THE EFFECTIVENESS OF PREVENTION AND REHABILITATION PROGRAMME RUN BY PUNARJIVAN KENDRA ON DRUG ADDICTS

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Munna Tumboęk Limbu
ABBREVIATIONS

A.A.    -  Alcoholic Anonymous
CBOs   -  Community Based Organisations
DADRP  -  Drug Abuse Demand Reduction Project
DAPAN  -  Drug Abuse Prevention Association Nepal
DUs    -  Drug Users
IDUs   -  Injecting Drug Users
LALS   -  Lifesaving and Lifegiving Society
N.A.   -  Narcotic Anonymous
NEADAP -  Nepal Association for Drug Abuse Prevention
PHC    -  Primary Health Care
PJK     -  Purnarjivan Kendra
SAV    -  Social Action Volunteers
SWC    -  Social Welfare Council
UMN    -  United Mission to Nepal.
UPCA   -  Underprivileged Children Association
ABSTRACT

The abuse of drug is an international problem, which affects almost every country in the world, both developed and developing. Current evidence from around the world reveals a continuing upward trend in the misuse of psychoactive drugs.

Nepal is also caught in the web of the drug addiction problem. Especially, younger generation are becoming the victims of drugs addiction. The likelihood of the transmission of HIV/AIDS through drug abuse has added new dimension to the drug addiction problem. Thus various counter-measures have been taken singly or jointly by government, NGOs and INGOs in order to combat with drug addiction problem. It is recognized that NGOs can play vital role in the reduction of demand to illicit drug and drug use.

The study entitled “The Effectiveness of Prevention and Rehabilitation Program Run by Punarjivan Kendra on Drug Addicts” was conducted in Dharan Municipality. It was intended to identify the causes of drug addiction in Dharan and to explore the effectiveness of prevention and rehabilitation programme run by Punarjivan Kendra on drug addicts of Dharan municipality.

To achieve the goals of this study, descriptive research design has been adopted. Primary and secondary source of data have been equally used. The study comprised 76 samples of outreach service holder (current drug addicts) for the study which represent 17 per cent of the total outreach
service holder at the time of the study. These sample population has been contacted through purposive sampling technique.

Two types of instruments were applied to collect information related to the objectives of the study. Quantitative information was obtained from individual questionnaire administered to outreach service holder and qualitative information was obtained through case study and key informants interviews.

For data analysis simple statistical methods like frequency count and percentage distribution were applied.

After collecting the data, it was found that the major causes of drug addiction in Dharan is due to the socio-cultural and psychological factors. Rai-Limbu were the most drug affected ethnic/caste group than other ethnic/caste group in Dharan. Unmarried and unemployed young people are amongst the drug addict population. Majority of drug addicts belonged to the age group (15-24) years. Besides, peer influence were the major reason for drug introduction. Furthermore, multiple drug use is most common practice among drug addicts. Synthetic drug has dominated the drug scene of Dharan. Nitrazepam, phencidyl and tedigesic are the most used drug amongst drug addicts of Dharan. Though, the drug addicts are not confirmed to only one mode of drug administration, injecting drug is most common amongst drug addicts. It is found that 31.67 per cent share common needle, which shows the likelihood of the transmission of HIV/AIDS still persists amongst IDUs.
Punarjivan Kendra (PJK) is the only NGO in Dharan that works for prevention, treatment and rehabilitation for drug addicts. Prevention programme is targeted at both, drug users as well as at risk group and community people. At risk groups such as students are given drug education/information at their school. Parents meetings are held and teachers are provided training because they can reach young potential users more effectively and efficiently. Overall, the efforts of prevention programme is to raise mass awareness about ill-effects and social consciousness regarding the hazards of drug abuse in the society. In other aspects of prevention programme, it is directed at the drug addicts in order to reduce drug related harm. Outreach service are provided to them (drug addicts) in which various services such as primary health care, counseling, education on safer sex, safe injection behaviour, HIV/AIDS, STD are given, and preventive materials such as condom, sterilized water, bleach are distributed. It has provided treatment and rehabilitation services and follow up services to the addicts in order to reintegrate into society. As far as drug detoxification is concerned, its achievement is 100 per cent but it has rehabilitated 44 per cent drug addict at the maximum which is satisfactory because for successful rehabilitation, not only the role of personnel at the centre is important but the role of family, relatives and society is also indispensable. The case study also indicates that treatment attempts is successful among the drug users who voluntarily go for admission at the centre. Overall, prevention and rehabilitation programme run by PJK for drug addicts in Dharan should be appreciated in light of the limited resources and fund available at its disposal.
Executive Summary

