on the lack of confidentiality in the OST site in Pokhara.

No confidentiality P1, P2, P3, P4 and P6: FGD, CSG, Pokhara

(Privacy and Confidentiality) That should be maintained P3: FGD, CSG, Pokhara

Giving an example of the situation of privacy and confidentiality, a participant said the following very noteworthy remark.

Like, while basking under the sun, staff talked among themselves saying this (person) used to take drugs. Now he has quit. P2: FGD, CSG, Pokhara.

4.3.12 The system of referral to external medical, social and legal services and collaboration

The system of referral to external medical, social and legal services and collaboration is that variable which aims to understand if there is a systematic approach to refer clients to relevant services: HIV testing, NSP, health care, social and legal services .

Referral to basic medical services

FGDs among service receivers showed that referral to medical services such as HIV testing and counseling, ART services, TB diagnosis, diagnosis of viral hepatitis, basic laboratory services were found to be of regular activities of all two OST sites. The following statements clearly provide proofs for medical services provided through referral.

Friends got Hep C treatment. P4: FGD, SPARHSA, Kathmandu

This study also recorded the following conversations when asked what about referral services that were not available at the OST site for example HIV, TB, and Hepatitis C? Where were these tests done?

All (tests were done). P4: FGD, CSG, Pokhara

They said go to that site, we would go there and conduct test. P1: FGD, CSG, Pokhara

Referral to legal and social services

The qualitative survey however no evidence for referral to other services notably for legal or social services.

4.3.13 Collaboration and support from law enforcement agencies

Collaboration and support from law enforcement agencies is the variable that is included with the intent of understanding if there is a systematic approach to engage with local law enforcement agencies and if it has been successful.

The KII with program managers observed that there existed a formal committee through which OST sites had very good coordination meeting with police and other law enforcement committed (CDO).

> *Other monitoring is that the joint monitoring with District OST (Management) Committee.* P1: KII, CSG, Pokhara

> *We have stakeholders meeting along with Police Administration. We conduct one (meeting) in one quarter.* P1: KII, SPARHSA

> *We do regular meeting with police we have good coordination with them. Even if there is custody of our client they phone call to our supervisor.* P1: KII, SPARHSA

> *We also have joint monitoring visit. We call CDO and last time assistant CDO came in this visit.* P1: KII, SPARHSA

4.3.14 Involvement of PWID in planning, management, implementation and monitoring of the OST

Involvement of PWID in planning, management, implementation and monitoring of the OST program is the variable that aims to understand if there is a systematic approach to engage people who use or have used drugs in OST programs.

Involvement of PWID planning, management, implementation and monitoring

The qualitative survey of this study found two different situations on the issue of involvement of PWID. For the first situation, KII at CSG, Pokhara revealed that there was no such representation of PWID in OST management committee at the time of survey. There used to be the representation of PWID in the OST Management committee in the past.

> *for implementation we have OST (current) user and ex users working here as staff and there is no formal structure for monitoring. For feedback mechanisms sometime interactions take place. Previously (they) were in management, not currently in management.* P1: KII, CSG, Pokhara

Participants - when asked if they were in the management committee - answered that they were not in management committee.

In the second situation, the study found PWID were included in OST Management Committee. However, it was also noted that OST Management Committee was not active and holding a meeting once a year. The following statements were obtained during the KII with the program manager of SPARSHA provide evidence.

> *In all three levels…..there is participation in OST Management Committee.* P1: KII SPARSHA

> *But OST Management is that much not active. It sits one in a year.* P1: KII SPARSHA

Involvement of PWID in feedback mechanisms

The following quotation of a program manager clearly puts forward that service receivers have, whatsoever, no role in quality monitoring and not provision of complaint box in the OST site.

In implementation we have OST (current) user and ex users working here as staff and there is no formal structure for monitoring. For feedback mechanisms sometime interactions take place. P1: KII, CSG, Pokhara

There is monthly meeting, we put our cases (problem). P5: FGD, CSG, Pokhara

When asked about had the sites contained any complaint box for the collection of complaints and grievances from services receivers. There was none in Pokhara as well as in Kathmandu.

No complaint box. P3: FGD, CSG, Pokhara

That should also be kept here. P1: FGD, CSG, Pokhara

I think we need a Complaint Box. P1: FGD, SPARHSA, Kathmandu

4.3.15 Monitoring and evaluation of the quality of OST services

The monitoring and evaluation of the quality of OST services is that variable that aims to understand if there is a regular monitoring of services provided with equal importance to quality along with coverage of OST programs

This study noted a district level monitoring committee functioning with the purpose of monitoring of effectiveness of OST service in each of these two districts.

We also have joint monitoring visit. We called CDO and last time assistant CDO came in this visit. P1: KII, SPARHSA

Other monitoring is that the joint monitoring with District OST (Management) Committee. P1: KII, CSG, Pokhara

4.3.16 Overall satisfaction with the quality of the OST services

Overall satisfaction with the quality of the OST services it that variable which aims to understand if the clients who have used OST services are satisfied with the quality of services.

More than a majority of respondents (64.10%) agreed among which a quarter of respondents (25.60%) strongly agreed and more than two-third (38.50%) agreed; that OST services they had been receiving was perfect. In contrast only 17.10 % either strongly disagreed or disagreed that OST services they had been receiving was perfect. In this regard, less than one-fifth of respondents (18.80%) were uncertain about OST services they had been receiving was perfect.

Table 25: Perception on OST services that respondents had been receiving

Perceptions of OST clients on maintenance of confidentiality at OST site							
		Kathmandu		Pokhara		Total	
		N	%	N	%	N	%
The OST services that I have been receiving is just about perfect.	Strongly Agree	18	23.70%	12	29.30%	30	25.60%
	Agree	26	34.20%	19	46.30%	45	38.50%
	Uncertain	13	17.10%	9	22.00%	22	18.80%
	Disagree	10	13.20%	1	2.40%	11	9.40%
	Strongly Disagree	9	11.80%	0	0.00%	9	7.70%
	Total	**76**	**100%**	**41**	**100%**	**117**	**100%**

CHAPTER 5
DISCUSSION

5.1 NSEP services

5.1.1 Provision and quality of drug use equipment and injecting paraphernalia

NHIP 2016-2021 stipulates the distribution of an average 10 needles/syringes per month for every person who injects drugs (4). However, the number of needles and syringes distributed per person among PWID who injects drugs per year has remained low over the years in Nepal as around 61 needles and syringes were distributed per person per year in 2017 (9) - nearly a half of that envisaged by NHIP (10). Despite this fact, it was noted that the overwhelming proportion of 99% of respondents perceived that they were supplied with sufficient amount of injecting equipment. The quantitative study also observed that about two-third (66.5%) respondents received less than 20 needles and syringes in a week whereas only 2 percent received more than 60 in a week with the median figure being 14 while the average figure around 19 per PWID per week (Table 3). Thus, it was found that a person who injects drug in an average received 19 needles and syringes in a week in Pokhara as well as in Kathmandu which is far higher than an average 10 needles/syringes per month for every person who injects drugs that NHIP 2016-2021 stipulates. Conversations with service receivers in FGDs noted the number of needles/syringes that a service receiver could get vary from a maximum of 3 at a time to as many as many as one can inject. The study further noted that they can take needle/syringe from outreach workers.

The study recorded that less than one-fifth (18.5%) of the respondents were unsatisfied with the quality of injecting equipment and a quarter of respondents (25%) neutral. More NSP clients were unsatisfied in Kathmandu (20.3%) than in Pokhara (15.7%) (Table 1).Varieties of drawback of needles such as weak, liable to break, flimsy was flagged in the FGDs. One interesting drawback of needle noted, was that service receivers perceived the needle could create chances of occurring abscess. Whereas for the quality of syringe, the qualitative study of this research gathered mixed responses. Male participants, in particular, at FGD expressed they were content with quality of syringes while female participants pointed a number of drawbacks on the quality of syringe.

