



OUT OF SIGHT

Women who inject drugs and access to harm reduction in Nepal

MAIN*line*

Funded by:



Save the Children



ACKNOWLEDGEMENTS

We want to express our deepest gratitude to all women and men who inject drugs for their courage in sharing their life experiences and recommendations with us. We acknowledge the professionals offering services to them for sharing their time, commitment, and reflections on assisting people who inject drugs daily.

We thank the participants and stakeholders for reviewing the assessment and providing valuable input.

Finally, this assessment only materialised due to the generous support of Save the Children Nepal, which funded the assessment with support from The Global Fund.

Colophon

Written by: Rafaela Rigoni

Revised by: Save the Children Nepal, The Global Fund, and all assessment participants.

Focus Groups and interviews by: Rafaela Rigoni, with interpretation by Erica Adhikary.

Layout by: Katja Berends

Published by: Mainline

Suggested citation: Rigoni, R (2023). Out of sight. Women who inject drugs and access to harm reduction in Nepal. Amsterdam: Mainline.

Funded by: Save the Children Nepal with support from The Global Fund

Copyright: Mainline

TABLE OF CONTENTS

<i>THIS REPORT</i>	4
Background	4
Objective	4
Methodology.....	5
<i>THE CONTEXT OF NEPALESE WOMEN WHO INJECT DRUGS</i>	7
Socio-economic development.....	7
Gender inequalities	7
Healthcare access.....	8
Violence.....	9
Drug use and related risks	9
Harm reduction services	11
Female-specific harm reduction services	11
<i>CHALLENGES FOR WOMEN WHO INJECT DRUGS IN NEPAL</i>	13
Gender-based stigma & discrimination	13
Criminalisation.....	14
Abscesses.....	15
Lack of access to primary healthcare.....	16
Lack of comprehensive care.....	17
Lack of privacy in mixed harm reduction services	19
Gender-based and intimate partner violence.....	20
Lack of income and financial independence	21
<i>RECOMMENDATIONS</i>	23
Scale-up safe spaces for women who inject drugs	23
1. Scale up female-only/female-led harm reduction services	23
2. Provide low threshold and female-only OAT.....	23
Promote gender equality in harm reduction services	24
3. Promote non-discrimination in existing programs	24
4. Sensitise male clients for gender equality	24
5. Provide gender-sensitive IEC.....	25
6. Hire female staff.....	25
Strengthen the capacity of existing female-only services	25
7. Build capacity of staff and clients around safer injection	25
8. Provide quality harm reduction materials.....	26
9. Support programs in providing more attractive services.....	26
Provide integrated services with a comprehensive approach	26
10. Provide primary health care within harm reduction services	26
11. Provide a comprehensive harm reduction package.....	27
12. Provide nutrition and transportation support	27

13. Provide childcare and support	27
14. Provide legal support for women who use drugs	27
Foster women’s empowerment and independence	28
15. Provide skills development and income generation	28
16. Promote female leadership	28
Invest in inter-organizational collaboration.....	28
17. Build synergies with other networks and essential services	28
<i>ACKNOWLEDGEMENTS</i>	1
Colophon	1

THIS REPORT

Background

In Nepal, people who inject drugs, especially women, are particularly vulnerable and disproportionately affected by HIV and other health and social harms due to structural factors such as stigma, gender-based discrimination and violence, human rights violations, and criminalisation. All contribute to an increased probability of certain risk behaviours and a lack of access to health services.

Harm reduction services available to the population using drugs in Nepal count on Global Fund (GF) support. Services funded include drop-in centres (DIC) and Opiate Agonist Therapy (OAT)¹, the first run by civil society organisations (CSOs) and the last by the national government and CSOs. In addition to mixed services, female only DICs/NSPs are available in five districts. These were supported by UNODC in 2008, stopped after some years due to lack of funding, and supported again by the GF since 2020.

The Global Fund HIV grant is implemented in Nepal between March 2021 and July 2024 by the PR Save the Children (STC), which implements programs for people who inject drugs through the Network of People Who Inject Drugs. As part of the current funding cycle, STC identified technical assistance needs related to community engagement to strengthen grant implementation. These include contributions in the following areas:

- Strengthen the capacity of women-led organisations to better engage in the GF and national HIV responses.
- Strengthen 'gender sensitivity' and understanding of PLHIV and PWID networks.
- Strengthen KP organisations and CSOs for social contracting.
- Situational analysis on gender and human rights challenges in the context of HIV and TB, including the policy and legal scan.
- Strengthen harm reduction programming to reach better women who inject drugs.

Objective

The present report addresses the need to strengthen harm reduction programming to reach better women who inject drugs. To this end, it reviews current harm reduction programs focusing on the perspective of women who inject drugs and the staff assisting them, formulating recommendations for service delivery improvements. Departing from a short desk review and consultations with women and men who inject drugs, team delivering services, and key informants, it:

- Reviews existing harm reduction programs regarding accessibility, availability, acceptability, and quality through a gender lens and identifies critical barriers to accessing and accepting harm reduction services.
- Formulates recommendations for harm reduction delivery that include women who inject drugs, informing programming for new funding cycles.

¹ Opioid Substitution Therapy (OST) is the term used in the GF guidance (https://www.theglobalfund.org/media/1279/core_harmreduction_infonote_en.pdf) and Opioid Agonistic Maintenance Therapy is used by the WHO <https://www.who.int/publications/i/item/9789240052390>. Opioid Agonistic Therapy (OAT) is stated as the preferred expression by INPUD (International Network of People who Use Drugs) and used in other global documents: <https://inpud.net/wp-content/uploads/2022/01/Words-Matter-Language-Guide-1.pdf>.

Methodology

The core of the information and the basis for the recommendations described in this report come from the consultations with women who inject drugs, networks representing them, and harm reduction staff working in female-specific services in Nepal. To offer a nuanced perspective, (male) staff working in programs available to male and female clients – but assisting mostly males – and their male clients were also consulted.

Seventy-six participants were consulted for this report, divided into six Focus Group Discussions (FGDs) totalling 68 participants, three site visits with informal discussions with 11 participants, and ten in-depth interviews with key informants. All **FGDs** were organised face-to-face in and around Kathmandu between 12 and 16 December 2022. FGDs lasted for about 90 minutes. Questions on FGDs concerned availability, accessibility, acceptance, and quality of services available for women who inject drugs in Nepal. They also included barriers and facilitators to access harm reduction services, the needs of women who inject drugs not being catered for, and women's acceptance of mixed services (male and female).

Site visits occurred in one Drop-in Center (DIC) assisting women who inject drugs only, one DIC available to both men and women injecting drugs, and one service offering harm reduction and comprehensive health care to male and female clients (one-third of them being people who inject drugs). Visits lasted for about two hours, and informal conversations followed observations. Observations were related to the structure and working of services, with a unique lens on gender. **Key informants** were from related governmental bodies (MOHA - Drug Control section, NCASC and MoHP), international organisations (UNAIDS, Save the Children and WHO), and local CSOs (Recovery Nepal, Recovering Nepal-Women, and Jagriti Mahila Mahasangh – a sex workers' network). Interviews lasted for about one hour and were around the evaluation of current services available and recommendations for improvement.

The topic lists for FGDs and interviews were inspired by the Community Monitoring Tool for Gender-Responsive Harm Reduction Services for Women who use Drugs,² developed by the International Network of People who use Drugs (INPUD) and the International Network of Women who use Drugs (INWUD). All FGDs, site visits and some interviews with key informants were done in Nepali with the help of an interpreter. They were voice recorded and analysed for content. Both participants and sites for a visit were selected with the support of Save the Children. The table below shows the number of participants per category.

