

The Voices of Injecting Drug Users: Harm Minimisation in Nepal

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Abstract:

This study explored the perception and strategies employed by 20 injecting drug users (IDUs) as they regularly confront life threatening complications from their drug use. The 20 IDUs were from four urban centres: Kathmandu Valley, Pokhara, Narayanghaat and Hetauda of Nepal. The phenomenological study was conducted, using individual in-depth interviews ranging from one to two hours in length. All data were analysed using the analytical approaches of grounded theory. This study found that the urgency and severity of withdrawal symptoms are the major precursors, leading drug users to share unsterile syringes and needles, thereby, increasing the risks of HIV transmission and other health harms. The study also found that IDUs seemed aware and worried about HIV and other health risks prompting them to devise their own seemingly suitable strategies for harm minimization. Understanding these high risk strategies should inform public health and intensive harm reduction services to be considered and implemented in Nepal. Attempts should be made to keep the IDUs in touch with suitable substitution therapies to overcome the withdrawal symptoms, thus minimizing the chance of sharing syringes/needles with other IDUs.

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Nepal context of drug use and HIV

Heroin was introduced in Nepal in the mid 1960s when “hippies” entered the region (Bhandari & Subba, 1992; Jutkowitz, Spielmann, Koehler, Lohani, & Pande, 1997). The first case of heroin abuse in Nepal was reported in 1976 (Ray, 1998). The pure form of heroin enters Nepal from South East Asia, whereas “brown sugar”, a raw form of heroin, comes from India, Afganistan and Pakistan. Pharmaceutical drugs, such as sedatives, buprenorphine and cough syrups enter predominantly from India. Besides these, India has been identified as one of the largest opium producers, which export raw opium and has been listed as having a large number of consumers too (Expert Forum on Demand Reduction in South and South West Asia, 1995; Paoli, Greenfield, Charles, & Reuter, 2009). Recently, tidigesic, a pharmaceutical drug, has replaced ‘brown sugar’ (the raw form of heroin) as a drug of choice in injecting drug users (IDUs) (UNAIDS, 2000a). Tidigesic is a morphine derivative. By 1982 to 1983 problems of drug abuse were apparent in Nepal (N. Shrestha, 1990). ‘Brown sugar’ was the widely used form of heroin, which was mostly smoked. Later, the mode of administration changed from smoking to injecting (DADRP, 2004; MOH, 2004; Seminar on harm reduction, 2000; UNAIDS, 2000b).

Mostly, drug users are youths (Bhandari & Subba, 1992; Jain, Pradhan, & Vibha, 2009; Kermode, Longleng, Singh, Bowen, & Rintoul, 2009; Seminar on harm reduction, 2000). It is estimated that there are between 40,000 to 50,000 drug users in Nepal (MOH, 2004; Seminar on harm reduction, 2000; I. Shrestha, 1999; UNAIDS, 2000b, 2001). Of this figure, it is believed that 20,000 people could be IDUs (Seminar on harm reduction, 2000). Another study reveals that the number of IDUs just in the Kathmandu Valley could reach up to 5000 (CREHPA, 2002). Predominantly, urban areas, such as Kathmandu Valley, Pokhara, Hetauda, Biratnagar and other towns are in the grip of epidemic drug use (Expert Forum on Demand Reduction in South and South West Asia, 1995; Niraula, Chhetry, Singh, Nagesh, & Shyangwa, 2009; Seminar on harm reduction, 2000).

Before 1990, the number of IDUs was low, and they tended to inject in isolated areas and in secret. After 1990, HIV started to increase rapidly in this core group (Chin, 1999). Importantly, in 2000, it was reported that 98% of drug users share syringes at Dharan, Southeast Nepal (Oppenheimer & Reynolds, 2000). Another study conducted in three states of India: Manipur, Nagaland and Maharashtra also reported that IDUs shared syringes and needles commonly (Mahanta, et al., 2008). The sharing of syringes in groups imposes a greater risk of HIV transmission (CREHPA, 2003; Peak, Rana, Maharjan, Jolley, & Crofts, 1995; I. Shrestha, 1999). Through unprotected sexual intercourse HIV is transmitted from IDUs to spouses or sexual partners. In other words, IDUs act as bridges from risk-taking populations to the general community (CREHPA, 2003; Kumar, Virk, Chaudhuri, Mittal, & Lewis, 2008; New ERA & SACTS, 2002, 2003a, 2003b).