Only one case in the entire KIIs and FGDs, a couple of female participants said that they did not take needles/syringes at all from the DIC. A further probe among female participants, these showed that because of self-stigma, the female participants perceived the service of DIC unacceptable.

5.1.2 Information provided on safer drug use, injecting and safer sex

The Program Implementation Guidelines issued from the Save the Children envisages education on, inter alia, safe injection behavior and safe sex behavior for PWID through the In-reach Process (7). Subscribing to the In-reach Model for the delivery of services related to Needle Syringe Program, the Program Implementation Guideline for PWID entrusts the trained members of PWID community to: a) identify other members from their community; b) provide them with information on HIV, Hepatitis & other blood borne infections; c) provide information on safe injection practices; and d)provide either one to one or group educational session; e) distribute IEC materials (7).

In alignment with the Guidelines, for dissemination of information, it was observed that for dissemination of information, a two-pronged approach entailing of a) holding group meeting with service receivers, and b) out-reach communication had been put in place. Safer sex, abscess, overdose, harm reduction including HIV, STI, Hepatitis were found to be contents of information disseminated to service receivers. In this context, the quantitative also survey showed that information on HIV, Hepatitis B and C were contents of information, as an overwhelming proportion 96.5% of respondents said that they had received information on HIV testing through an NSP site or outreach staff or peer educators (Table 5). Similarly, around 90.2% (Table 6) of respondents said that they had received information on Hepatitis B and C through an NSP site or outreach staff or peer educators.

The qualitative survey however found mixed responses for information on overdose management as some service providers admitted that overdose management had not been among the contents of information disseminated to service receivers. Likewise, the study did not find information on important issue of vein management being passed on to the clients of NSP.

About eight out of ten (79.50%) of NSP clients were either very satisfied or satisfied with information provided on safer drug use and safer sex. Only a remarkably low proportion of the clients (1.70%) clients were unsatisfied with information provided on safer drug use and safer sex, while nearly one-fifth of them (18.5%) were found neutral. None of them were found to be very unsatisfied.

Conversations with program managers clarified that the organizations participated on this study did not receive IEC materials or just received electronic copy without any budget for printing. In absence of IEC materials, these organizations were doing away with IEC materials for their part of Behavior Change Communication (BCC).

Regarding training of staff members, out of all three KII conducted with three NSEP executing agencies, it was only the staff members of Sathi Samuha who had received training relevant to BCC.

5.1.3 Modality (specialized NSP, outreach, other, e.g. drug treatment service)

Subscribing to the In-reach Model for the delivery of services related to Needle Syringe Program, the Program Implementation Guideline for PWID entrusts the trained members of PWID community to: a) identify other members from their community; b) provide them with information on HIV, Hepatitis & other blood borne infections; c) provide information on safe injection practices; d) provide either one to one or group educational session; e) distribute IEC materials, Condom & Syringes; f) arrange for community based HIV testing; g) make sure the members of key population get tested for HIV; g) refer to OST sites and rehabilitation centers, h) provide continuum of care services for positive PWIDs and their families; and i) support HIV negative PWID to remain HIV negative throughout the life (7). This Guideline, further, entrusts In-reach (4) workers should primarily carry out their works with the support from Peer Educators (PEs) especially in identifying new members of the PWID community (7). Giving a loose guidance, the Guideline further instructs each In-reach worker should reach somewhere around 100 to 150 PWIDs every month. This Guideline, however, does not mention any differential approach to bring Female, Transgender and MSM who use drugs into the fold of In-reach.

The study noted In-reach model along with DIC at its center was put in practice for the delivery of BCC, commodities - including needle syringe and condoms, and community led testing directly

to PWID. Other services such as treatment of STI, screening of HCV and TB were found carried out through referral to appropriate health care delivery sites.

National HIV Implementation Plan 2016-2021 stipulates screening of HCV as well as of TB once per year among PWID, the qualitative survey, however, found that many respondents had not been screened in a yearly manner.

Through the service providers participated in this study in Pokhara as well as in Kathmandu it became clear there was not any differential approach put in place for targeting MSM and TG to make them beneficiaries of NSP program. When it comes to targeting female injecting drug users, it appeared that female field workers were put in place for enhancing the catchment of female injecting drug users into NSP.

The study observed that service providers were not adopting any differential approach targeting MSM and TG to make then beneficiaries of NSP program. When it comes to targeting female injecting drug users, it appeared that female outlets and female field workers were put in place for enhancing the catchment of MSM and TG.

5.1.4 Success of referral/utilization of HIV testing

Nepal's National HIV Strategic Plan (NHSP 2016–2021) envisions a mix of the facility- based testing (FBT) and community-based testing (CBT) approaches for greater reach at the earliest stage of HIV infection (11). In this context, the Facility-based testing is put in place in settings such as stand- alone HIV testing services through HIV Testing Center (HTC), clinical settings along with antiretroviral therapy sites, specialized public health laboratories, antenatal care settings and labor rooms, opioid substitution therapy sites, TB care sites and private clinics. Whereas Community-Based Testing (CBT) is adopted for: in-reach among key populations using mobile units, entertainment sites, and hotspots for sex work and injecting drug use, and also focusing on remote birthing sites and areas with higher numbers of male labor migrants and their partners. Further to this, NHSP 2016–2021 has endorsed, Community-led HIV testing (CLT) as a part of the Community-Based Testing (CBT), following the 'test for triage strategy' for screening and referral (12). In this community-led HIV testing CLT approach, screening tests are carried out at community by lay providers, and it is only If this screening test turns out to be positive, then the individual is accompanied to a fixed HTC for further HIV testing. The CLT guidelines recommends that all clients with the reactive test should be accompanied to a fixed site for confirmatory test on the same day or the next day. All clients who are tested negative are asked for a follow-up test in 3 months. For the repeated clients, the CLT guidelines recommends that a test should be also offered once every 3 months. Further to this, the approach of index testing has also been put in practice to follow the spouses and children of those were tested HIV positive.

The quantitative survey of this study noted that eight out of ten (81.9%) respondents utilized HIV testing service while they were in NSP. Among those who utilized more than one-tenth (11.50%) utilized HIV service through referral (Table 7). Further in this context, it is also pertinent to note that one third (34.4%) of PWID in Kathmandu valley had tested HIV in the past 12 months and among them 98.3 % know their HIV status (13). Similarly, 29 percent of PWID in Pokhara had tested HIV in the last 12 months and all of them know their HIV status.

The qualitative survey noted that, the screenings of HIV among PWID were carried out at the community through CLT approach. Accompanied referrals to mostly ART sites or Facility-based testing for confirmatory test, of all clients with the reactive test result, were found taking place

at all three service sites that participated in this study. The study also noted a few challenges of taking those clients who tested positive during screening to an ART site or any other diagnosis center for performing a confirmatory test. These challenges largely stemmed from: a) shortage of IRW in the fields, and b) most of reactive clients did not reveal their real name, address and phone number adding difficulty in tracking them.

The qualitative survey observed that efforts were put in place for partner testing by all the three NSP service providers that participated in this study. In this context, applying the index testing approach, CSG of Pokhara rather than conducting partner testing of all the clients focused on only the partners of positive cases.

5.1.5 Success of referrals to ART, TB management, diagnosis and treatment of Viral Hepatitis

The Program Implementation Guideline for PWID envisages referral of the following ; a) STI services, b) ART services and community care centers for positive PWID c) CD4 count, Viral load services for positive PWIDs, d) DOTS (TB) centers, e) linkages with networks of people living with HIV, and d) linkages with social welfare schemes and legal aid. In this context, the findings of qualitative survey are structured around the following referrals

The qualitative survey got an impression that referral services for treatment of abscess and STI were inadequate. In contrary, it got a good impression that PWID when tested positive for HIV they were invariably referred to ART services.