Participants	Locations	N
FGD 1 - Women who inject drugs (clients of female-only services)	Lalitpur	13
FGD 2 - Female staff from female-only harm reduction services	Kathmandu, Bhaktapur and Lalitpur	11
FGD 3 - Women who inject drugs (clients of female-only services)	Kathmandu and Bhaktapur	11
FGD 4 – Female representatives of women who use drugs	Kathmandu, Pokhara, Lalitpur, Chitwan	13

² INPUD, 'On the A-Gender: Community Monitoring Tool for Gender-Responsive Harm Reduction Services for Women Who Use Drugs' (International Network of People Who Use Drugs, 2020), http://filesserver.idpc.net/library/INPUD%20Gender%20Sensitive%20Monitoring%20Tool_0.pdf.

FGD 5 – Men who inject drugs (clients of mixed services)	Kathmandu	10
FGD 6 - Male staff from mixed services	Kathmandu, Bhaktapur	10
Key informants		10
Site visits (3 sites)	Kathmandu, Lalitpur	11
Total		89

A **desk review** was completed to complement the consultations, bringing more understanding around the context of Nepalese women who inject drugs and allowing for situated recommendations.

THE CONTEXT OF NEPALESE WOMEN WHO INJECT DRUGS

Socio-economic development

Despite its diverse cultural and natural resources, Nepal remains one of the poorest countries in the world, with a low standard of living for most of its citizens. High levels of poverty, inequality, and underdevelopment characterise the socioeconomic context in Nepal. Nearly one in four Nepali people live below the poverty line, and, despite recent progress, the country still ranks low (143rd out of 189 countries) in the Human Development Index³ (HDI)⁴. Significant factors contributing to the country's low HDI are its inadequate infrastructure and limited access to primary healthcare, education, and sanitation services. The lack of job opportunities and high levels of unemployment further exacerbate poverty in the country. These were accentuated by the earthquake in 2015, followed by the COVID-19 pandemic.

According to the International Labour Organization⁵, a significant proportion of the Nepalese workforce -approximately 5.7 million individuals or 80.8% - operate within the informal economy. These workers lack the safety net of social protection coverage and have no income if they cease working; most women work in highly informal sectors. Lockdown measures during COVID-19 have resulted in a considerable decline in income for informal workers, such as retail trade in markets. Besides, approximately 1.4 million home-based workers in Nepal – nearly all women – produce goods for export, which have also been drastically affected due to the pandemic. This has made women even more dependent on their husbands for financial support. Economic dependence and cultural factors pose a significant obstacle to leaving abusive marriages that entail physical, psychological, and sexual violence.

Gender inequalities

Nepal is a patriarchal society where women face high levels of subordination to men. Social taboos against associating with members of the opposite sex, such as restrictive laws and socio-cultural norms, interfere with women's ability to participate in many development initiatives actively. Women's lives remain generally centred on their traditional gender roles, which include taking care of most household chores, looking after children, collecting water, fuelwood and doing farm work in less structured areas. Their social standing mainly depends on their husbands' and parents' social and economic positions. Male family members are likelier to be involved in the formal economy and make significant budget decisions⁶.

Several legal reforms have happened since 2017, bringing notable progress towards achieving gender equality and empowering women and girls. Improvements include increased female representation in politics, and the establishment of higher forms of punishment for gender-based violence. The legal affirmation of women's right to safe motherhood and reproductive health, education, health, employment, equal pay, social security, and property rights was also established. While the legal frameworks provide solid ground for advancing women's

³ UNDP, *Human Development Report 2021/2022: Uncertain Times, Unsettled Lives : Shaping Our Future in a Transforming World* (New York, NY: United Nations Development Programme, 2022).

⁴ The HDI is a measure of a country's average achievements in terms of health, education, and standard of living and is used to rank countries globally.

⁵ ILO, 'COVID-19 Labour Market Impact in Nepal' (Nepal: International Labour Organization, 21 May 2020), https://www.ilo.org/kathmandu/whatwedo/publications/WCMS_745439/lang--en/index.htm.

⁶ Lasch, Trina, 'Gender Strategies in Nepal: Breaking Down the Barriers' (Master of Arts in International Development Studies, Nova Scotia, Saint Mary's University, 2005), <https://library2.smu.ca/handle/01/22303>.

rights, recent progress reports⁷ show that challenges to effectively implementing these laws remain. Traditional norms and cultural practices, along with the need for further improvement, often undermine the implementation of new legal provisions:

- The deeply entrenched patriarchal mindset challenges the enforcement of the legal guarantee of equal rights for daughters to inherit family property.
- Low conviction rates and lack of implementation of court decisions challenge the combat of violence against women.
- Women have been denied the right to confer nationality to their children on an equal basis with men and the right to acquire, change, or retain their nationality or confer nationality to spouses on an equal basis with men.
- Women, and in particular single mothers, are denied citizenship certificates and registration of their children, preventing them and their children from opening bank accounts, voting, managing their property, gaining access to education, acquiring travel documents, applying for employment in the public sector, and benefitting from social services.
- The continuity of child marriage and lack of resources challenges women's rights to health care, especially SRHR.
- The high load of unpaid domestic labour (around 12 hours/day), the prohibition from seeking foreign employment without the permission of their guardian/spouse and the Government of Nepal, and the continuous unequal pay severely challenge women's economic opportunities and equal access to employment.

Consequently, despite the advances, gender inequality in Nepal remains high, as revealed by several international indicators. The Gender Inequality Index⁸ and the Gender Development Index⁹ ranked Nepal 143 out of 191 countries in 2022. The Global Gender Gap Index 2022 ranked Nepal at 96 amongst 153 countries¹⁰: while political empowerment performs better, health and education access, as well as economic opportunities for women, in comparison to men, are still very low.

Healthcare access

Access to healthcare in Nepal remains limited, particularly for marginalised groups. While some free public health services are available, most healthcare services require payment. This lack of access to quality healthcare services contributes to higher rates of illness and death. Women, in particular, face significant challenges in accessing healthcare services due to poverty, lack of awareness, cultural beliefs and practices, and limited mobility. Especially those living in rural or remote areas lack the availability of services and transportation and are even more affected by culturally entrenched beliefs prioritising men's health over women's. Maternal health is also a significant concern in Nepal. Many women face difficulties accessing prenatal and postnatal care, leading to higher rates of complications and death

⁷ UN Women Nepal, 'Mapping Progress on Women's Rights in Nepal' (United Nations, February 2020), <https://asiapacific.unwomen.org/en/digital-library/publications/2020/03/mapping-progress-on-womens-rights-in-nepal>.

⁸ Gender Inequality Index is a composite measure reflecting inequality in achievement between women and men in three dimensions: reproductive health, empowerment and the labour market.

⁹ Gender Development Index is a ratio of female to male Human Development Index (HDI). 2022 results available at <https://hdr.undp.org/data-center/documentation-and-downloads>

¹⁰ World Economic Forum, 'Global Gender Gap Report 2022' (Geneva: World Economic Forum, 2022), <https://www.weforum.org/reports/global-gender-gap-report-2022/>.

during childbirth. Additionally, limited access to family planning and reproductive healthcare services also poses challenges for Nepali women.

Violence

Obtaining precise data on gender-based violence (GBV)¹¹ and intimate partner violence (IPV)¹² is challenging in Nepal, as the stigma attached to victimisation tends to discourage women from reporting incidents of violence or seeking assistance. Yet, various forms of GBV and IPV are present. The United Nations Population Fund in Nepal says¹³ that 48% of women have experienced some form of violence in their lifetime, and 61% of those never told anyone about it. The same study found that 27% of women have experienced physical violence, and 15% have experienced sexual violence; only 25% were aware of services available to GBV survivors.

GBV and IPV in Nepal include domestic violence, dowry-related violence, child marriage, human trafficking, female infanticide, "honour killings", and *Cchaupadi* (a custom prohibiting menstruating women and girls from staying within their homes during their menstrual cycles as they are considered "impure"). Women who use and inject drugs are even more vulnerable to gender-based violence in all its forms, as further explained in the section "Challenges for women who inject drugs in Nepal". Reports of harassment and sexual violence in the context of mixed drug treatment services have unfortunately been present long before the current assessment¹⁴.

The Nepali government has taken steps to address GBV and IPV, including enacting laws to criminalise violence against women and providing support services for victims. However, the implementation of these laws and access to services remain inadequate.