The abuse of drug is an international problem, which affects almost every country in the world, both developed and developing. Nepal is also caught in the web of drug addiction problem. The Minister of Health (1998) estimated that there were more than 50,000 drug users in Nepal excluding those using cannabis, alcohol and tobacco. According to LALS, a NGO working with drug addicts, there are 60,000 drug users in Nepal of which 30,000 are in Kathmandu valley itself. Out of these 30,000 drug users, 15,000 are in Injecting Drug Users (IDUs) and 40 percent of these IDUs are already infected with HIV/AIDS (Cited in Kathmandu Post, October 12, 2001). The likelihood of the transmission of HIV/AIDS amongst injecting drug users has added new dimension to the drug addiction problem. The various counter-measures have been taken singly or jointly by government, NGOs and INGOs in order to combat with drug addiction problem. It is recognized that NGOs can play vital role in the reduction of demand to illicit drug and drug use. Amongst the NGO working for the drug addicts, Punarjivan Kendra (PJK) is the only treatment and rehabilitation center in eastern part of Nepal. It was established in February 26, 1996 as a Day Care Center in Dharan. Later on, PJK developed treatment and rehabilitation center in December 1997. The target populations of the PJK are drug addicts, youth at-risk and community people. Admission into treatment and rehabilitation center is either voluntary or refer by family member or police. The treatment period is interrelated with the problem of concerned person but the total period of treatment programme is minimum three months.

Dharan is large municipality and one of the most drug-affected areas. The recent survey of PJK (1999) shows that the total numbers of drug users in Dharan are 5,000. Amongst them, 70 percent of are Injecting Drug Users (IDUs). The primary mode of drug use is injection. Tedigesic (Bupronorphine) is the choice of drug amongst drug addicts. The survey shows that 90 percent IDUs share needles. Thus, there is high risk for transmission of HIV through the needle. This indicates how seriously Dharan is caught in the web of drug addiction problem.

The study entitled 'The Effectiveness of Prevention and Rehabilitation Programme run by Punarjivan Kendra on Drug Addicts' was conducted in Dharan Municipality. The specific objective of this study is to find out the present situation of drug addiction and socio-demographic characteristics of drug addict in Dharan. The effectiveness of prevention and Rehabilitation programme was explored in term of the appropriateness of programme it has launched to combat the drug addiction problem in Dharan.
To achieve the goal of this study, descriptive research design has been adopted. Primary and secondary source of data has been equally used. Applying different research tools for primary data used various study populations such as outreach service holders, key informants and residential client. Secondary data has been taken from annual report of PJK, journals and newspaper etc. The study comprised 76 number of outreach service holder (current drug addicts) which represent 17 percent of the total outreach service holder at the time of this study and 3 key informants and 1 residential client of PJK. These sample populations have been contacted through purposive sampling techniques.

Individual questionnaire was administrated to outreach service holder and interview schedule was administered to the key informant and residential client of PJK.

For data analysis, simple statistical methods like frequency count and percentage distribution.

It was found that the majority of respondent is the highest (35.53%) for 20-24 years age group followed by the age group (15-19 years) which is 28.95%. Majority of drug addicts (59.21%) are from Rai-Limbu group. 67.48% of the drug addicts are single. All the respondents are literate. Amongst them, majority has educational attainment of secondary level (85.53%). The prevalence of drug addiction is 6 times higher amongst unemployed youth than that of employed youth. Majority of respondent's father occupation is British-Indian Army (46.05%).