It was noted that the treatment of Viral C Hepatitis for PWID for a limited number of those infected with HIV were being carried out with the support from the Global Fund. In this context, this study also come across the fact that PWID were supported for HCV testing through referral to appropriate sites. But it was also noted PWID were not tested for HCV regularly. Participants in an FGD in Pokhara said they had not tested for TB when asked if they had tested for TB. In the context that National HIV Implementation Plan 2016-2021 stipulates HCV Screening and TB screening once per year among PWID, the qualitative survey, however, found that many respondents had not been TB and HCV screened in a yearly manner.

5.1.6 Availability of Naloxone at the service provision sites and provision of the take-away Naloxone

The Program Implementation Guideline envisages education on, inter alia, overdose management through the In-reach Process (7). The Program Implementation Guideline however nowhere mentions Naloxone in it. The quantitative survey showed that less than one third (31%) of the entire 378 PWID who participated in the quantitative survey experienced overdose on any drugs to the point they lost consciousness and more than three-fourth (79.9 %) of PWID did not know about Naloxone. During the FGD, it was observed that a common practice, among PWID, of putting a spoon into mouth and hitting/patting on feet or chin when over dosage happened to their mates.

The quantitative survey noted that 16.1% PWID considered that Naloxone was provided in the area they lived. In contrast to this finding, the KII with service providers clearly showed there had not been any use of Naloxone. During KII with service providers, it was found that service providers were not using Naloxone because they did not come across any cases of overdose and no had asked for Naloxone.

During the qualitative survey it was evident none of the organizations adopted the practice of giving take away of Naloxone. Despite this, it was surprise to note that 1.1 % of respondents

during quantitative survey said that they had obtained take-home dosage of Naloxone. During the qualitative study, service providers also raised the issue of difficulty of the distributing injection form of Naloxone as they perceived only trained person should give the injection of Naloxone.

5.1.7 Stockout of NSP supplies

Both KIIs and FGDs showed that stock out of NSP supplies in Pokhara as well as in Kathmandu rarely happened, if not all. As such, only one service CSG faced one occurrence of stock out of two commodities, notably of; alcohol swab and 5 ml syringe. But they managed this problem through local procurement ensuring that its clients did not return empty handed from the service site. This finding however does not support the finding of quantitative survey. As it was found that nearly one-fifth (18.9%) of NSP users were refused to obtain clean needle /syringe on the ground of shortage at the NSP site.

5.1.8 Service-based stigma, perceived confidentiality, behavior of service providers

Probing the behaviors of service providers to PWID, the quantitative survey recorded that an overwhelming proportion 97.6% of respondents felt they were treated with respect and dignity by the health workers/staff at NSP sites (Table 12). Along the same line, it was also noted that more four-fifth (84.7%) of the respondents did not felt any experience of insult form the health workers while visiting NSP sites, while only 2.9% of the respondents felt they were insulted by the health workers (Table 11).

Regarding the stigma and perceived confidentiality, the qualitative study came across mixed responses i.e. positive from male and negative from female service providers. Among the positive responses recorded were that service receivers found that services provided were of confidential, secured, well treated and loving. Most importantly, they perceived DIC secured from the police. FIDU in the qualitative survey raised their concerns about self-stigma, and perceived lack of confidentiality- making them reluctant to visit DIC.

Regarding training to service providers with the contents on "sensitivities" while providing services to people who use drugs to service providers, no training, to have given to staff member. It was found orientations that too only to newly recruited staff were given.

5.1.9 Collaboration and support from law enforcement agencies

Underpinning the importance of woking closely with local law enforcement agencies, National Targetted Intervention Operational Guidelines, envisages the following measures aiming at reducing the chances of harrasment of PWID;

- Involving the senior police officials at the planning stage of the project
- Inviting them as chief guest to project related functions
- Collecting from senior police official in the locality a Letter of Support to project components accepting in principle the objectives of the project and its scope.
- Using sensitized police who are convinced about the program and its effectiveness to advocate and sensitize other police officials. Particularly when a sensitized police is getting transferred, request the person to directly brief the new person and introduce the project.
- Regular sensitization in the local police station. This has to be a continuous process and should be part of the project monthly work plan
- Organizing the HIV and drug awareness programs in the community in the presence of police officials.

The study observed that service providers has adopted the practice of holding regular meetings with law enforcement agencies. It was observed that service providing agencies were holding coordination meeting with the local police regularly. Furthermore, it was also noted that Dristi Nepal, which works exclusively for FIDU, has adopted the practice of coordinating with female police.

Despite the regular coordination meeting with police at the local level, the qualitative survey clearly revealed that police harassment including imprisonment was a common problem among NSP service users in particular for male PWID. As it was found that these service receivers had been arrested for the possession of syringe in the pocket. FIDU, in contrast were not harassed to that extent of male PWID, but even they were also arrested for the possession of syringe.

5.1.10 Involvement of PWID in planning, management, implementation and monitoring of NSP

The qualitative survey found that no role of service recipients in management as well as in monitoring. As peer educators of NSP were recruited from the pool of current users or ex users, on this ground, their involvement, was found in the implementation level to the extent that peer educators were involved in the service delivery of NSP.

5.1.11 Monitoring and evaluation of the quality of NSP services

The indicators for NSP, being singularly targeted to monitor the country progress towards achieving 90-90-90 by 20/21, hence are limited only to a number of quantitative indicators entailing of a) percentage of PWID : i) reached with HIV programs, ii) tested HIV and known their test results, b) number of commodities distributed, and c) number of STI cases diagnosed and treated. As such, a couple of these indicators effectively measure the program reach coverage and testing coverage. However, indicators on quality of NSP programs are very few, notably: number of needle/syringes distributed per person per year. The study found some cogent proofs supporting Save the Children through periodic visits, on-sight monitoring as well as monitoring through periodic progress reports had put in place a regular monitoring mechanism.

The study found these service sites did not have any formal mechanism for receiving complaints, grievances from service receivers in particular no provision of complaints box. Service providers however claimed that they had maintained a practice of collecting feedbacks through their peer educators and In-reach Workers. One of the service sites however claimed that it conducted questionnaire survey among its service receivers with contents including the number of services taken, behaviors of staff member.

5.1.12 Time, cost and other burdens among those who access the NSP services

The quantitative survey of this study showed that more than two-third respondents (71.1%) did not spend at all in a day for buying needle syringes from pharmacy. It also noted that not more than 2% spent NRS 100 to NRS 200 in a day. More than a quarter (27.3%) spent in NRS 1 to NRS 100 for buying needle syringes. In this context, FGDs with NSP users revealed they needed to buy needle/syringes especially due to holiday only occasionally but not normally. Difficulty of buying needle syringe from pharmacy was also noted in the qualitative survey. As it was found that pharmacists at times threatened to call the police. Participants at FGD also complained about paying exorbitantly high costs for buying needling syringes in pharmacy.

The FGDs at service sites recorded two versions of opinion on the issue of appropriateness opening and closing hours of NSP services. For the first version, some service receivers said that current business hours of NSP services were appropriate for them. The study also noted a

contrary voice from service receivers in which they demanded the expansion of current business hours of NSP services. The qualitative survey also revealed that NSP users did not need to travel much to obtain the needles/ syringe as outreach workers supplied them with adequate numbers.

5.1.13 Overall satisfaction of quality of NSP

The quantitative survey found that 92% of respondents were either very satisfied or satisfied with the overall quality of survey while around 7% were neutral to the overall quality. Less than one percent were found unsatisfied with the overall quality. This finding of quantitative survey was also corroborated by the findings of qualitative survey as many research participants in FGDs in their own words said that " they were totally satisfied".

5.2 OST services

5.2.1 Waiting time to first treatment admission

The Standard Operating Procedure (SOP) for Opioid Substitution Therapy Programme (2014) stipulates the following three criteria for the enrollment: i) person who use drugs specially who is practicing injection drug use, ii) person who agrees to follow the code of conduct of service, iii) person with history of legal accusations, had a history of crime or imprisoned in past shall not be bound to access the treatment (14). The SOP for OST Programme envisages the family members of clients should give their consent for the enrollment. The SOP has stipulated that the OST service in Nepal should be delivered free of cost, however, for the sustainability of OST Programme, a minimum cost can be charged on the OST service after taking the approval from concerned authority (15).