Drug use and related risks

The national Nepal Drug Users Survey conducted in 2020 by the Ministry of Home Affairs estimated the number of people who use drugs in Nepal at 130,424, with 29,3% of them, or 38,000 people, injecting drugs. Approximately 6,7% (8,732 people) of the total number of people who use drugs were estimated to be female.¹⁵ The survey interviewed 2000 people who use drugs, 5% of whom are women. The most prevalent substances (lifetime) were cannabis (ever used by 84,7% of participants) and tranquillisers (73,1%), with opiates (46,8%) in third place. Thirty-one per cent declared using other prescribed medications such as Tramadol, Gabapentin, and Pregabalin. A higher proportion of females (83.8%) reported having ever used tranquillisers than their male counterparts (72.5%). In comparison to the previous survey, opiate use drastically decreased, accompanied by an increase in the use of tranquillisers.

¹¹ GBV refers to violence directed towards individuals based on their gender and encompasses a wide range of abuse including physical, sexual, emotional, and economic violence.

¹² IPV specifically refers to violence within a romantic or intimate relationship and can take many forms including physical, sexual, emotional, and psychological abuse.

¹³ UNFPA, 'Gender-Based Violence in Nepal' (Nepal: United Nations Population Fund (UNFPA), 2017), <https://un.org.np/resource/fact-sheet-gender-based-violence-nepal>.

¹⁴ Kunze, 'Women Drug Users in Eastern Nepal: A Silent Story', *The Kathmandu Post*, 13 February 2018, <https://kathmandupost.com/miscellaneous/2018/01/13/women-drug-users-in-eastern-nepal-a-silent-story>.

¹⁵ MoHA, 'Nepal Drug Users Survey. 2076' (Kathmandu: Ministry of Home Affairs, 2020), <https://nepalindata.com/resource/NEPAL-DRUG-USERS-SURVEY-2076/>.

The same survey found that, compared to men, more women declared to use drugs at home (47,5% of women against 19% of men). Isolated places were the second option for females (35,4%) and the first (51,9%) for males. A more significant proportion of females were unemployed (71,7%) compared to males (38%)¹⁶.

The latest survey, specifically among people who inject drugs in Nepal, was conducted in 2020 in all seven provinces; from the 1840 participants, only 150 were female¹⁷. More than half of the participants were above 25 years old (59% male, 54% female). Unlike males, most women injecting drugs (55%) were married. The study showed very little knowledge of HIV prevention, especially for women (between 37-16%). Less than half of women (48%) knew where to get an HIV test, compared to 74% of the man. Proportionally, fewer women declared to have visited a drop-in centre (DIC) (35%), an HIV testing and counselling service (21%) or received free syringes from an HIV program (38%) in the past 12 months compared to men. Similarly, only 52% female used condom in the last sexual intercourse as compared to 76.3% male. However, approximately half of the participants, both males (53%) and females (56%), declared to have interactions with a peer or outreach educator or community mobiliser. While 10% of males were currently under Opiate Agonist Treatment (OAT), this was the case for less than 1% of females.

The last study explicitly conducted among women who use drugs in Nepal¹⁸ dates from 2011. It interviewed 393 women across seven districts (Kathmandu, Lalitpur, Chitwan, Kaski, Pupandehi, Sunsari and Morang), 323 (82,2%) being women who inject drugs. The most injected substance was buprenorphine, often mixed with substances such as Diazepam and anti-histaminic; half of those injecting did so daily. The 2011 assessment reported that women inject in a group (72,8%), and sharing practices were standard for about a third. Besides injecting, women also often said to use cannabis (84,2% in the past month), Diazepam tablets (74,8%), smoked heroin (57,8%), codeine-based cough syrup (44,5%) and Dextropropoxyphene (45,8%). Most women declared unemployment, and about a third (27%) reported engagement in commercial sex work. Sex workers were 5.6 times more likely to have not completed primary school education and nine times more likely to live alone or with friends than with families.

Women participating in the current assessment seemed to have many similarities to the 2011 study. Regarding drug use, apart from smoked heroin (which was not mentioned in the current assessment), the use of other substances seems to be like the one found in 2011. The most mentioned substance, apart from cannabis, was the injection of the mix of Diazepam, Fenergan and Buprenorphine. The mix costs between one thousand to 1200 rupees (a set for one fix) and is usually purchased directly from a dealer. Its relatively low costs compared to heroin – a heroin fix would cost around 10 thousand rupees – was mentioned as the leading reason to refrain from its use. “Tablets” – different sorts of prescribed medication such as tramadol and benzodiazepinic used without prescription- were also widely mentioned by

¹⁶ MoHA.

¹⁷ NCASC, ‘National Integrated Biological and Behavioral Surveillance (IBBS). Survey among People Who Inject Drugs (PWID) in Nepal - 2020’ (National Center for AIDS and STD Control (NCASC), 2020), <https://www.aidsdatahub.org/sites/default/files/resource/nepal-national-ibbs-pwid-fact-sheet-2021.pdf>.

¹⁸ UNODC, ‘Profile, Drug Use Pattern, Risk Behavior & Selected Bio-Markers of Women Drug Users from Seven Sites in Nepal’ (Nepal: UNODC, Regional Office for South Asia, 2011), https://www.unodc.org/southasia/frontpage/2012/March/nepal_-new-study-maps-female-drug-use-in-country.html.

women in this assessment. Tables cost 25-35 rupees and are bought directly from a pharmacy - not every pharmacy would sell them, only the ones they are used to. Due to their lower costs, these were often used when women did not have enough money to buy the Diazepam, Phenargan and Buprenorphine mix for injection. As explained in the following section, women also often mentioned unemployment as a challenge.

Harm reduction services

Nepal officially supports harm reduction in national policy documents, and Global Fund is the largest funder for the harm reduction program in Nepal. Harm reduction programs are provided and include Needle and Syringe Programs (NSP), Opiate Agonist Therapy (OAT) and HIV testing and counselling. Naloxone, harm reduction for stimulant drugs or in prison settings are currently unavailable in the country¹⁹.

Eight civil society organisations (CSOs) run programs dedicated to people who inject drugs in Nepal, funded by the GF via the PI Save the Children, covering 27 districts. In 2020, more than half (64.1%) of people injecting drugs reported getting their needles and syringes from institutions like drop-in centers; this was the case for both females (69%) and males (63.8%)²⁰. The distribution of syringes, however, is still insufficient, with only 94 syringes provided despite national guidelines recommending a minimum of 120 needles and syringes per person per year, and international guidelines suggesting 300 needles per year, along with two alcohol swabs per syringe²¹.

The Government of Nepal, in partnership with other organizations, has implemented OAT programs at 12 sites across 10 districts. Out of the 12, 8 OAT sites are operating at public hospitals and are supported through the conditional grants from government of Nepal and the Global Fund; the remaining four sites (Bhaktapur, Kathmandu, Lalitpur and Chitwan) are operated through CSOs and supported by Save the children-Global Fund grant. During the COVID-19 pandemic, the success of peer-led take-home OAT has led to new guidelines being developed for future programming²². The current OAT coverage, however, remains low, at only 4.3%. This is attributed to several factors, including restrictive policies, limited funding, inadequate geographic coverage, and stigma and discrimination from service providers²³.

Female-specific harm reduction services

According to key informants consulted for this assignment, since the 1990s, harm reduction outreach workers have seen women using drugs in the field. Specific support for women who use drugs first came from UNODC to help start the first female network. Due to a lack of sustainability, the network was closed, creating challenges to keep women engaged:

¹⁹ Harm Reduction International, 'The Global State of Harm Reduction 2022' (Harm Reduction International), accessed 28 February 2022, <https://hri.global/flagship-research/the-global-state-of-harm-reduction/the-global-state-of-harm-reduction-2022/>.

²⁰ NCASC, 'National Integrated Biological and Behavioral Surveillance (IBBS). Survey among People Who Inject Drugs (PWID) in Nepal - 2020'.