There is significant variation between the viewpoint of causation of drug addiction in Dharan. According to the key informants, the causation of drug addiction in Dharan is due to the lack of parental guidance, adequate pocket money given at the small age. According to drug addict (46.05%), peer influence is the main cause of the initiation of drug abuse.

Almost 92.11% of drug addicts use more than one drug. The most used drugs amongst respondents are nitrazepam, tedigesic, phencidyl and Ganja. With regards to the age grouping with the use of different types of drugs, nitrazepam, phencidyl and ganga is much used in the age group (15-19) years than tedegescic. Tedigesic is much used in the age group (20-29 years and above). Single way of administration of drug is rare. Majority of the respondents administer drug through both oral and intravenously and 78.94% of the respondents are injecting drug users. Amongst the IDUs, 38.33% of respondents always use new syringe, 31.67% share syringe and 30% use their own syringe number of times.
The effectiveness of prevention and rehabilitation programme of the PJK has been assess in terms of programme incorporated in order to combat the drug addiction problem in Dharan. The following are the programme of PJK.

a. Treatment and rehabilitation programme.

b. Prevention program by creating public awareness and harm reduction approach.

The analysis of the above programme has been done on the basis of the target and achievement of the programme in three consecutive year 1999, 2000 and 2001.

Treatment and rehabilitation facilities are provided to the residential clients. Very few numbers of drug addicts come for residential treatment. There were 28, 27 and 24 clients admitted in the year 1999, 2000 and 2001 respectively. As a part of treatment 100% of the clients were detoxified but only 22%, 44% and 44.66% were rehabilitated in the year 1999, 2000 and 2001.

As a part of prevention programme, public awareness campaign is carried out. The target groups are at-risk youth such as students and general public such as parent. Students of class 8-9 of Dharan, Damak, Inaruwa were provided drug and HIV/AIDS education. The target was set to provide drug and HIV/AIDS education to 40 and 300 students in the year 2000 and 2001 but altogether 44 and 305 students attended such class. Parent meeting is another important activity under public awareness campaign. The target was set to held meeting with 1000 and 150 parents in the year 2000 and 2001 but 1450 and 1280 parents have attended meeting.

Harm reduction approach is another aspect of prevention programme in an attempt to prevent blood borne disease like HIV/AIDS amongst drug addicts. The activities under harm reduction approach are DUs and IDUs contact in the street (outreach service), Annonymous Counseling (Detox, Pre-post, antibody, family counseling), preventive material distribution (condom bleach, sterilized water) and PHC service.

The out reach service was provided to 770 drug addicts in the year 1999. The target was set to provide outreach service to 1000 drug addicts in both year 2000 and 2001. But 1175 and 1051 were contacted in the year 2000 and 2001.

Annonymous counseling was provided under three category - Detox counseling, Pre-post antibody test counseling and family counseling.
Detox counseling was provided to 251, 435 and 398-drug addict in the year 1999, 2000 and 2001. The target was set to provide detox counseling to 400 drug addicts in each year.

Pre-post antibody test counseling was provided to 208, 51 and 7 drug addicts in three consecutive years 1999, 2000 and 2001. The target was set to provide pre-post antibody test counseling to 50 drug addicts in each year.

The family counseling was provided to 301 family in the year 1999. Family counseling was provided to 475 and 406 family in the year 2000 and 2001. The target was set to provide family counseling to 400 family in each year.

Preventive materials such as condom, bleach and sterilized water were distributed to drug addicts. 5968 piece of condom was distributed in the year 1999. The target was set to provide 5000 piece of condom in both year 2000 and 2001 but 5201 and 5007 piece of condoms were distributed. Likewise, 1651 bottle of bleach was distributed in the year 1999. In the year 2000 and 2001, 3600 and 3504 bottles of bleach was distributed. The target was set to distribute 3500 bottle of bleach in both years.