Data suggests that 68% of male IDUs and 14% of female IDUs are reported to be infected with HIV in Kathmandu Valley (DADRP, 2004; New ERA & SACTS, 2002).

Another study found that 40.4% IDUs had HIV (UNAIDS, 2000b). Those who have injected for more than five years had a higher rate of HIV compared to those who had injected for a shorter duration (New ERA & SACTS, 2003a). After 1997, the rate of HIV transmission accelerated amongst IDUs in Nepal (Furber, Newell, & Lubben, 2001; Oelrichs, Shrestha, Anderson, & Deacon, 2000).

Providing harm reduction services to drug using populations in the South-East Asia region, including Nepal remains insufficient, despite accelerated HIV transmission and other drug related harms in this group. For instance, only 1.5% of drug users from a sample of 800000 could access opioid substitution therapy, and 20 to 25% of the drug users could access syringe and needle programs only once a year (Sharma, Oppenheimer, Saidel, Loo, & Garg, 2009).

Studies conducted in the past reflected the growing interest and concentration on the epidemiological aspects associated with harm minimisation and IDU, such as measuring the prevalence of HIV in drug using populations. Far less empirical research has been conducted as to interactions in the IDU groups, their perception of HIV and related risks, and their understanding of possible approaches and challenges as they attempt to avoid these risks. This qualitative study explores these factors in hopes of increasing understanding and proposing appropriate public health countermeasures.

Methodology

This study explored the 'lived' experiences of 20 injecting drug users (IDUs) by using phenomenological strategies (Heidegger, 1962; Moustakas, 1994). This paper focuses attention on how drug users perceive and attempt to overcome the high risks and challenges associated with their injecting drug use. The participants were from four urban centres, including Kathmandu Valley, Pokhara, Narayanghaat and Hetauda in Nepal. They were recruited using purposive and snow ball sampling (Llewellyn, Sullivan, & Minichiello, 1999). All the participants were over 18 years of age. The participants were approached through local HIV/AIDS treatment organizations. An information sheet detailing the research was provided to the prospective participants. The participants were encouraged to approach the researcher voluntarily, and those who gave informed consents, were interviewed. Anonymity and the use of pseudonyms were assured. Interviews were one to two hours in length and were conducted in Nepalese, the principle researcher's first language. The quotes used in this manuscript reflect transliteration.

All data were analysed by using a grounded theory methodology (Strauss & Corbin, 1998). Similar data was placed in open codes where similarities in meaning or content became apparent. After reading and rereading the data line by line the open codes became clearer and more defined. After careful and meticulous analysis major or higher level categories were encapsulated as major themes. These categories were further verified by interviewing subsequent participants, whose characteristics contrasted in some ways with previous participants. This rigorous process was employed to ensure the presence of the themes across the diverse categories of IDUs (Anells, 1997; Hall & Callery, 2001;

Strauss & Corbin, 1998). Therefore, it is hoped that the themes presented in the next result section, illustrates the issues for IDUs across Nepal.

Results

HIV Risks

Throughout the participants' narratives the harm associated with drug use is perceived as the risk of HIV transmission. In the participants' discourses, the hurry and rush to inject drugs' emerged as a dominant theme. The participants were clear, the highest priority for IDUs is obtaining and using drugs and safety precautions were secondary. The participants seemed to be quite aware of the risk of HIV as a serious life threatening issue but also identified that they used largely ineffectual precautionary strategies. These precautions differ from individual to individual. For example, Saroj thinks if his IDU group members 'clean' a syringe and needle there will not be any harm to them. Of concern, to avoid such risks participants used various substances to 'clean' a syringe. Water was commonly used by the participants.

On some occasions, we share the same syringe. It is like someone has money to buy a horse but doesn't have money to buy a 'lagaam' [bridle]. Such situations happen to the drug users. They become 'sick' [withdrawal]. In that case, the same syringe is washed with water and is shared in the group. [Saroj, p7]

While describing his experiences, Saroj feels that injecting drug users are constrained by a lack of money to pay for drugs. When they are in withdrawal, they make every effort to purchase drugs rather than a syringe. If they have drugs, they do not consider it urgent to buy a syringe. He has compared buying a syringe with a 'bridle' and drugs with a 'horse'. The quotation in Nepali '*ghoda kinnalai paisa hunchha tara lagaam kinna paisa hundaina*' means people can afford somehow to buy a horse and do not worry about buying a bridle if they do not have sufficient money. This quotation clearly describes an IDUs purchasing priorities. The 'horse' (drugs) is a major concern whereas the 'bridle' (syringe) is considered as less important than the horse.