²¹ UNAIDS, 'Country Factsheets. Nepal 2021', Official, UNAIDS, 2023, <https://www.unaids.org/en/regionscountries/countries/nepal>.

²² Harm Reduction International, 'The Global State of Harm Reduction 2022'.

²³ NCASC, 'HIV Epidemic Update of Nepal 2020 -Factsheet 8' (Nepal: NCASC, 2020), <http://www.ncasc.gov.np/WAD2020/Factsheet-2020-S.pdf>.

“... suddenly, the donor stopped everything. We don’t know precisely why and after a while, they said there was money to continue for six months. It was not stable. The women we reached were scattered during that time, and we lost many connections. It was as if we were joking with them. [...] they lost the trust, and I don’t blame them.”
(Female key informant)

In 2018 new seed funding from INPUD (via the Bridging the Gaps program) strengthened a new female network between 2018-2020. A national consultation was done with 60-70 women; a committee was formed. The funding allowed for advocacy and leadership capacity building, network strengthening, and monitoring visits in services. It also supported the registration of Recovery Nepal women, officially registered as a separate legitimate entity of Recovery Nepal (RN) in 2020.

Since 2020 a new grant from the GF (via Save the Children) has supported the specific service delivery for women who inject drugs in five provinces. The DICs/NSPs are all run by women-led organisations and are entirely women-friendly; all staff are female, from managers to outreach workers, and all have lived experience of drug use. Around 1300 females injecting drugs are assisted yearly across the five branches. ViiV Healthcare also supports programs for women who use and inject drugs, intending to reduce the prevalence of HIV/AIDS, HCV, blood-borne diseases, and other health-related harms in five districts (Chitwan, Rupandehi, Banke, Makwanpur and Lalitpur). The grant covers project management costs, while StC/GF supports the harm reduction commodities through the National Center for AIDS and STD Control (NCASC). A possible lack of sustainability of the ViiV Healthcare-funded projects worries key informants and staff consulted in this assessment since ViiV Healthcare funding will end in August 2023. Even if current activities would be supported in the GC7 (New Funding Cycle of the Global Fund), a gap of at least 11 months (September 2023 to July 2024) would still occur.

CHALLENGES FOR WOMEN WHO INJECT DRUGS IN NEPAL

The challenges described below come from consultations with women and men who inject drugs and the staff working with them. The focus is on the challenges of women, and preference was given to illustrative quotes from female participants.

Gender-based stigma & discrimination

As described in the previous section, women who inject drugs face a harsh stigma in Nepal. Stigma directly impacts women's access to harm reduction services and other types of drug-related care. According to both female and male participants consulted for this report, societal expectations around women's behaviour have much higher standards than towards men. The fact that women are seen as solely responsible for taking care of children and household chores makes it harder for them than men to manage time to access services while still being accountable for daily responsibilities. Moreover, women are usually blamed when something "goes wrong", for instance, in case they or their partners use or depend on drugs. Male clients mentioned that it is easier for them to tell their families that they are using drugs than women: families may not like it, but generally will accept it and try to support the male using drugs. The same does not occur with women, who are highly likely to be thrown out of the house without any help or property rights.

"Society takes it lightly if boys are using drugs, but if a girl is using drugs, they take it very severely. They will say we are evil people. It will affect our whole life. If other people come to know about it, they will assume we are sex workers and talk badly about us; society will stop them from being friends with us, they won't trust us, and they won't give us credit or a job. Even in our home, they won't trust us." (Female client 5, FGD3).

"Even if our husband uses drugs and leads us to use them, our mother-in-law will say it is our fault." (Female client 2, FGD1)

According to female participants, families will avoid assigning women who inject drugs to any drug-related treatment. This is not only due to the high costs, which families often cannot bear, but also to avoid societal stigma towards other family members. This leads women to hide their drug use as much as possible.

"Sometimes clients want to go to rehab, and the family says, 'no, no, no, this will be bad for our honour'. They won't send them" (Female staff 3, FGD4)

Our family doesn't trust us just because we are using drugs. (Female client 4, FGD1)

Those women who can break the hiding cycle and search for harm reduction services must face several challenges to being identified as a woman who injects drugs. Women are often cat-called in the streets close to the harm reduction facilities, as males assume that they are vulnerable and would readily engage in sexual or other favours. Moreover, virtually all women participating in this assessment felt very uncomfortable accessing harm reduction services that are also open to men. Women fear being identified as using drugs by male clients, an

older brother, an uncle or family member, a known individual in their residential areas, or a family friend. They referred to feeling very comfortable and welcomed in the female-only harm reduction services they frequent. Nonetheless, several also declared to know other women reluctant to reach even female-only services, fearing societal stigma.

“We know a lot of other women who use drugs and don’t come here. They are not comfortable showing their faces. There is much judgment in society, and they fear that” (Female client 11, FGD1)

As will be further explained later, women often refer to being harassed by both male clients and male staff and tend to avoid mixed services to protect themselves from that.

Criminalisation

Besides stigma, criminalisation also sets a high threshold to search for care or help in case of need. Drugs are illegal in Nepal, and possession, sale, and trafficking are criminal offences. The punishment for drug-related crimes can range from fines to imprisonment and, in severe cases, long imprisonment.

Many women in this assessment mentioned having given up searching for help from authorities or public health clinics due to fear of punishment or repeated negative experiences.

“We (women) are always at fault; whatever we do, we are always to blame. Even if we go to the police to complain about sexual harassment, the police always say we are at fault. You are using substances, you are wrong. We have nowhere to go. This (female drop-in) is the only place we can come.” (Female client 2, FGD1)

“When I had an abscess, I stayed home because my doctor would tell others when I went to the hospital. If I had not waited, it would have helped me a lot.” (Female client 3, FGD1)

Criminalisation can also lead women and men to engage in riskier drug use behaviour to protect themselves from police harassment. A clear example of that, mentioned by both males and females in this assessment, is the habit of injecting in the groin area.

The safest place is the groin area. We call it 90. In that way, police do not look at us; they only look at our hands and arms and do not see anything. (Female client 7, FGD3)

As described later, injection in the groin leads to severe health harm to people who inject drugs in Nepal.

Sex work is also illegal and considered a criminal offence under Nepalese law, rendering sex workers the risk of arrest and prosecution.

“Sex workers in general, those who use drugs, third-gender women, those living with HIV, everyone does it for their livelihood. People think this is easy money, but that is not true. It is highly vulnerable;

you can get killed or arrested, you are not treated well.” (Key informant 2, female)

Abscesses

Women (and men) who inject drugs and staff assisting them reported severe and frequent abscess problems. The problem is multifold. Women inject only in the groin area due to fear of criminalisation and stigma. They fear suffering from violence and getting expelled from their house if discovered as someone who injects drugs. Injection marks on the arm are too quickly visible to the police, family members, and society.

Groin injection has been linked to various health-related harms, including deep vein thrombosis (DVT) - a condition where a blood clot entirely or partly blocks a deep vein, causing redness, pain and swelling of the lower leg²⁴. Injecting in the groin can cause dangerous blood clots to form in leg veins, and repeatedly injecting into the femoral vein can cause it to collapse, especially when done jointly with “flushing”, a technique commonly reported by women partaking this assessment and the female staff working with them. A collapse to the groin vein can take longer to happen than in other veins, but it is much more severe. It causes sore, swollen legs and cold, blue toes since the blood cannot flow through the leg quickly enough to keep the leg healthy and warm. Repeated injection into a blocked femoral vein can lead to tissue death and amputation.

Women and staff working with them have reported all these severe health consequences, including several cases of DVT, during the assessment. Similar cases have also been reported by men and staff working with them.