Sterilized water was also distributed to drug addicts. Altogether 3302 bottles of sterilized water were distributed in 1999. Though the target was set to distribute 7000 bottles of sterilized water in the year 2000 and 2001 but 7200 and 7008 bottle were distributed.

Primary Health Care (PHC) service was provided to 270-drug addict in the year 1999. PHC service was provided to 579 and 513 drug addicts in the year 2000 and 2001. The target was set to provide PHC service to 500 drug addicts in each year.

From the above data, it indicates that many drug addicts have come in the hands of professional personnel. Actually, the outreach service has been playing an important role in establishing ‘contact and prevention’ strategy. Not all drug addicts come for or could afford residential treatment. Only small segment of drug addicts come for treatment. Thus, under outreach service, the outreach worker literally reach out to individuals or group in their own setting like street and provide numerous types of services who otherwise might not come forward to ask for help such as people in marginal situations, youth at risk, family. The out reach service provides the general platform for early intervention of the problem.

The life history of the residential client was taken in an attempt to assess in depth information about drug addict - before treatment and after treatment phase. The life history revealed the general picture of drug addict’s
life - initiation of drug abuse, drug experience risk taking behavior, treatment and relapse episode, post HIV period and current situation.

It was found that multiple causes have attributed to the respondent for initiation of drug use. The indirect causes are the adjustment problem, affordability, easy access to and availability of drug. The direct cause is own desire to take drug.

It was found that the respondent is poly drug user and use variety method of administration of drug. At first, drug is taken for fun but later on drug is taken to adjust to immediate physical ailment. A vicious circle is created - the continuous use of drug cause physical trouble and addict take drug to get relief from the trouble. The more drug is used, the more the physical ailments are produced and more needs for the drug is created. That is why, drug addicts experiment with many drugs - drugs being stronger than before and frequency of intake of drug is also increased along with variety of method in administration of drug.

It is found that even though, transmission of HIV/AIDS is known, risk-taking behavior still persists. Condom use is not regular and syringe sharing behavior is seen.

It is found that if the family member without the willingness of the drug addict forces for the treatment, there is high chance of relapse.

It is found that counseling is important for person going for HIV test so that the person can handle the situation. Otherwise, the person may opt for suicidal attempt.

It is found that motivation on the part of the drug addict to remain free of drug paved the way for successful rehabilitation along with the effort of the treatment team and constant support from family.

It is concluded that there are multiple causes behind the growing use of drug in Dharan. It is a cumulative result of social influence related to family, social and cultural adjustment and behavioral problem as a whole. Majority of drug addicts in the present study was from Rai-Limbu group. The age of the initiation into illicit drug use is going down. Unmarried and unemployed young people are found more prone to drug addiction. With regards to educational attainment, increasing prevalence of drug use means decreasing educational attainment.
Drug scene in Dharan is dominated by synthetic drug. Nitrazepam Tedigesc and phencidyl are much used by drug addicts of Dharan. Nitrazepam is the most common drug amongst all age group. The consumption of Tedigesc is more prevalent among veteran drug addicts than those who have recently started using drug. The majority of drug addicts in Dharan are poly drug users and the primary mode of drug administration is injection.

The effectiveness of prevention and rehabilitation programme of PJK was assessed in terms of the activities it has carried out to address the need of the drug addicts as well as the at risk group and community people.

The effectiveness of the rehabilitation programme is relatively low. But it is already recognized that rehabilitation is very complex process. It is not only the sole responsibility of staff and professional personnel involved in the programme but the self-motivation on the part of drug addict, the constant support from the family and society is also important.

The activities under the prevention programme are public awareness programme and harm reduction approach.