According to these participants, sharing a syringe within their IDU group, is an obligation for an injecting drug user. Although they wish to use a sterile syringe or a sterilizing substance, such as bleach, they do not have ready access to such substances. In addition, many of them do not have appropriate knowledge and skills to avoid the risks associated with sharing a syringe. For example, Hairan warned a drug user not to use the syringe of another drug user who was known to have HIV. The drug user, not having his own syringe, used the HIV drug user's syringe. The syringe was cleaned with urine before use.

I told one guy not to use another guy's syringe because he had AIDS. He did use that syringe but he cleaned the syringe using his urine. Cleaning syringes by urine doesn't kill HIV. [Hairan, p7]

Participants appear to be using diverse approaches to sterilizing a syringe. For example, Saroj used plain water 3 to 4 times to clean the syringe. He notes that he believes that heating of the needle will kill the HIV virus.

It is said that the HIV virus dies in two seconds. We wash syringes with water 3-4 times. Then dry this using cotton. Then we heat the needle on a flame for a while and use that syringe. This happens when there is no new syringe. [Saroj, p7]

Some participants tried to avoid the risk of HIV transmission by being the first in a group to use a syringe. They thought that the risk for HIV transmission is higher for those who injected subsequently or last.

My habit was I used to take drugs spending around Rs 2500 including a syringe for Rs 50. Still I don't know which day I made a mistake. I used to share syringes but I used the syringe first and then my friend used it. [Sapan, P11]

Despite taking what he considered as a precaution, Sapan wonders how HIV was transmitted to him. This suggests that either he did not always inject using a sterile or new syringe, or that he engaged in other risk behaviours which lead to HIV transmission, such as unsafe sex with someone who had HIV. The participants were not always aware when or how they acquired HIV and seemed to be aware that there were multiple possibilities for exposure to the virus.

The participants identified another tactic used to reduce high risk strategies. In contrast to Sapan, Pooja, a woman who was an injecting drug user with HIV was protective towards the IDU group members. When sharing a syringe in the group she injected last. After her use she prevented others from using the syringe. In such a way she tried to avoid HIV transmission from her to other IDU group members.

I thought I am HIV positive in any case. I stopped letting others fix my syringe but I used to take others' syringe to fix drugs. [Pooja, p2]

Other risks

Besides the threat of HIV transmission as discussed above, participants who were drug users commonly experienced abscesses associated with the use of injecting drugs. Bhawana revealed that inappropriate injecting techniques and using an old syringe caused her to develop an abscess. She stated that the needle missed the vein causing the drug to be deposited in soft tissue which led to the development of an abscess. Although there is pain associated with such soft tissue injection, under the influence of 'buprenorphine', a narcotic drug, such pain is suppressed and not clearly identified as problematic. Failure to identify early warning signs of infection and/or abscess leads people to ignore the need to consult a doctor. Not seeking health care at an early stage continues the progression of abscesses, and the complications can become severe. Bhawana cautions that after seeking health care in such cases, the hands or legs of some drug users are amputated.

Once I was injecting 'ampoule' [buprenorphine] it didn't get into the vein but was injected outside the vein in my leg. After one and a half years, I noticed a slight pain there. I went to the doctor and was diagnosed with an abscess. There was a collection of pus. Later it was operated on. I couldn't even walk properly. If I had delayed for a week it might have been necessary to amputate my leg. [Bhawana, p2]

Hairan, another IDU also highlights the possibility of amputation as a result of poor injecting techniques:

When a drug user experiences 'sick' [withdrawal], he/she is in a rush to inject drugs. The needle needs to be injected in the vein properly. If it is outside the vein, it may lead to swelling and a wound. To treat these conditions, amputation of the hand or leg will be required. Some IDUs had amputation for their hands or legs. [Hairan, p6]

Early health seeking interventions by Bhawana prevented the development of further complications due to the abscess.

Other health problems experienced by the participants included overdosing. The context of overdosing varied from participant to participant. Mostly they overdosed during the chaos associated with the withdrawal period or as they relapsed. For example, although Raj detoxified from drugs and was staying drug free, he could not control his desire to take drugs when he met his friends who were drug users. While taking drugs he overdosed and lost consciousness.