“I’ve seen that when they inject in the groin area, sometimes the blood bursts. And they are taking it so easily [...] I’ve seen such big holes, and still, they are using there. They can’t even walk, and some abscesses are the size of a hand.” (Key informant 4, female)

“They are distributing pens (syringes) but are not helping us with health care. I have lots of abscesses over my body.” (Female client 3, FGD1)

Staff partaking in the assessment reported having tried educating clients about safer injection forms. Nevertheless, it needed to be made clear if either clients or staff were fully aware of safer injection practices. Besides injecting only in the groin, also flushing techniques were reported by most clients and staff. Clients report practising flushing for believing they will get higher from it. Staff says this technique is used to check if they use the right vein. It was also reported that many people use saliva to clean the syringe.

Moreover, both clients and staff complained about the quality and inadequate type of syringes being provided. According to them, the needles are fragile, as they often break inside clients’ bodies, further increasing the risk of abscesses. Besides, the barrel is not large enough given that clients must mix the 3 vials - Diazepam, Phenergan and Buprenorphine – before

²⁴ Lianping Ti et al., ‘Groin Injecting among a Community-Recruited Sample of People Who Inject Drugs in Thailand’, *Substance Abuse Treatment, Prevention, and Policy* 9, no. 1 (December 2014): 4, <https://doi.org/10.1186/1747-597X-9-4>.

injecting. Clients would like to have 10 ml syringes, while programs are distributing 5 ml syringes. According to staff, earlier assessments have been performed to define the materials which would best suit clients, but the results have not been used to improve the quality of the supply, even after repeated requests from their side.

“... the syringe we give is not safe at all. [...] They use it and the tip breaks, and it breaks again. It’s not good quality. Many clients come, and the needle is stuck. We use the tweezer to pluck it out.” (Female staff, FGD4).

Lack of access to primary healthcare

The problem of abscesses is further compounded by the high costs associated with health care in Nepal and the lack of primary health care provision by (most²⁵) harm reduction programs. Fearing stigma, criminalisation, and unbearable costs, women partaking in the assessment do not search for care at other health facilities when they notice a small abscess or the first symptoms of what could be(come) a DVT. They will continue injecting the wound and enduring pain until they can no longer walk, the pain is unbearable, or the artery “blows”. Lack of primary wound care leads to more severe health consequences and higher healthcare costs. Staff at the DICs mentioned that they refer clients to primary health care services or hospitals, but the fact that all health care is paid, compounded by fear of stigma, poses a barrier to care access.

Programs have a minimum budget they can use to help cover clients’ costs in emergency cases, but according to staff, the budget is far from enough to protect clients’ needs. In some cases, it is possible to negotiate an extra budget with the PR, but the process is lengthy, and often the situation is urgent and cannot wait. Staff reported collecting money among themselves to pay hospital bills from clients since emergencies are too frequent.

“When she came to us, she was already so severely wounded. We were scared. It was almost in a condition where she would have to lose her leg. We got her to the hospital, and she got treatment, but we had to pay 80 thousand rupees, and we did not have the money.” (Female staff 9, FGD2)

“We don’t have money and have abscess problems in our legs. That’s the main problem. And we cannot get support for this in the DIC. So, we need to go to the hospital and pay a lot of money we do not have. And the DIC does not have enough to support us; sometimes they can pay 50%, but we do not have the other 50% either.” (Female client 5, FGD3)

In this context of lack of universal health care, the fact that harm reduction programs do not offer primary health care contributes to abscesses and other illnesses remaining untreated and becoming a severe threat to people’s health and sometimes life. Besides problems such as DVT or member amputations, women often mentioned a lack of care for hepatitis C and

²⁵ Primary healthcare is funded in programs supported by ViiV Healthcare in the districts of Chitwan, Rupandehi, Banke, Makwanpur and Lalitpur (according to a presentation held at the High Level Meeting on June 2nd 2023 to discuss Harm Reduction for Women Who Use drugs in Nepa).

SHRH services. Both staff and clients (male and female) spoke about the need to have primary health care available at the current services as a top priority.

“Primary health care is so critical. Suppose we had that, we wouldn’t have to lose time going here and there. We could at least do the basic treatment and prevent abscess cases from getting into such severe conditions as DVTs and clients losing their legs. The first and foremost priority is primary health care for us right now.” (Female staff, FGD2)

Participants expressed their desire for harm reduction programs to count on health professionals who could offer basic health and wound care. This could guarantee better education about safer injection practices and care for abscesses in an earlier stage. According to staff, some Nepalese harm reduction programs offered primary health care in the past, but it became no longer possible due to changes in the funding stream. The teams from female services reinforced that providing primary health care services could also positively affect improving service intake by women. Female clients also echoed this.

“If we have an abscess, we avoid going to the doctor. We use drugs instead to cover the pain. If we could get help for abscesses here at the DIC, we would treat that before it worsens.” (Female client 4, FGD3).

“We come here (DIC) to get syringes, swabs, and condoms and to bring back old syringes. We also meet them in the field. They also conduct HIV tests, and we can share our problems and discuss our things. But we need to get more comprehensive packages.” (Female client FGD3)

“If we bring syringes to the field, clients accept that. Many will ask about checking HCV. DVT, they ask if there is treatment available from the DIC. Most people ask for free health care services.” (Female staff 4, FGD2)

Lack of comprehensive care

Besides access to primary health care, clients and staff spoke about the need to provide comprehensive care at the DICs.

Female clients mentioned they would like the DIC to have more activities, to be a place where they could spend the day, have nutrition, watch TV, play games, get female products (like sanitary pads), be provided with SRHR services, capacity building, female-targeted information, talk about personal hygiene (and get hygiene packs), and maybe be offered help with the education and care for their children. Many clients said that even though they like the DIC, there needs to be more being offered there to compensate for the costs and risks (societal stigma) of reaching the service. Since only syringes are provided at the DIC, transportation costs may not pay for what clients would spend if they purchased the syringes themselves.

“If we stay home, we tend to use the substance more, so it is better to come to the DIC. It would be good if they could provide food and help

with transportation. Many of us live far and spend too much just to be here.” (Female client 7, FGD1)

“When I come here, I use much less. The sisters here share many positive things; I learn a lot and feel welcomed. If I had money, I would come here every day. Here we can share our feelings and are comfortable sharing our things.” (Female client 3, FGD1)

Staff also recognised the need for comprehensive care and an attractive DIC for women to increase their reach.

“We are only distributing syringes and condoms, but this is not enough. We need to give them primary health care services as well. Gather them and do recreational activities, offer capacity-building training, and help them financially with issues like their children. So especially for those from a lower income level, we will attract them, and the reach will increase.” (Female staff 2, FGD2)

SRHR services are also crucial in the offer of comprehensive care. Many female clients have children but lack information on how to reduce the harm of drug use during pregnancy and lactation or manage drug use and care for children. Several engage in transactional sex but lack access to primary SRHR care.

“Women get pregnant, they menstruate, and the child is affected after they conceive if they continue using the drug. Currently, we do not have SHRH programs, and we need that. We must provide education and awareness about what to do during pregnancy and how to monitor our menstruation cycle.” (Female staff 4, FGD2)

“If we can have STI services here at the DIC, that would be nice. If we have something, we have to go outside. It would be helpful to get pads and medicines.” (Female client 4, FGD3)

The staff considered female clients to have more complex and diversified needs than male clients. These were, in general, interlinked with gender-based roles and societal stigma.

“When men come, they come with one issue: dependence on drugs. When women arrive, they come to multiple topics: sexual reproductive programs, child problems, spouse problems... We don’t say that men don’t face other issues as well, but women have so many more things. To be able to go to a treatment centre, she must think in advance: “where do I keep my child? What should I tell my mother-in-law? How should I deal with my husband? What if I come clean, and if he does not come clean?” (Female staff 2, FGD2)

“The women have a lot of SHRH problems, and they fear marginalisation, and fear of being recognised, so they do not go to public health services. So, if we can provide these services in the DIC,

that would be better. It is pretty different from the male. They keep using, have a family, and have a support system. But women are alone; they have been isolated from their families and have many needs. We often need to provide social support mechanisms and do not have that in our programs. We have been saying that harm reduction must offer a comprehensive package.” (Key informant 1, male)

Female clients also recognised these challenges, and those with children especially asked for support for their children’s education. This was more often the case for single mothers and those who divorced their partners.