The preventive programme is effective in term that it has timely provide awareness and education on drug and HIV/AIDS to the at-risk group such as student and general public such as parent. Prevention through awareness and education is fundamental to reduce the demands for drug and such preventive measures are effective means for long-term success towards preventing drug abuse.

The vulnerability of the transmission of HIV/AIDS to the injecting drug users has added new dimension to the drug addiction problem. PJK has launched harm reduction approach to combat with the problem. Harm reduction approach is the drug component of HIV/AIDS programme. The activities carried under harm reduction approach is effective in terms that the drug addicts come into contact with the professional personnel and then can take advantages of the counseling and primary health care. It is the medium of the early intervention of the problem.
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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

A drug is defined as 'a substance which affects the body functions of persons.' It may occurs naturally or synthesized. Some drugs directly affect the body physically, others affect the mind, other affect both body and mind. Drugs can thus change the functioning of body and mind in many ways. When a drug (say antibiotics) is used to treat infections or we use aspirin to relieve pain or we use other drugs for allergy, cough and cold, or for sleeplessness etc., under advice of a physician, we call the drug a medicine. Thus a drug that is used under medical advice for the treatment of an ailment is medicine. The positive use of drug could give us longer life, keeps us healthy, protect against diseases, and relieve tensions, anxieties, fatigue and pain. But if a person uses drug as usual habit or for intended use without the advice of a physician and suffering particular diseases, they become harmful and the practices can be termed misuse. In a common parlance, using chemical substance for non-medical reasons is drug abuse.

Drug abuse has become an epidemic in most societies and is a matter of considerable public concern. Many experts believe that the drug culture is a recent phenomenon but history indicates that the drugs is by no means a matter of a modern phenomenon. For good or bad, drugs have been used by men from prehistoric time to reduce physical pain or to alter the state
of consciousness. But in the earliest time, the range of available substance was not large and alcoholic beverages, opium, cannabis, cocoa usually become the local drugs of choice, and have been used to satisfy the individual's desire to enhance vitality and performance, to improve moods and induce a feeling of well-being, or to escape reality, for religious or merely recreational purpose. Many plants containing ingredients with stimulant effects-such as caffeine, cocaine or ephedrine are available in different part of the world where traditional use in social functions and ceremony persists. In the past, the use of mind altering drugs was limited largely to a persons who have attended the age of responsibilities within their communities and as such tended to be taken much more frequently and in substantial amount by man and women. Only small proportion who took those drugs for recreation and other purposes become dependent on them. But the contemporary drug scenario is different. The drug user and the types of drugs available is not the same.

Today's problem is that, drug abuse is increasingly shifting from plant based drugs like cannabis, opium, marijuana, alcohol beverages to synthetic drugs. Synthetic drugs are a product of the developing pharmaceutical industry and are phenomenon of the 20th century. As a result of the growing body of knowledge in medicine and natural science and it's closed link to the development of the pharmaceutical industry, the 20th century is characterized by the refinement of natural products by extraction/isolation of the active ingredients for e.g.: caffeine and ephedrine or cocaine from cocoa leaves. The therapeutic use of fully synthetic drug-substance can be produced in unlimited amounts from readily available chemicals. Many of these substances were designed as
structural modifications of naturally occurring drugs with similarly, yet more, specific and/or enhanced therapeutic effects. Thus this progress in technology, which permitted the use of refined natural products or of purely synthetic substances, marked not only on milestone in medicine but also a new era of abuse of psychoactive drug.

Drug abuse has many dimensions and can be defined in more than one way. ‘Persistent or sporadic excessive use of drug inconsistent with or unrelated to acceptable medical practice or the use of unspecified drugs, in unspecified manner and amount which is judged by some to be wrong or harmful to user or society or both, is drug abuse’. Drugs are classified into four groups by their effects.