The study has observed that the OST sites conduct two rounds of assessment before enrolling a client into OST service. The first round of assessment is done by the SSU, which is followed by the second round of assessment that is done by the MU. The study, through Facility Observation (FO) has come across medical records maintained for the purpose of medical assessment. Both of these assessments are also the normative requirements of the SOP for OST Programme.

The quantitative survey revealed that more than a two-third (70%) of respondents did not have to wait at all i.e. 0 day for their first treatment, and around more than one-tenth of the respondents (11%) waited for one day. Revealing the cause of the delay, the qualitative survey noted that, often times, the second round of assessment that ought to be done by doctor was the major factor causing in delay in OST. In this context, the qualitative survey found that difficulty in getting appointment of psychiatric doctor that was one major reason for delayed OST initiation. The participants of the qualitative study were of the opinion that other requirements such as citizenship of clients, family consent could create a hurdle for the OST enrollment but there were alternative solutions to them. As other similar documents could work in absence of citizenship. In failing to get the family consent, evoking a waiver for such a case, the SOP has also a provision of getting the consent from the service receiver itself in the witness of Social Support Unit (SSU). The qualitative survey neither found any case in which clients were kept in the waiting list because of the unavailability of the slots at the OST sites nor a case of expulsion from the OST site. The study found that no cost for enrollment was charged and the client did not have to pay even the laboratory costs as they were paid from Global Fund.

5.2.2 Appropriateness of Methadone/Buprenorphine dosage

The Clinical Guideline for OST in Nepal, 2015 prescribes the first dose of the first day between the range of 10-20-30-40 mg Methadone. Adhering to the clinical guidelines, it appeared that the OST

sites commonly started with an initial dosage usually 20 mg of Methadone (less commonly also of 10 mg) for their newly enrolled service receivers make changing in their dosages after observing the clients.

Apart from this, study also gathered evidence for low starting dosage for their newly enrolled clients as well as inadequate adherence to the Clinical Guideline. The study did not obtain evidence for the practice of starting with 30 or more than 30 mg of Methadone for their newly enrolled clients. Though, the prescriptive range of the first dosage comes with a caution that an initial dose higher than 30 mg can only be administered if the client has higher degree of tolerance. This Guideline further instructs the patient has to be screened for signs of overdose/withdrawal after 3-4 hours of the first dosage preferably by applying the "COW Scale". In contrast, reportedly OST sites were not following COW scale. Service providers during their interview said they had a lack of understanding in the Clinical Guidelines itself.

Central to the determining an appropriate dosage for a patient on OST lies the role of a doctor. The quantitative survey and qualitative survey brought forward evidence of difficulty in changing their dosages due to unavailability of doctors at the OST site.

5.2.3 OST availability (including new initiation) in prisons

The SOP for OST service has set up a provision for custody dose in the form of delivery dose allowing the access of OST to those service receivers who are convicted and put into custody (14). One of indicators for the OST Monthly Report that an OST site has to submit is the number of clients received 'Custody Dose'. In this context, the monthly reports of the year 2018 showed that two OST patients in Pokhara had received their custody doses. The qualitative survey also revealed that practice of delivering dosage to PWID in the during their stay in custody but not in Prison.

5.2.4 OST costs including transportation to and from the site

The SOP has stipulated that the OST service in Nepal should be delivered free of cost. Premising upon this provision, the OST service in Nepal is being provided free of cost. However, there are other costs covering both direct costs, namely; travel costs laboratory costs, etc. that are invariably linked to the uptake of OST service for any service receiver.

The SOP has provisioned free delivery of cost, in contrast to this, the quantitative survey observed that more than two-third, 77% respondents were paying out of pocket expenses for the uptake of OST. Among those who paid out of pocket expenses, an overwhelming proportion of 97.8% paid these out out-of-pocket expenditures on their own. The study recorded the categories of out-of-pocket costs include expenses paid for such as registration/ enrollment, laboratory and diagnostics, hospitalization, transportation, accommodation and food.

It is for only negligible proportion (1.1%) that their expenses were paid by insurance, government and other sources. Gathering evidence for such a payment, the qualitative survey noted that the costs of routine diagnosis for PWID such as Hepatitis and Liver Function were provided by OST program though GFATM.

5.2.5 Diagnosis or detailed assessment of current substance use, individualized therapy planning

The study observed that the enrollment only took place after the first round of assessment done by the SSU probing into drugs, and diseases which was followed by the second round of assessment done by the MU. Both of these assessments are also the normative requirements of

the SOP for OST Programme. The study also noted the doctor at OST sites prescribed the initial dosage after taking accounts of history of drugs used including nature and quantity of drugs.

An overwhelming proportion of respondents (95.70 %) opined that health workers at OST site took a detailed assessment on substance use prior to their enrollment into OST Program.

The study, through FO came across medical records maintained for the purpose of medical assessment. It was found that the OST clients were followed up by the doctors for the monitoring purpose at least for the beginning of OST.

It appeared that one potential reason was lack of understanding of clinical guideline among OST service providers that could make the task of taking detailed assessment of substance use harder. This Guideline further instructs the patient has to be screened for signs of overdose/withdrawal preferably by applying the COW Scale. Despite, OST sites were found not applying this cow scale. It was also observed that unavailability of doctors at that OST site which hoisted a challenge on developing a tailored treatment plan and furthering use it.

5.2.6 Take-home OST available/required/desired Discussion

The operational frameworks and clinical guidelines in Nepal for OST Programme has set up, for the take away dosage, the following three conditions: a) custody dosage, b) mourning dosage, and c) sick dosage for hospitalized period (16) (14) (15). It allows the dispensation of only one day dose at one time through family member or outreach workers. The qualitative survey, interestingly, observed the practice of delivering take away dosage that was not limited to the above-mentioned three criteria also but also providing to those OST patients who needed to go for a foreign trip. It was also noted that for those OST clients who wanted to take away dosage for the reason of travelling out of the country they needed to show documentary evidence such as plane tickets or bus tickets.

The quantitative survey found a strong preference of take- home dosage among OST users as two-thirds 67.6% respondents preferred take-home dosage. The demands for take-dosage were also recorded in the qualitative survey. Considering inconvenience caused by strikes and bandhs for accessing OST sites, service receivers demanded for the advance dosage especially of anticipated bandhs or strikes, this is apart from the stipulated three conditions: a) custody dosage, b) mourning dosage, and c) sick dosage for hospitalized period mentioned in the operational frameworks and clinical guidelines in Nepal for OST Programme.

The study also noted a prominent demand of take-home dosage for a longer period (than stipulated in the guidelines) among OST users. The demand for the length of take-home dosage among OST users was in a range between three weeks to one week. A number of OST users also raised a concern on misuse of take-home dosage as well during their KII.

The service providers as well as policy makers were in favor of take away dosage policy. However, service providers did not second to the notion of the stipulation of fixed number of days for the take away dosage. They were of the opinion that the number of days for take away dosage should be on the case by case basis after conducting a need assessment for each case in which the family members have to be involved.

5.2.7 Availability of adherence counseling and encouraging positive behaviors

Aiming at motivating and reinforcing of positive behaviors among service receivers, the SOP for the OST Programme has envisaged: 1) individual counselling sessions, 2) input sessions, 3) group discussion, and 4) self-help group. Input sessions, in the SOP are referred to orientation classes, that are to be conducted in a classroom setting by one of the programme staff or counselors, to provide accurate information on issues that are of concern to the service receivers.

Despite the strong provision in SOP, the quantitative survey of this study, however, showed that three out ten (29.06%) OST clients had not received adherence counselling and behavior change communication.