After detoxification I met my friends. They asked me to try drugs I said okay it's fine to try only one day. My uncle's home was locked; I broke the backdoor with a knife and entered the house. We took drugs. I overdosed and became unconscious. [Raj, p7]

Samarat related his experience of overdose:

Once I reached to coma due to an overdose of drug. I was hospitalised and was in coma for 22 days. [Samarat, p2]

From the above discourses, it is clear that the drug user participants accurately assessed the risks associated with drug use. The participants seemed universally aware that clean needles were important in reducing the transmission of HIV, that poor intravenous technique could increase the incidence of abscesses and the risk of overdosing loss of consciousness was prevalent.

Discussion:

This study identified that 'withdrawal symptoms' the participants experienced while not taking drugs, seriously undermine their efforts aimed at decreasing the risk of HIV transmission, other infections, and drug related harms. Although some drug users

practised safe injection some of the time, they described that ‘withdrawal symptoms’ usually interfered with such practices. They noted that drug users in the throes of withdrawal prioritise acquiring drugs; and safety measures, such as using sterile syringes or needles are inconsequential and unimportant. This finding supports the study of Harvey et al. (Harvey, Strathdee, Patrick, & Ofner, 1998), which suggests that drug users give priority to satisfying addiction in the first instance, rather than preventing HIV transmission.

The current study also highlights that while looking for drugs, the local context where drug users are able to find drugs, determine whether they use sterile syringes and needles or not. For instance, none of the participants carried sterile syringes or needles due to the fear of confiscation of syringe paraphernalia and their possible arrests. In such cases, if they are able to find drugs, their first need is to inject drugs rather than rushing elsewhere to get sterile syringes or needles. Also, most of the drug users in this study revealed that they do not have enough money to buy syringes or needles other than drugs. These issues predominantly compelled drug users, in this study, to use or share unsterile syringes and needles, which increase the chances of the transmissions of HIV and other bloodborne viruses. Such circumstances and potential carelessness, also increased the risk of drug overdoses and other health harms, such as abscesses.

Although injecting their drugs appears to be the priority, IDUs worry about HIV and other health harms too. This finding is consistent with other studies (DuPont, 1991; Pristera, Casini, Perino, & Degiorgis, 1987). In the current study, the participants devised what they considered appropriate strategies to protect themselves from HIV and other drug related health harms. For instance, Pooja, an IDU with HIV, did not let others to use her syringe following her own use. Sapan always injected first and did not use a syringe which his IDU group had used before. Some drug users’ attempt to heat the tip of the needle in a flame before reusing. And still others used urine to clean their syringe, further illustrating the urgent need and employment of significant, supportive and accessible public health harm reduction measures.

The tainted social image of IDU in the Nepalese context, such as engaging in antisocial and criminal activities, often attract unfavourable, inadequate responses from policy makers, law enforcements, health sectors, families and communities. In Nepal, intensive efforts to promote the health and well being of drug using populations is seriously compromised and a low public health priority. Paradoxically, the realization that drug users act as a ‘bridging group’ in the transmission of HIV into general populations, have found policy makers and public health authorities finally to begin to think about drug related issues.

Conclusions

The key issues identified in this study are a poor understanding of the potency of withdrawal symptoms and its affects on harm minimisation strategies as well, the expanding gaps in access to appropriate services for injecting drug users.

It is crucial to restructure the policies and strategies, informed by the findings here, which aim to create an enabling environment bringing IDUs in touch with appropriate services. The expanding gap in services and IDUs are now becoming obvious. Several factors are associated with the separation between the IDU and harm-minimisation services. The Nepalese culture, the general perception and marginalisation of drug users, poorly informed law enforcement and general lack of availability of targeted and friendly services to IDUs are all part of the inadequate approaches to this important Nepalese public health issue. Given the complex issues surrounding drug users, and their needs, it is essential to implement integrated strategies, which will suit the various categories of drug users. For example, harm reduction services including readily available sterile syringes, peer education approaches, methadone treatment, oral buprenorphine and other substitution programmes, and health services focussed to drug users are all important for Nepal's public health. Understanding the lived experiences of IDU as identified in this research is an opportunity to reassess and then improve harm reduction strategies in Nepal. Understanding the powerful influence of withdrawal symptoms and their sequelae and the absence of readily available cost-free sterile syringes, would greatly minimize the chances of HIV transmissions and other drug related harms.

Acknowledgement:

The author is thankful to the participants who provided their critical insights, which helped to understand significant issues around drug use and HIV that remain unaddressed in Nepal.

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