They are:

(a) Stimulants (b) Depressants (c) Hallucinogen (d) Narcotics

a) Stimulants
It is that kind of drugs which stimulates the central nervous system of a person. Its examples are cocaine and amphetamines and their derivatives. Generally cocaine is either sniffed or injected, whereas amphetamines are administered orally or used intravenously. Cocaine is made from the leaves of the coca bush, whereas amphetamines are synthetic drugs manufactured for medical purposes. The major symptoms produced by the stimulant upon its abuse are hyperactivity, irritability, excitability, talkativeness, aggressiveness and restlessness. Their chronic abuse may end up with psychological dependence and mental derangement.
b) **Depressants**
Depressants are those substances which relaxes the central nervous system of a person. They include barbiturates, tranquilizers and are taken either orally or intravenously or both. The symptoms produced by depressant in addicts are slurred speech, quick temper, slow responses and reaction, appearance of drunkenness without an alcoholic breadth. The addiction of depressant is extremely difficult to be cured and its chronic abuse increases physical as well as psychological dependence.

c) **Hallucinogens**
These are psychedelic substances which affect the mind causing changes in perception and consciousness. They are called 'mind benders'. Lysergic acid Dethylamid (LSD), marijuana and hashish are the examples of Hallucinogens. LSD is chemically manufactured, whereas marijuana and hashish are derived from plants. The addict manifests symptoms such as talkativeness, distortion of time and distance, difficulty in thinking and remembering clearly, and get lost in illusions. Hallucinogen are mostly taken orally and smoked. It produces psychological dependence and the addict is prone to crime and sometimes go to the extent of committing suicide.

d) **Narcotics**
Narcotics make the addict senses dull. Their examples are heroin, codeine, morphine, etc. They may be sniffed or taken orally or used intravenously. The symptoms produced by narcotics are slurred speech, euphoria, flushed face etc. Also the addict becomes aggressive, when
desperate for drug. The addiction of narcotics makes the addict physically dependent.

Depending upon their strength to intoxicate a user, the aforementioned drugs can be categorized into two broad groups.

They are:

(a) Hard drug (b) Soft drug

a) Hard Drug
Hard drugs are strong in nature and produce physical dependence in addicts. One or two doses of hard drugs make the user an addict. Its examples are morphine, heroin, cocaine etc.

b) Soft Drug
Soft drugs are mild in nature in comparison to hard drugs. They produce only psychological dependence in an addict. Its examples are Ganja, Charesh, marijuana, etc.

The continued use of these drugs, natural or synthetic by a person is called drug addiction. World Health Organization (WHO) defines drug addiction as ‘Drug addiction is the state of periodic or chronic intoxication produced by the repeated consumption of a drug, either natural or synthetic’. The person who is under the influence of drug addiction is called ‘Drug Addict’. Drug addiction is one of the greatest social problems of our times. It is a problem which recognizes no boundaries and affects all aspects of society. Apart from the human
suffering and family disruption which addiction leaves in its wake, there is incalculable economic burden imposed on society in term of providing prevention, treatment and rehabilitation services and the loss of skilled manpower. It can affect all social strata, sex and age groups but its predominant use among youth is of particular concern. Worldwide, adolescence and young adulthood are the periods most associated with the on-set of illicit drug use. The adolescent is at the in-between stage, no longer child but not yet an adult, characterized by stress and anxiety. The absence of ideological paradigms, the loosening of social rituals, the lack of support systems, family disintegration and the anonymity in the big cities make the adolescent passage more complex and potentially hazardous. These factors have a powerful effect upon young people. Risk taking behaviour, already more likely among adolescents, is more frequent still, and includes the use and abuse of psychoactive drugs.