Apart from those sessions mentioned in the SOP, the study found that consultative discussions with family members were in practice aiming at highlighting their role on bringing about and behavioral changes in OST patients.

The study also recorded the quality issues of counselling in terms of dissatisfactions over lack of content in counselling, inadequate counselling sessions as well as inadequate length of time of counselling.

5.2.8 Time, cost and the other burdens among those who access services

The quantitative survey of this study revealed that a little less than one-fifth, 19% of respondents did not have to spend any cost for travelling to and from OST site, while one percent paid up to NRS 400. Respondents considered that travel cost was a barrier in the uptake of OST services in a relatively big metropolitan like Kathmandu, only if service receivers had to travel from its outskirts to OST sites. Respondents of Pokhara considered travel cost was not a barrier for the uptake of OST service in a relatively small city like Pokhara. Thus, the potential of travel cost being a barrier for the uptake of OST is contingent upon distance.

The SOP for the OST Programme has directed the transportation costs of a) custody dosage, b) mourning dosage, and c) sick dosage delivery dosages be factored in during the project planning. The study noted the practice of paying travel costs on a lump sum on monthly basis to some but not all OST users. In this context, the qualitative study observed some clients were getting travel costs from the OST program and some were not regardless of distance or any other criteria, raising the concern of governance.

In the resource poor setting of Nepal, the doling of travel costs to OST users invariably is linked to many issues such as sustainability and governance. The study noted some concerns related to governance that stemmed from the practice of paying travel costs to some service receivers selectively but not to others. The study also recorded that complaints of some service receivers; according to them that those who needed to travel farer distant daily were not getting travel costs but some of those who were residing near to OST sites were getting travel cost.

5.2.9 Stockout of medicines and supplies Discussion

It was also observed that a sound of system of logistic management was in operation. This system requires a placement of request for medicines on a bi-monthly basis from an OST site with a forecast of consumptions for the period of four months to the Logistic Management Unit of NCASC. However, conversations with the OST users FGD discussion, it appeared that missing of dose due to stock out took place forcing OST clients to take expired medicines, at least, in one occasion. Service providers also in KII informed that one rare case of stock out of medicines taking long back in 2011. The quantitative survey revealed that only 3.4% missed their dosages because

of the stockout of medicine. Furthermore, only 3.9% and 2.4% missed their dosages in Kathmandu and Pokhara because of stockout respectively.

5.2.10 Service-based stigma, perceived confidentiality and behavior of service providers

The study during the KII with the program mangers found that staff members working at OST sites, were trained - including on "sensitivities" towards people who inject drugs by GIZ, i.e., before the Global Funds took over these sites.

Majority of OST clients (52.10%) perceived that their medical records were not kept confidentially at the OST site. This fact was strongly triangulated by the as mixed responses from OST users were collected during the qualitative survey in Pokhara. Many among them complained over the lack of confidentiality in these OST sites. These complaints over the breach of confidentiality were reportedly stemming from the conducts and behaviors of service providers, in particular, at the OST site located the premises of a government hospital of Pokhara. Despite all these, it appeared from the FO that the both of OST sites had maintained a computerized data base with the system of coded client identity.

5.2.11 The system of referral to external medical, social and legal services and collaboration

The OST Operational Directive issued by Ministry of Home Affairs (15) has explicitly listed the following services for referral to other appropriate sites:

a) HIV testing and counselling,
b) TB and Hepatitis Testing,
c) ART services,
d) Basic Laboratory services including Hemogram and Liver Function Test
e) Abscess Management and other surgical services
f) Detoxification and Rehabilitation Centers,
g) Harm Reduction Centers,
h) Shelter and Nutritional Services, and
i) Infant and Maternal Care.

Apart from this, The SOP for OST Programme has directed all Social Service Unit of OST to prepare and orients its entire staff on a referral directory of a list of comprehensive services and agencies (14). The SOP for instructs to update this referral directory on a yearly basis. The SOP for OST Program has included the number of clients - referred to HTC, STI, ART, TB, and rehabilitation to be reported in the monthly report.

FGDs among service receivers showed that referral to medical services such as HIV testing and counseling, ART services, TB diagnosis, diagnosis of viral hepatitis, basic laboratory services were of regular activities of these two OST sites. The qualitative survey however no evidence for referral to other services notably for legal or social services.

The SOP for OST Program has included the number of clients - referred to HTC, STI, ART, TB, and rehab - to be reported in the monthly report. This suggests systematic approach has been maintained to refer clients to relevant services, notably: HTC, STI, ART, TB.

5.3.12 Collaboration and support from law enforcement agencies

The OST Operational Directive issued by Ministry of Home Affairs (15) has set up a provision of a district level monitoring committee with the purpose of monitoring of effectiveness of OST service. This district level monitoring committee is headed by the Chief District Officer with one of

the members is an officer level representation of the District Police. Along the same line, the SOP has also envisaged an OST Management committee with the of local law enforcement agency as a member of the committee.

The above-mentioned District OST Management Committee is headed by the Chief District Officer, who also assumes the primary responsibility of law enforcement. The study has gathered a copy of meeting minutes of one of the meeting held in Kaski district. The meeting minutes itself seemed to be a proof for District OST Management Committee as a powerful platform for maintaining coordination and seeking support from the law enforcement. The presence of Chief District Officer as an ex officio chair has also lent a strong leverage to District OST Management Committee, in particular, for building up a coordination mechanism and drawing support from the law enforcement.

Apart that, the documentary evidence obtained during FO's also showed these OST sites also periodically held the stakeholders meeting with the participation of police. As a result of all these, it appears that these OST sites were appeared to have mutual cooperative relationship with police.

5.3.13 Involvement of PWID in planning, management, implementation and monitoring of the OST

The SOP for OST programme has also envisaged a OST Management committee with the representation of service receiver/ people who use drugs a member of the committee. Further to this, the SOP for the part of quality assurance has suggested for setting up of a)patients' feedback, and b) patients complaints box. Despite that the provision of the representation of PWID in the OST Management committee, KII at CSG, Pokhara revealed there was no such representation of PWID in OST management committee at the time of the survey. In the context of OST site at Sparsha Kathmandu, it was found PWID were included in OST Management Committee. However, it was also noted that OST Management Committee was not active and holding a meeting once a year.

The SOP for the OST for the part of quality assurance has suggested for setting up of a) patients' feedback, and b) patients complaints box. Despite this, it was observed that there were no provisions of complaint box for the collection of complaints and grievances from services receivers at both of these OST sites.

5.3.14 Monitoring and evaluation of the quality of OST services

As mentioned repeatedly earlier, the OST Operational Directive issued by Ministry of Home Affairs (15) has set up a provision of a district level monitoring committee with the purpose of monitoring of effectiveness of OST service. In this context, these district level monitoring committees were found holding monitoring meetings under the leadership of Chief District Officer with other district level key authorities.

Nepal has put in place a strong monitoring and evaluation framework entailing a number of indicators. These indicators, being singularly targeted to monitor the country progress towards achieving 90-90-90 by 20/21, are only limited to coverage indicators for the monitoring of OST program. Moreover, indicators on quality of OST service are scarce.

The study found some cogent proofs supporting Save the Children along with NCASC through periodic visits, on-sight monitoring as well as periodic progress reports has put in place a regular monitoring mechanism.

5.3.15 Overall satisfaction with the quality of the OST services

More than a majority of respondents (64.10%) agreed among which a one-fourth of respondents (25.60%) strongly agreed and more than two-third (38.50%) agreed; that OST services they had been receiving was perfect. In contrast only 17.10 % either strongly disagreed or disagreed that OST services they had been receiving was perfect. In this regard, less than one-fifth of respondents (18.80%) were uncertain about OST services they had been receiving.