Especially regarding basic needs like nutrition and transportation, staff from female-only services reported paying from their pockets to ensure clients get some support. Some female staff reported using more than half of their salaries to support clients, ending up needing more money to keep their basic expenses.

“We feel that they live in such dire conditions that they don’t even have enough food. So, we buy for them. But we cannot always support them with that.” (Female staff 5, FGD2)

“We use our salary to pay for snacks, drinks, and sometimes transport. Women come to the DIC and say, “I’m hungry; please give me some food”. How can you be deaf to that? But then, at the end of the month, we are short of paying our bills.” (Female staff 2, FGD2)

Lack of privacy in mixed harm reduction services

Current mixed harm reduction services cannot offer enough privacy for their clients, especially when considering gender and cultural sensitivities. At mixed DICs, the clientele is primarily men; as mentioned before, women fear being recognised or harassed in mixed environments. Moreover, people injecting drugs usually inject in the groin area. Male staff working at mixed services reported perceiving that female clients are uncomfortable showing abscesses to male staff or letting the male team perform primary wound care. Female clients confirmed that perception and added that they also do not feel comfortable uncovering the groin area in a service or a room where male staff or male clients are around and may unexpectedly enter.

Women partaking in this assessment have repeatedly reported not being willing to go to services where males are also assisted for fear of being recognised, stigmatised, and harassed.

“We don’t go there where men go. We fear there might be some of our uncles, brothers and their friends, people we know can be there and identify us. And later they tell it in our society, in our circle, so we don’t go. That’s to keep our security and privacy.” (Female client 2, FGD 3)

“Other services are also for males; we do not like going there. Here is only for females, and we feel more comfortable coming.”(Female client 4, FGD1)

Also at OAT programs, clients line up to get their prescription directly from the person behind the counter in front of other clients. The room where OAT is dispensed may be integrated into a larger healthcare service, with the consequence that also clients of other services - which may not be drug-related - can see and identify people standing in the OAT line. This is especially sensitive for women, given the stigma attached to female drug use.

“For methadone, there is no separate place for women to go. The people who go there are older, they are senior to us. So, they think we are kids and don’t feel comfortable in front of them.” (Female client 7, FGD1)

“Women are having problems getting buprenorphine in male DIC. So if we can have female-only buprenorphine with female staff, there shouldn’t be any males.” (Female staff 2, FGD4)

“Having a facility for female clients is very important because women are misused. They are highly vulnerable, and then you see unwanted pregnancies and harassment. If you have female-only facilities, women can be open and free; they are not scared about who will see them.” (Female staff 3, FGD 4)

Gender-based and intimate partner violence

While arriving or leaving services, female clients referred to be often cat-called by men passing by in the streets or working close to the facilities. Inside harm reduction services, harassment could go from being looked at from head to toe in a way that they feel “undressed” to being asked for sex in exchange for services. Being identified as a woman who injects drugs inside a mixed-sex harm reduction service could also bring problems outside services. As male clients learn that women are using and are dependent on drugs, some may use this information to try taking advantage of them. Some female clients reported that male clients might offer to purchase the drugs for them, asking for more money or drugs in return. Other types of favours, including sexual, were also reported.

“Boys will ask girls to have sex with them and share the drugs. In that way, women sleep with several men. At that moment, they do not think about condoms. Then many will get STIs or HIV, and after that, they will turn to sex work.” (Female client 4, FGD3)

“We refer women to the OAT centre, but again there is no female-friendly or centric OAT. And women get abused, even by staff. I ask them, ‘why don’t you go to the OAT centre?’ and they always say, ‘Ah, some of the staff is taking me in different ways’, or ‘The other clients are talking shit about me’. They are not comfortable.” (Female key informant)

“Harm reduction staff has also committed sexual harassment. I had a close friend who was abused in an OAT program. The male staff told her he would provide her treatment but only if she would sleep with

him. She was mentally vulnerable and unstable; when we filed the case, no one gave her the right. [...] Emotionally and physically, women are harassed. Sometimes they look at us and degrade us, using bad words to define us.” (Female staff 4, FGD 4)

Intimate partner violence also seemed a chronic problem affecting women who inject drugs. Female staff working on female-only programs referred often hear from clients who are beaten by their partners and exploited by them in different ways. Female staff also referred to having suffered from violence. Traditional gender roles and widespread social and cultural acceptance of violence against women challenges staff’s trials of raising awareness among clients. Female clients tend not to talk about the violence they suffer and endure toxic relationships until they can no longer bear it physically (or mentally). Women's economic dependency, fear for their children's future, and societal stigma are solid reasons for many to endure intimate partner violence.

“I don’t understand why people misbehave with us. Even the cops, even inside our own house. Why do they misbehave with us?” (Female client 5, FGD1)

Lack of income and financial independence

When women build awareness around intimate partner violence and can cut toxic relationships and improve their self-care, they end up with other problems, such as not having financial support or a roof above their heads. Traditional gender roles imply that women are usually financially dependent on men. Single or divorced women may get money from their families (usually their fathers or brothers); otherwise, they must provide for themselves. Nonetheless, traditional gender roles imply that women tend to receive less education than men and have more difficulties getting a job; once they do, their pay tends to be lower than men performing the same position. Lack of opportunities often leads women to opt for more vulnerable ways of making a livelihood, including very temporary jobs and sex work.

“Sometimes I clean dishes or help to clean after patties; previously, with the boys – they know how to do pickpocketing- we helped them by distracting the person or staying on the way; then they gave us drugs. Some women sell drugs.” (Female client 4, FGD3)

“Sometimes women have multiple boyfriends and have several relations; out of those, they get their drugs; there are also many women who sell sex.” (Female clients FGD3)

“There is a social tabu, and women who inject drugs don’t have money. So, they will spend time with anyone who gives them money. For the lower cast, the only thing they can do is sell sex. They have no other opportunity.” (Female staff 2, FGD2)

Women who decide to leave their marriage –due to intimate partner violence or the willingness to quit drug use while the spouse is actively using - usually leave the house without financial or moral support. Besides struggling with their basic needs, those with children face challenges in supporting their children and paying for their education.

“Many of us have kids, but we cannot put them in proper school and cannot afford other needs they have. That’s why we need this support.” (Female client, FGD3)

Fragile financial independence was also part of the realities of female staff, given the lack of sustainability of harm reduction programs and their extra responsibilities related to childcare. Some female staff referred to what they perceived to be a gender pay gap in harm reduction services.

“I divorced and cannot afford to pay for my children’s needs. I couldn’t bear the school fee, so I took them out [...]. I can’t afford to buy good clothes for them or food they want; it hurts me a lot when it comes to them. People badmouth me; society talks about me a lot. I had no place to stay and luckily, my parents sheltered me.” (Female staff 2, FGD2)

“Even in harm reduction programs, if a man’s salary is 80 thousand rupees, for the same position, a female gets 35 thousand rupees. The salary difference is too high. We feel like we are being discriminated against.” (Female staff 3, FGD 2)

To financially empower women, both clients and staff suggested that DIC should provide capacity building.

“Training in beauty parlours, stitching, or handicraft to make bracelets and necklaces would be good. Any skill training so that we could get some money for us.” (Female client 5, FGD1)

According to some, capacity-building programs have been provided before but were short-term and have yet to offer any follow-up or continuation. Staff suggested coaching clients on how to build a business, perhaps linked to seed funding for a startup. Clients also referred to the possibility of having their (eventual) products sold by the DIC.

“Maybe it was a three days workshop without any further incentive. It is difficult for women to start a new business after three days.” (Female staff 3, FGD 4)

“Some organisations give training but do not provide any funding for you to start a job. For instance, if it is knitting or working with beads, the organisation could be the mediator in selling it. Open something there to sell it. So, we have another reason to go. People outside don’t trust us, if they can provide work here (at the DIC), we can come, and there is no discrimination.” (Female client 5, FGD3)

RECOMMENDATIONS

Scale-up safe spaces for women who inject drugs

1. Scale up female-only/female-led harm reduction services

Virtually all women partaking in the assessment agreed that there is a need for more female-only harm reduction services with female staff. This would improve the accessibility and acceptability of services for women, offering them better protection. Women also believe that confidentiality will be enhanced with female-only services, further protecting women from the harm caused by the compound stigma around drug use and gender.