During the past thirty years, due to the rapid growth in mass media, economic system, political consciousness and influence of multicultural lifestyles, the general lifestyle of urban youth has changed quite considerably leading youth to imitate western youth culture. As a result of this, the youth are demanding more independence from family, and more closely identifying themselves with their peer group than had been in the case of earlier generation. The increasing number of young addicts of school or college level in Asia or SAARC countries is a potential threat to the society as well as to the addicts. The use of drugs is usually experimental in the beginning among the youth, and later is used to adjust to their immediate problems.
Classic reasons advanced to explain drug use include peer pressure, personal problems, insecurity, worry over work or study, curiosity, pleasure seeking behaviours. However, certain different but consistent factors are found to be associated with drug taking behaviours in different societies depending upon their social, cultural and economic condition. At a deeper level, however drug abuse may reflect some level of personality disorder associated with family disruption and other personal problems. However, the existence of a stable, supportive family life is frequently though by no means always thought to be a vital protective factor. People from perfectly healthy family may also become drug addicts. Sometime due to the stress, high expectation of parent, and easy access of drug and money may be the reason behind it. Whatever the reasons behind taking drugs, it means a very pathetic life. Socially, they are rejected, personally they lack self-confidence and personal competitiveness and psychologically abusers are disintegrated.

1.1.1 Historical and Contemporary Drug Scenario in Nepal

Impaired health is a clear and visible immediate symptom. An individual keep on losing his body weight and does not shows any appetite resulting in a decrease in disease resisting capacity of the body. The body shows the symptoms of malnutrition and become susceptible to tuberculosis, bronchitis, pneumonia, tetanus, jaundice, AIDS etc. It reduces the memory and concentrating power of the mind and an individual shows some symptoms of mental derangement. Increasing tolerance to drug further drains the individual's financial resource, energy and will to work and he/she may turn to crime to pay for the habit. The heavier the use of alcohol and other drugs by the young people, the more likely it is that
they will do poorly in school withdraw from peer group activities, and have emotional problems.

The drug problems of one member often disturb the entire family unit. This may cause animosity and hatred which erupt in the form of violence and aggression. The general weakening of the family structure causes the addict to be deprived of essential emotional and family support. Divorces and separation are common and predictable in such situations, moving the addict further into the fringes of society. Employment being less likely, the addict is forced into the criminal subculture. Criminality becomes the order of the day; pushing drugs, dealing, stealing etc. It is clear that the step by step process of alienation has an impact on the individual, the family and the community of which the direct and the indirect costs to society become incalculable.

1.1.1 Historical and Contemporary Drug Scenario in Nepal

Drug addiction is the recent phenomenon in the Nepalese society. But the use of drug in Nepalese society is not a new phenomenon. During the vedic or per-vedic era a kind of extracted liquid from the herbal plant known as 'soma ras' was in extensive use. The soma-ras was an integral part of the socio-cultural and religious tradition of Hindus. The use of cannabis, opium and alcohol have a long history. Their use are embedded in our culture and are often associated with social rituals, religious beliefs and socio-economic condition.

Ever since the day immemorial, large quantity of 'Ganja and Bhang' were consumed around the holy temples of Nepal during festivals like
Shivaratri and Holi as 'Shivabuti' or 'Shivajiko Prasad'. Cannabis preparation is known in Nepal since a long time. Some rural inhabitants still use it to overcome fatigue and pain. Its therapeutic use is prevalent in the society even today. Even elderly and higher caste people who were forbidden to consume alcohol used to indulge in puffing Ganja during special religious festival. The use of cannabis and its derivatives, alcohol were accepted among certain segments of Nepalese society. However, the problem faced by the country is not the use of Ganja but the rising use of dangerous drug such as heroin (often called smack, brown sugar, white powder in local market) by the younger generation. There has been shift in the trend of drug use from Shiva's disciples to younger generation, a rapid increment in experimentation with other dependence producing illegal drugs, and an alarming rise in the addict population. It is in fact, a matter of serious concern because of its undesired effect on youth and its resulting consequences on society as a whole.