CHAPTER 6
CONCLUSION

6.1 NSEP services

Provision and quality of drug use equipment and injecting paraphernalia

It was noted that the overwhelming proportion of 99% of respondents perceived that they were supplied with sufficient amount of injecting equipment. The study also observed that about two-third (66.5%) respondents received less than 20 needles and syringes in a week whereas only 2 percent received more than 60 in a week with the median figure being 14 while the average figure around 19 per PWID per week. The average of 19 per PWID per week is far higher than that the national average figures of 61 needles and syringes were distributed per person per year in 2017 (3).

The study recorded that less than one -fifth (18.5%) of the respondents were unsatisfied with the quality of injecting equipment and a quarter of respondents (25%) neutral. More NSP clients were unsatisfied in Kathmandu (20.3%) than in Pokhara (15.7%) (Table 1).

Information provided on safer drug use, injecting and safer sex

Safer sex, abscess, overdose, harm reduction including HIV, STI, Hepatitis were found to be contents of information disseminated to service receivers as the quantitative survey also showed that an overwhelming proportion 96.5% of respondents had received information on HIV testing through an NSP site or outreach staff or peer educators. Likewise, 90.2% respondents said that they had information Hepatitis B & C through an NSP site or outreach staff or peer educators. The qualitative survey however noted that overdose management was not among the contents of information disseminated to service receivers. Likewise, the study did not find information on important issue of vein management being passed on to the clients of NSP. Regarding overall satisfaction, only a remarkably low proportion of the clients (1.70%) clients were unsatisfied with information provided on safer drug use and safer sex.

Out of all three NSP service delivery sites, it was only the staff members of only one site were trained on BCC. In addition to this, these NSP service delivery sites did not receive IEC materials or just received e -copy without any budget for printing. In absence of IEC materials, these organizations were doing without IEC materials for their part of BCC.

Modality (specialized NSP, outreach, other, e.g. drug treatment service)

In-reach Model along with DIC at its center was found put in practice for the delivery of BCC, commodities - including needle syringe and condoms, and community led testing directly to PWID. Other services such as treatment of STI, screening of HCV and TB were found carried out through referral to appropriate health care delivery sites. The National HIV Implementation Plan 2016-2021stipulates screening of HCV as well as of TB once per year among PWID, the qualitative survey, however, found that many respondents had not been screened in a yearly manner.

Success of referral/utilization of HIV testing

The quantitative survey of this study noted that eight out of ten (81.9%) respondents utilized HIV testing service while they were in NSP. Among those who utilized more than one-tenth (11.50%) utilized HIV service through referral (Table 7). Accompanied referrals to mostly ART sites or Facility-based testing for confirmatory test- of all clients with the reactive test- were found invariably taking place at all three service sites. It was also observed that efforts were put in place for partner testing by all the three NSP service providers. In this context, applying the index testing approach, CSG of Pokhara rather than conducting partner testing of all the clients only focused on only the partners of positive cases.

Success of referrals to ART, TB management, diagnosis and treatment of Viral Hepatitis

The qualitative survey got an impression that referral services for treatment of abscess and STI were inadequate. This qualitative survey noted that PWID were tested for Viral C Hepatitis mainly through referrals but not regularly. It was found that PWID were not at all screened for TB in Pokhara.

The study also noted a few challenges of taking those clients who tested positive during screening to an ART site or any other diagnosis center for performing a confirmatory test. These challenges largely stemmed from: a) shortage of IRW in the fields, and b) most of reactive clients did not reveal their real name, address and phone number adding difficulty in tracking them. Despite these challenges , this study got a good impression that PWID when tested positive for HIV they were mostly referred to ART services.

Availability of Naloxone at the service provision sites and provision of the take-away Naloxone.

The quantitative survey showed that more than one third (31%) of PWID experienced overdose on any drugs to the point they lost consciousness and more than three-fourth (79.9 %) of PWID did not know about Naloxone. The qualitative survey of this study observed that PWID were practicing poor methods for overdose management such as putting a spoon into mouth and hitting/patting on feet or chin when over dosage happened to their mates.

Service providers during the qualitative survey clearly revealed that showed there had not been any use of Naloxone and none of them had adopted the practice of giving take away of Naloxone. It was observed that take away of Naloxone was fraught with difficulty of the distributing injection form of Naloxone as many service providers and service users perceived only trained person should give the injection of Naloxone.

Stockout of NSP supplies

The qualitative survey showed that stock out of NSP supplies in Pokhara as well as in Kathmandu were very rare in occurrence if not entirely absent. This finding however does not support the finding of quantitative survey. As it was found that nearly one-fifth (18.9%) of NSP users were refused to obtain clean needle /syringe on the ground of shortage at the NSP site.

Service-based stigma, perceived confidentiality, behavior of service providers

Probing the behaviors of service providers to PWID, the quantitative survey recorded that an overwhelming proportion 97.6% of respondents felt they were treated with respect and dignity by the health workers/staff at NSP site. Along the same line, it was also noted that more four-fifth

(84.7%) of the respondents did not felt any experience of insult form the health workers while visiting NSP service centers, while only 2.9% of the respondents felt they were insulted by the health workers.

Regarding the stigma and perceived confidentiality, the qualitative study found that service receivers, in particular, perceived that services provided were of confidential, secured, well treated and loving. Most importantly, they perceived DIC secured from the police. While, FIDU in the qualitative survey raised their concerns regarding self-stigma, and perceived lack of confidentiality particularly among FIDU- making them reluctant to visit DIC.

The system of referral to external social and legal services and collaboration with them

Programme Implementation Guideline has also inter alia prescribed for linkages to social welfare schemes and legal aid (7). In this context, this study has not found any substantial evidence for linkages to social welfare schemes and legal aid being put in place.

Collaboration and support from law enforcement agencies

The study observed that service providers has adopted the practice of holding regular meetings with law enforcement agencies. Despite the regular coordination meeting with police at the local level, the qualitative survey clearly revealed that police harassment including imprisonment was a common problem among NSP service users in particular for male PWID. As it was found that these service receivers had been arrested for the possession of syringe in the pocket. FIDU, in contrast were not harassed to that extent of male PWID, but even they were also arrested for the possession of syringe.

Involvement of PWID in planning, management, implementation and monitoring of NSP

Literatures reviewed showed that PWID had participatory involvements of national level planning, i.e. in the preparation of National HIV Strategic Plan as well as of the National HIV Implementation Plan. Further in this context, their involvement, in the implementation level was found very limited - to the extent that peer educators were involved in the service delivery of NSP. Apart from these, their involvement in management and monitoring of NSP was found none at all.

Monitoring and evaluation of the quality of NSP services

The study found that the monitoring framework even at the national were not adequately equipped to monitor the quality of NSP. As such, indicators on quality of NSP put in place for the monitoring the quality of NSP were very few. The study found the service sites did not have any formal mechanism for receiving complaints, grievances from service receivers, in particular, no provision of complaints box.

Time, cost and other burdens among those who access the NSP services

The study found that for more than two-third (71.1%) NSP users, utilizing NSP services did not cost at all in a day for buying needle syringes from a pharmacy. In this context, the qualitative survey also revealed that NSP users did not need to travel to obtain the needles/ syringe as outreach workers supplied them with adequate numbers regularly. It was around quarter (27.3%) of NSP users who spent in NRS 1 to NRS 100 in a day for buying needle syringes from a pharmacy. Participants at FGD also complained about paying exorbitantly high costs for buying needling syringes in pharmacy. Apart from paying high cost, buying needles/syringe from pharmacy was not easy, as it was found that pharmacists at times threatened to call the police.

Overall satisfaction of quality of NSP

It was found that 92% of respondents were either very satisfied or satisfied with the overall quality of survey while around 7% were neutral to the overall quality. Less than one percent were found unsatisfied with the overall quality.

6.2 OST services

Waiting time to first treatment admission

The quantitative survey revealed that more than a two- third (70%) of respondents did not have to wait at all i.e. 0 day for their first treatment, and around more than one-tenth of the respondents (11%) waited for one day. Revealing a cause for the delay, it was found that difficulty in getting appointment of psychiatric doctor that was one major reason for delayed OST initiation.