Harm reduction services that specifically target women have demonstrated that when unwanted attention and violence from men are eliminated, it can enhance access and adherence to programs. This results in women feeling safer and more comfortable in a non-threatening environment. Services that cater exclusively to women have also proven to be successful in acknowledging their agency, addressing gender-based violence, and dealing with legal and emotional issues about women who are pregnant or parenting while using drugs²⁶.

When not possible to offer female-only fixed sites, female-targeted outreach connected to existing programs may be a feasible solution. Outreach teams must be composed of female staff and target women only. Female-targeted community-based outreach has shown to be instrumental in coping with barriers and facilitating access to harm reduction and sexual and reproductive health services by women who inject drugs. Female-targeted outreach counter stigma by building trust and personal support, counter lack of privacy by confidentially handling women's information, counters unfamiliarity with healthcare facilities by accompanying women and assisting their navigation through the system, and counter unliked services with multiple appointments by building integrated care for women²⁷.

2. Provide low threshold and female-only OAT

Besides introducing additional women-only DICs, having OAT only for women, potentially integrated into the DIC, would also be beneficial. Due to the compounded stigma of being a woman and using drugs, women avoid missed services and considering the lack of privacy in current OAT services; they get exposed not only to the community of people using drugs but also to the community at large. Providing OAT within a female harm reduction service would lower the threshold and provide a safer environment for women to access and accept treatment²⁸. Services, however, must be low-threshold, for instance, by no longer requiring women to bring a family member for enrolling in OAT, as this could lead women to refrain from accessing treatment. Other low-threshold measures include reducing bureaucratic

²⁶ Kate Dolan et al., 'Six-Month Follow-up of Iranian Women in Methadone Treatment: Drug Use, Social Functioning, Crime, and HIV and HCV Seroincidence', *Substance Abuse and Rehabilitation*, February 2012, 37, <https://doi.org/10.2147/SAR.S21349>; UNODC, 'Women Who Inject Drugs and HIV: Addressing Specific Needs. Policy Brief.' (United Nations Office on Drugs and Crime, 2014), https://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf; Jade Boyd et al., "'Bed Bugs and Beyond": An Ethnographic Analysis of North America's First Women-Only Supervised Drug Consumption Site', *International Journal of Drug Policy* 78 (April 2020): 102733, <https://doi.org/10.1016/j.drugpo.2020.102733>.

²⁷ Ayon et al 'Barriers and facilitators of access to HIV, harm reduction and sexual and reproductive health services by women who inject drugs: role of community-based outreach and drop-in centers', *AIDS Care*, 30:4, 480-487, 2018.

²⁸ Dolan et al., 'Six-Month Follow-up of Iranian Women in Methadone Treatment'.

requirements to sign up (passport, residence permit), doing away with requiring multiple drug treatment attempts before starting on OAT, and being able to receive services the same day without needing to navigate medical bureaucracy before receiving care or encouraging take-home for more extended periods.

Finally, bringing OAT directly to women instead of expecting them to visit a clinic can also help improve access and uptake. Outreach delivering OAT medication has proven to be an optimal complement to fixed sites, often better in accessing the most vulnerable and stigmatised subgroups of people who use opioids, which are not connected to other health services²⁹. Outreach services are crucial to identify their needs, refer them to fixed sites or general health services, and improve their linkage to care³⁰. Outreach can encompass various methods of service delivery, such as mobile units or vans, street outreach by community health workers or peers, and regular satellite services hosted at other agencies. To lower the threshold for women, outreach teams must be composed of female staff and target female opioid users only. Female-targeted and female-friendly outreach helps women to navigate gender-related stigma making a personal connection that facilitates their entry into OAT and other types of care³¹.

Promote gender equality in harm reduction services

3. Promote non-discrimination in existing programs

Staff can discuss discrimination and gender roles in current service activities. An open discussion is essential to understand the gender roles and inequalities in communities of people who use drugs and within the services and programs. Ultimately, all service users must be fairly treated regardless of age, sex, gender identity, ethnicity, religion, class, occupation, and drug use status³². It is also recommended to develop policies and procedures to safeguard staff and clients against sexual harassment, to ensure a safe environment for all. The Global Fund's Operational Framework on the Protection from Sexual Exploitation and Abuse, Sexual Harassment, and Related Abuse of Power guidance recommends that Primary Recipients build the capacity of implementers to recognize, prevent and address sexual exploitation and harassment in service delivery settings³³.

4. Sensitise male clients for gender equality

Sensitising male clients for gender equality will also increase the chances that women are treated respectfully and can feel safe visiting mixed services. It can also have a beneficial effect beyond services within the community of people who use and inject drugs. Women who inject drugs often experience gender-based or intimate partner violence from their male

²⁹ Gerod Hall et al., 'Mobile opioid agonist treatment and public funding expands treatment for disenfranchised opioid-dependent individuals', *Journal of Substance Abuse Treatment*, Volume 46, Issue 4, 2014.

³⁰ European Centre for Disease Prevention and Control (ECDC) and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Prevention and control of infectious diseases among people who inject drugs: first update 2022. Stockholm: ECDC; 2022.

³¹ Zamudio-Haas et al. 'Generating trust: Programmatic strategies to reach women who inject drugs with harm reduction services in Dar es Salaam, Tanzania', *International Journal of Drug Policy*, Volume 30, 2016.

³² UNODC, 'Addressing the Specific Needs of Women Who Inject Drugs Practical Guide for Service Providers on Gender-Responsive HIV Service' (New York, NY: United Nations Office on Drugs and Crime, 2016).

³³ The Global Fund, 'Guidance Note Protection from Sexual Exploitation, Abuse and Harassment Allocation Period 2023-2025'. The Global Fund, 2022.

partners or other male clients of harm reduction programs. Although harm reduction services serve many male users, there are no efforts to educate male clients about violence against women. However, harm reduction staff have close and reliable relationships with clients, which puts them in a position to create a secure space to talk about issues related to different types of masculinity, fatherhood, and violence against women in intimate relationships.

5. Provide gender-sensitive IEC

Providing gender-based communication and information material is crucial to ensure that women who use and inject drugs can feel recognised and supported to access the services they need. Gender-specific communication helps address women's unique needs and challenges, including gender-based violence and reproductive health issues. By tailoring the information and resources to the specific needs of women, harm reduction programs can ensure that they receive the support they need to improve their health and well-being. Additionally, gender-sensitive communication can help to reduce stigma and discrimination against women who inject drugs, encouraging them to seek help without fear of judgement or social repercussions. Existing harm reduction information materials, specially those related to groin injecting³⁴ can be used but must be adapted to women, the local context and local languages.

6. Hire female staff

Women who inject drugs usually stay hidden and gather in different places than men. Most of the women in this assessment mentioned they would feel more comfortable discussing their drug use or gender-specific topics with other women than men. Teams in existing female-only programs are already composed of exclusively female staff. The same should be followed for new female-only or female-targeted (outreach) programs. Female program managers are better positioned to understand female clients' gender-related challenges. They may also be more open to the contributions and development of female staff when compared to male managers due to existing gender inequalities in the country. Female primary health care nurses will be able to care for women's abscesses, provide primary sexual and reproductive health rights care, and, together with other team members, help link women to other services. Women with lived experience of drug use should be hired as staff for drop-in centres and outreach work. Peers have personal experience and knowledge, which can help them to empathise and understand the situations of women who inject drugs. Participants explicitly mentioned that women who use drugs could assist in locating and accessing new clients, thereby encouraging other women who are hesitant to access these services. Once hiring women, as regular staff or peers, they should be provided with fair and equal pay compared to men.