Appropriateness of Methadone/Buprenorphine dosage

The overwhelming proportion 114 (97.4%) were satisfied with Methadone/ Buprenorphine dosage they were taking. Having said that, the study also gathered evidence for low starting dosage for their newly enrolled clients even though for a very low proportion (2.5%). The quantitative survey and qualitative survey brought forward evidence of difficulty in changing their dosages due to unavailability of doctors at the OST site.

OST availability (including new initiation) in prisons

The SOP for OST service has set up a provision for custody dose in the form of delivery dose allowing the access of OST to those service receivers who are convicted and put into custody. The qualitative survey also revealed that practice of delivering dosage to PWID in the during their stay in custody to ensure uninterrupted OST treatment, but not in prison.

OST costs including transportation to and from the site

The study found that more than two-third, 77% respondents were paying out of pocket expenses for the uptake of OST. Among those who paid out of pocket expenses, an overwhelming proportion of 97.8% paid these out out-of-pocket expenditures on their own. The study recorded the categories of out-of-pocket costs include expenses paid for such as registration/ enrollment, laboratory and diagnostics, hospitalization, transportation, accommodation and food. It is for only negligible proportion (1.1%) that their expenses were paid by insurance, government and other sources.

Diagnosis or detailed assessment of current substance use, individualized therapy planning

The study found that enrollments of clients were preceded by a round of assessments (including medical assessment. An overwhelming proportion of respondents (95.70 %) opined that health workers at OST site took a detailed assessment on substance use prior to their enrollment into OST Program. Despite the detailed assessments, for the implementation of individualized therapy planning, OST sites facing a number of challenges: a) lack of clear understanding on the Clinical Guideline among staff members and b) inadequate availability of doctors.

Take-home OST available/required/desired

The operational frameworks and clinical guidelines in Nepal for OST Programme allow the take away dosage for the following three conditions: a) custody dosage, b) mourning dosage, and c) sick dosage for hospitalized period. It allows the dispensation of only one day dose at one time. In this context, the study noted a prominent demand of take-home dosage for a longer period (than

stipulated in the guidelines) among OST users. Service providers working at OST sites were of the opinion that the number of days for take away dosage should be on the case by case basis after conducting a need assessment for each case with the involvement of family members. Concerns on misuse of take-home dosage were also noted in the study. The demands for take home dosage, in particular, for bandh and strike were prominently observed.

Availability of adherence counseling and encouraging positive behaviors

The study observed that 30% of OST users were yet to receive adherence counselling. The study also recorded the quality issues of counselling in terms of dissatisfactions over lack of content in counselling, inadequate counselling sessions as well as inadequate length of time of counselling.

Time, cost and the other burdens among those who access services

The quantitative survey of this study revealed that a little less than one-fifth, 19% of respondents did not have to spend any cost for travelling to and from OST site, while one percent paid up to NRS 400. Taking average of both cities i.e. Kathmandu and Pokhara, an average one-time cost for traveling to and from OST site comes around NRS 77. The potential of travel cost being a barrier for the uptake of OST, was found to be, contingent upon the distance that an OST client to travel. Respondents during qualitative survey considered that travel cost could be a barrier in the uptake of OST services in a relatively big metropolitan like Kathmandu, only if service receivers had to travel from its outskirts to OST sites. Respondents of Pokhara considered travel cost was not a barrier for the uptake of OST service in a relatively small city like Pokhara. The study noted some concerns related to governance that stemmed from the practice of paying travel costs to some service receivers selectively but not to others.

Stockout of medicines and supplies

A well-functioning system of logistic management has been put in place, this system requires a placement of request for medicines on a bimonthly basis with a forecast of consumptions for the period of four months. As a result, occurrence of stock out medicines was found very rarely, in fact the lone case of stock out medicines took place that in 2011.

Service-based stigma, perceived confidentiality and behavior of service providers

In so far as the issue of privacy and confidentiality among OST users, about a half of OST clients (52.10%) perceived that their medical records were not kept confidentially at the OST site. This fact was strongly triangulated by the similar responses from OST users collected during the qualitative survey. Many among them complained over the lack of confidentiality in these OST sites. These complaints over the breach of confidentiality were reportedly stemming from the conducts and behaviors of service providers, in particular, at the OST site.

The system of referral to external medical, social and legal services and collaboration

The OST Operational Directive issued by Ministry of Home Affairs (15)has explicitly listed the following services for referral to other appropriate sites including but not limited to: HIV testing and counselling, TB and Hepatitis Testing, ART services, basic laboratory services including Hemogram and Liver Function Test. In this context, referral to medical services such as HIV testing and counseling, ART services, TB diagnosis, diagnosis of viral hepatitis, basic laboratory services were, found to be, of regular activities of OST sites. The SOP for OST Program has also included the number of clients - referred to HTC, STI, ART, TB, and rehab - to be reported in the monthly report. This suggests systematic approach has been maintained to refer clients to relevant services, notably: HTC, STI, ART, TB. This study did not find any mechanism put in place for referral to other services, notably: legal or social services.

Collaboration and support from law enforcement agencies

District OST Management Committees were found to be working as a powerful institutional framework for maintaining coordination among local stakeholders and drawing support from the law enforcement. The presence of Chief District Officer as an ex officio chair also lent a strong leverage to District OST Management Committee, in particular, for building up a coordination mechanism and drawing support from the law enforcement.

Involvement of PWID in planning, management, implementation and monitoring of the OST program

Despite that the provision of the representation of people who use drugs (PWUD) in the OST Management committee, the study revealed either there was no such representation of PWID in OST management committee or these OST Management Committees were not active. it was observed that there were no provisions of complaint box for the collection of complaints and grievances from services receivers at OST sties at CSG Pokhara as well as at Sparsha, Kathmandu.

Monitoring and evaluation of the quality of OST services

The OST Operational Directive issued by Ministry of Home Affairs (15)has set up a provision of a district level monitoring committee with the purpose of monitoring of effectiveness of OST service. In this context, these district level monitoring committees were found holding monitoring meetings under the leadership of Chief District Officer with other district level key authorities and stakeholders. It was also observed these district level monitoring committee occasionally visited OST sites for monitoring purpose.

Nepal has put in place a strong monitoring and evaluation framework entailing a number of indicators. These indicators, being singularly targeted to monitor the country progress towards achieving 90-90-90 by 20/21, are only limited to coverage indicators for the monitoring of OST program. Moreover, indicators on quality of OST service are scarce.

Overall satisfaction with the quality of the OST services

More than a majority of respondents (64.10%) agreed —among which a quarter of respondents (25.60%) strongly agreed and more than two-third (38.50%) agreed; that OST services they had been receiving was perfect. In contrast only 17.10 % either strongly disagreed or disagreed that OST services they had been receiving was perfect. In this regard, less than one-fifth of respondents (18.80%) were uncertain about OST services they had been receiving was perfect.

CHAPTER 7
RECOMMENDATIONS

7.1 NSEP services

- The study 18.5% of the respondents were unsatisfied with the quality of injecting equipment. Their complaints were mainly on the quality of needles. This complaints on the quality of needle should be addressed.
- Provide training to staff members of NSP sites on Behavior Change Communication (BCC).
- The study found that NSP sites were not provided with adequate supply of IEC materials or they were provided with only electronic copies of IEC materials, thus adequate supply of IEC materials including hard copies should be provided to NSP sites.
- Provide information on vein management to PWID along with IEC materials.
- The Program Implementation Guidelines for NSP should adopt differential approach targeting PWID MSM/TG to make them also one of the beneficiary group of NSP program.
- Conduct HCV test integrated with HCV through CLT approach regularly.
- Conduct TB screening once per year among PWID in a yearly manner.
- Provide information on the use of Naloxone for the treatment of overdose of drugs among PWID and make Naloxone easily available to PWID.
- Many among FIDU were found to have the services of DIC unacceptable for them because of self-stigma prevailing within themselves. This calls for orientations program for FIDU for dispelling self-stigma.
- Set up a well-functioning system of referral for external social and legal services at NSP sites.
- Ensure effective and efficient referral services for treatment of abscess and STI.
- Set up a framework ensuring the effective involvement of PWID in especially management, implementation and monitoring of NSP.
- Include mechanism for monitoring the quality of NSP services in the Monitoring and Evaluation Framework

7.2 OST services

- Adherence to clinical guideline should be strongly emphasized paying attention to details such as application of COW scale. This also calls for training to relevant staff members of OST site.
- Increase availability of doctors at the OST site.
- The operational frameworks and clinical guidelines in Nepal for OST Programme allow the take away dosage for the following three conditions: a) custody dosage, b) mourning dosage, and c) sick dosage for hospitalized period. However, it allows the dispensation of only one day dose at one time. The findings of however suggest that the number of days for take away dosage should be on the case by case basis after conducting a need assessment with the involvement of the family members.
- Improve the quality of adherence counseling focusing on appropriate contents with adequate time for each session.