Strengthen the capacity of existing female-only services

7. Build capacity of staff and clients around safer injection

This can include information on how to properly prepare and inject drugs, safer and unsafe spots to inject, identify and treat infections, and safely dispose of needles and other drug paraphernalia. It is also essential that this training is delivered in a way sensitive to the needs

³⁴ For instance, Going in the groin: www.exchangesupplies.org/pdf/D8_4.pdf and Going in the Groin: a Guide to Femoral injecting: <https://nrch.com.au/wp-content/uploads/2019/07/Going-in-the-Groin-brochure.pdf>

and experiences of women who inject drugs. This can involve creating safe and supportive environments that allow for open communication and respect for individual experiences and perspectives.

Ideally, clients would no longer inject in the groin. However, for those unwilling to switch methods, clear indications of risks and how to reduce the harms should be given. As mentioned above, existing harm reduction information materials on groin injecting³⁵ can be adapted to women.

8. Provide quality harm reduction materials.

Quality harm reduction materials, such as clean needles and syringes, sterile water, alcohol swabs, and disposal containers, are critical in preventing the transmission of blood-borne infections like HIV and Hepatitis C. They also provide a safer injection experience, reducing the risk of abscesses, infections, and other health complications. Harm reduction materials must be tailored to the specific needs and experiences of women who inject drugs. Female clients and staff in this assessment mentioned the need for syringes with a larger barrel (10 ml), so clients can mix their drugs. They also said needles must be stronger to avoid breaking during the injection. It is recommended that the community is consulted about the best materials to fulfil their needs and that previous recommendations and requests for better materials are considered.

9. Support programs in providing more attractive services

Both clients and staff mentioned that current DICs need to offer more services to be attractive to women who inject drugs. DICs should be supported in becoming centres where women can spend the day and engage in various activities, both educational, social, and pleasurable. As mentioned by clients, activities can include conversational groups, workshops, games, movies, or a visit to a place women usually do not frequent. Such activities can be planned at a considerably low cost. More specific recommendations for harm reduction services to be more attractive to women and better provide for their needs are described in the section below.

Provide integrated services with a comprehensive approach

10. Provide primary health care within harm reduction services

Providing primary health care within harm reduction services in Nepal can have multiple advantages. Given the lack of universal health coverage in the country, it can allow for women (and men) who inject drugs to have much-needed access to basic health care. This can help prevent severe health harms currently caused by non-treated abscesses. It can also help improve the health and access to care in general for a population that is extremely marginalized and stigmatized. In the case of women, a female health practitioner would be instrumental in treating wounds, abscesses, and helping find safer ways of injection. When not possible to have a female-only service, a female practitioner could be hired as part of a mobile female-targeted outreach team.

³⁵ For instance, Going in the groin: www.exchangesupplies.org/pdf/D8_4.pdf and Going in the Groin: a Guide to Femoral injecting: <https://nrch.com.au/wp-content/uploads/2019/07/Going-in-the-Groin-brochure.pdf>

11. Provide a comprehensive harm reduction package

The WHO advocates for providing a comprehensive harm reduction package for the prevention, treatment and care of HIV among people who inject drugs. The package includes NSP; OAT and other drug dependence treatment; HIV testing and counselling, and antiretroviral therapy; prevention and treatment of sexually transmitted infections; condom distribution for people who inject drugs and their sexual partners; targeted information, education and communication; vaccination, diagnosis and treatment of viral hepatitis; and the prevention, diagnosis and treatment of tuberculosis. These nine evidence-based interventions have the most significant impact on HIV prevention and treatment³⁶. Especially in a context of severe stigma and discrimination based on drug use and gender, a comprehensive package at a low-threshold harm reduction service can enormously protect the health of women who inject drugs.

12. Provide nutrition and transportation support

Both nutrition and transportation support can improve female clients' accessibility and acceptance of harm reduction services. Many women partaking in this assessment are not receiving essential nutrition. Harm reduction providers have identified that providing food is crucial to engaging women in services and ensuring they have enough energy to focus on activities and manage the side effects of medications and treatments. Nutrition packages are essential for pregnant women and those caring for children in their families.

To increase access to services, offering bus tickets or transportation reimbursements as incentives for participation in groups and activities can be effective. Some women may need more resources to pay for transportation; incentives can also help with immediate needs. Female staff often provide these incentives from their salaries, leaving them vulnerable.

13. Provide childcare and support

Providing childcare can be essential to improve harm reduction access for women. This can include providing on-site childcare at harm reduction facilities, offering flexible appointment scheduling, and ensuring that service providers are sensitive to the needs and experiences of mothers and caregivers. Childcare services can also help reduce mothers' stress and anxiety, allowing them to focus on their healthcare needs and participate more fully in appointments and programs.

14. Provide legal support for women who use drugs

It is imperative to provide legal support to ensure women are granted their fundamental rights, particularly property rights. Even though national laws have been modified to safeguard women's rights, families often do not comply with or implement these laws, depriving women of support for themselves and their children. Paralegals can be instrumental in raising awareness among women about their legal rights and assisting them in following the necessary legal procedures to obtain them. As a comprehensive approach, legal aid should be incorporated into harm reduction programs to provide a one-stop shop for women in an environment where they feel safe and supported.

³⁶ World Health Organization et al., 'WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users', *OMS, ONUDC, ONUSIDA : Guide Technique Destiné Aux Pays Pour La Définition Des Objectifs Nationaux Pour l'accès Universel à La Prévention, Au Traitement, Aux Soins et Au Soutien En Matière de VIH/SIDA*, 2009, 40.

Foster women's empowerment and independence

15. Provide skills development and income generation

Financially independent women are in a stronger position to negotiate and ensure their safety. On the other hand, economic dependence is a significant risk factor, particularly for women who inject drugs. In the current assessment, several women highlighted that financial dependence leads women to engage in unsafe practices and be exploited by men. Often, women lack formal education or employable skills and resort to transactional sex for income generation. To reduce vulnerability, it is critical to facilitate women's economic independence through skills development and alternative income generation.

Skill development programs should be designed considering the interests and preferences of the women and the business opportunities available in the local environment. Women partaking in this assessment referred, for instance, to barista and bakery courses, jewelry making, or learning how to cultivate crops. Additionally, programs should include education on financial management, budgeting, and starting and managing a business. Given the lack of financial capacity and societal stigma, suggestions included offering seed money for women to start their businesses or harm reduction programs helping women to sell the products they produce.

16. Promote female leadership

In Nepal, traditional values, cultural norms, and laws reinforce the concentration of power in the hands of men. Women's limited access to resources, restricted participation, and decision-making opportunities inhibit their ability to transform entrenched gender inequality. But changing how power and resources are distributed is difficult and takes a long time. The unfair systems favouring men can prevent women from fully participating in society. Women often have basic needs like healthcare, food, and clean water related to their roles as women. But they also have strategic interests, which challenge gender, cast, and stereotypes and aim to improve women's status in society. Strategic interests include being involved in decision-making, having economic independence, and having control over reproduction. If we only focus on women's basic needs and ignore their strategic interests, negative stereotypes will continue, and women won't be able to change their subordinate position in society. This approach highlights the importance of women being decision-makers to help shape the direction of harm reduction programs and their societal roles. For this, female leadership should be supported, also within harm reduction programs.

Invest in inter-organizational collaboration

17. Build synergies with other networks and essential services

Harm Reduction services alone cannot meet all the requirements of women who use drugs. Women necessitate and can benefit from a multitude of other advantages offered by services that concentrate on sex work, gender-based and intimate partner violence, nutrition, housing, skills development, income generation, and sexual and reproductive health rights, among others. Creating alliances and formal referral mechanisms with these services can help ensure that more women who inject drugs have access to their fundamental rights. To achieve this, engaging in sensitisation efforts concerning harm reduction and the needs of women who inject drugs with the staff of such services and networks might be necessary. This may require frequent communication and advocacy with these services and possibly a dedicated staff member, such as an advocacy officer, to carry out these activities effectively.