- This study calls for ensuring adequate frequency of counselling for OST clients based on the case management approach – more frequency of counselling to new clients, than to old and stable clients.
- A majority of OST clients (52.10%) perceived that their medical records were not kept confidentially at the OST site. On this ground, the study recommends the service providers should take adequate measures to ensure that privacy and confidentiality is maintained at OST sites.
- This study calls for orientation/ training on importance of legal and other social services among service providers working at OST sites. Further to this, OST sites should be provided with resources for making referrals to other services notably for legal or social services.
- The study recommends the representation PWID in the OST management committee in every district where OST Management Committee exits. Moreover, Meetings of these OST Management Committee should take place regularly.
- OST sites should maintain several methods for collecting complaints including through emails. Moreover, all OST sites should mandatorily maintain at least one complaint box.

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TABLES

Table 26: Gender of respondents of quantitative survey

Gender of respondents of quantitative survey						
Gender	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Male	200	82.6	107	78.7	307	81.2
Female	39	16.1	29	21.3	68	18.0
Transgender	3	1.2	0	0.0	3	.8
Others	0	0.0	0	0.0	0	0.0
Total	**242**	**100.0**	**136**	**100.0**	**378**	**100.0**

Table 27: Current marital status of respondents of quantitative survey

Current marital status of respondents of quantitative surve						
Current Status	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Married or cohabitating and husband/ wife/ partner is currently living in a household.	72	29.8	53	39.0	125	33.1
Married or cohabitating but husband/ wife/ partner is temporarily living/ working away from the household.	6	2.5	12	8.8	18	4.8
In a relationship but not living together	1	.4	5	3.7	6	1.6
Single	154	63.6	60	44.1	214	56.6
Divorced/separated	9	3.7	4	2.9	13	3.4
Widow/widower	0	0.0	2	1.5	2	.5
Total	242	100.0	136	100.0	378	100.0

Table 28: Education level of respondents of quantitative survey

Current marital status of respondents of quantitative surve						
level	Kathmandu		Pokhara		Total	
	N	%	N	%	N	%
Illiterate	10	90.9	1	9.1	11	100.0
Primary completed	76	60.3	50	39.7	126	100.0
Secondary completed	91	59.9	61	40.1	152	100.0
Higher secondary completed	49	68.1	23	31.9	72	100.0
College level or higher	16	94.1	1	5.9	17	100.0
Total	242	64.0	136	36.0	378	100.0

Table 29: Age group of respondents of quantitative survey

Age Group of respondents belonging to quantitative survey		
Age group (In Years)	N	%
18- 20	36	9.5
20-24	94	24.9
25-29	100	26.5
30-34	72	19.0
35-39	54	14.3
40-44	17	4.5
More than 45	5	1.3
Total	378	100.0

Table 30: Reponses of those respondents who were either neutral or dissatisfied on the quality of needle and syringe

Perceptions of OST clients on maintenance of confidentiality at OST site							
		Kathmandu		Pokhara		Total	
		N	%	N	%	N	%
The size of syringe is smaller (than I need)	Yes	9	22.5	4	10.0	13	16.3
	No	31	77.5	36	90.0	67	83.8
The size of syringe is bigger (than I need)	Yes	6	15.0	1	2.6	7	8.9
	No	34	85.0	38	97.4	72	91.1
The size of needle is smaller (than I need)	Yes	10	25.0	10	25.6	20	25.3
	No	30	75.0	29	74.4	59	74.7
The size of needle is bigger (than I need)	Yes	29	72.5	26	66.7	55	69.6
	No	11	27.5	13	33.3	24	30.4
Because it is not reusable	Yes	11	27.5	2	5.1	13	16.5
	No	29	72.5	37	94.9	66	83.5
Other: Low-dead space syringes (LDSS)	Yes	1	2.6	2	5.1	3	3.8
	No	38	97.4	37	94.9	75	96.2
	Total	**39**	**100.0**	**39**	**100.0**	**78**	**100.0**

Table 31: Out of pocket expenditures for receiving OST services by cost category

Perceptions of OST clients on maintenance of confidentiality at OST site							
		Kathmandu		Pokhara		Total	
		N	%	N	%	N	%
OST Medicines	0	57	100	32	100	89	100
Enrollment/registration fee	0	57	100	20	60.6	77	85.6
	10	0	0	1	3	1	1.1
	15	0	0	1	3	1	1.1
	25	0	0	9	27.3	9	10
	100	0	0	1	3	1	1.1
	150	0	0	1	3	1	1.1

	0	56	98.2	6	18.8	62	69.7
Laboratory fee & diagnostics	25	0	0	1	3.1	1	1.1
	50	0	0	1	3.1	1	1.1
	100	0	0	3	9.4	3	3.4
	200	0	0	2	6.3	2	2.2
	400	0	0	9	28.1	9	10.1
	500	0	0	1	3.1	1	1.1
	600	0	0	1	3.1	1	1.1
	1200	0	0	1	3.1	1	1.1
	1400	1	1.8	0	0	1	1.1
	1500	0	0	1	3.1	1	1.1
	1700	0	0	4	12.5	4	4.5
	2200	0	0	2	6.3	2	2.2
Procedures or hospitalization	0	56	98.2	17	56.7	73	83.9
	25	0	0	6	20	6	6.9
	29	0	0	1	3.3	1	1.1
	50	0	0	1	3.3	1	1.1
	200	1	1.8	0	0	1	1.1
	225	0	0	2	6.7	2	2.3
	525	0	0	2	6.7	2	2.3
	1700	0	0	1	3.3	1	1.1
Transportation to and from the site (one time)	0	3	5.3	14	46.7	17	19.5
	15	0	0	1	3.3	1	1.1
	30	7	12.3	2	6.7	9	10.3
	40	2	3.5	4	13.3	6	6.9
	50	13	22.8	0	0	13	14.9
	60	9	15.8	2	6.7	11	12.6
	70	2	3.5	1	3.3	3	3.4
	75	1	1.8	0	0	1	1.1
	80	1	1.8	0	0	1	1.1
	85	1	1.8	0	0	1	1.1
	90	1	1.8	0	0	1	1.1
	100	9	15.8	4	13.3	13	14.9
	150	3	5.3	1	3.3	4	4.6
	200	3	5.3	0	0	3	3.4
	300	2	3.5	0	0	2	2.3
	400	0	0	1	3.3	1	1.1
	0	45	78.9	29	96.7	74	85.1
	25	1	1.8	0	0	1	1.1
	40	2	3.5	0	0	2	2.3
	50	3	5.3	0	0	3	3.4
	60	1	1.8	0	0	1	1.1

Food	80	1	1.8	0	0	1	1.1
	150	1	1.8	1	3.3	2	2.3
	200	2	3.5	0	0	2	2.3
	400	1	1.8	0	0	1	1.1
Accommodation	0	56	98.2	29	100	85	98.8
	50	1	1.8	0	0	1	1.2

ETHICAL APPROVAL