Drug use began to be seen as problem in the county for the first time only in mid 60s and early 70s with the influx of large number of hippies. Not only in Nepal, but hippies culture had spread to almost all the accessible world society during 60s and it was synonymous with drug sub-culture. After the political changes of 1950, Nepalese government adopted an open door policy to foreigners. As a result, tourist and hippies started to pour into Nepal. The youth of Nepal were exposed to hippies who were everywhere in the street, around temples, squares and parks. The youth, who were linked to tourist trade and to imitate the western culture and to identify themselves with the foreigners and their culture, language and mannerism, become the victim of drug. At that time, the traditional
meaning, practices and attitude to drug that exist in Nepalese society for
hundred of years were very much distorted. The use of drugs ceased at
the end of the semantics and the abuse of drug began. The abuser further
introduced new drugs which were not only addictive but life threatening.

The move to hard drugs from the easily accessible non addictive drugs by
Nepalese youth has been growing at an alarming rate over the past 20
years. Heroin use was in epidemic form in Nepal from 1980
(Shakya, 1997). At first, the abuse of hard drugs was sporadic and
confined to certain localities of Kathmandu only. There were only about
50 addicts in 1979, which amounted to 1000 in 1981. And concerned
expert estimates about 25,000 addicts have been found using drugs in
entire Nepal in 1988. Many research finding revealed that the majority of
drug addicts in Nepal are among the youth of the 15-30 years. The trend
of drug use over the last few years to now is as follows:

<table>
<thead>
<tr>
<th>Years</th>
<th>No. of users</th>
</tr>
</thead>
<tbody>
<tr>
<td>1978</td>
<td>50</td>
</tr>
<tr>
<td>1980</td>
<td>500</td>
</tr>
<tr>
<td>1981</td>
<td>1,000</td>
</tr>
<tr>
<td>1985</td>
<td>15,000</td>
</tr>
<tr>
<td>1986</td>
<td>20,000</td>
</tr>
<tr>
<td>1987</td>
<td>25,000</td>
</tr>
<tr>
<td>2001</td>
<td>60,000</td>
</tr>
</tbody>
</table>

Source: Extracted from Students and Drug in Nepal, 1992 and Lifesaving and
The above data indicates that the number of drugs addicts has been increased five hundred times over within the span of 10 years time. The Ministry of Health (1998) estimated that there were more than 50,000 drug users in Nepal excluding those using cannabis, alcohol and tobacco. According to LALS, there are 60,000 drug users in Nepal of which 30,000 are in valley itself (Kathmandu Post, October 12, 2001). But the serious matter of concern for Nepal is not the number of current users alone, but the recruitment of new drug users at an alarming rate and the higher risk of transmission of HIV/AIDS amongst these drug addicts.

The drug abuse problem is increasing in high number in the kingdom of Nepal not only among campus level students but also among high school students and drop out (Sinha, 1988). Many research conducted in Nepal revealed that the primary reason of taking drugs is peer influence and other reasons such as curiosity, broken homes, frustration, inadequate parental love and influence of western subculture are taken into consideration. For a country like Nepal, the unprecedented pace of growth in drug addict population may lead the whole country into inextricable disaster. Drug abuse is now, no longer an urban phenomenon. It has started to shows its ugly head in the rural and semi-urbanized area of Nepal such as Pokhara, Siddharatha Nagar, Butwal, Hetuauda, Birgunj, Nepalgunj, Biratnagar and Dharan.

Seeing its undesirable effect on youth and society, it is a high time that the appropriate mechanisms towards preventing drug abuse should be developed. Attempts were being made at government and non-
government level. Consequently, the Narcotic Drugs Control Act was passed in 1976 and many other remarkable efforts were made by the government. However, the efforts made by the government are not adequate enough to combat the drug addiction problem.

The role of non-governmental organization is very important in tackling with drug related problem, particularly in the area of drug demand reduction. Especially, NGOs role is indispensable in developing countries like Nepal where efficiency on the part of the government as well as other sector has yet to achieve. Mental Hospital at Patan and Teaching Hospital at Maharajgunj are only two hospitals where drug addicts get treatment at some extent. There are numbers of NGOs such as Freedom Centre, Youth Vision, Richman Fellowship, Navajivan Asharam, etc. working in drug related field. In some cases, NGOs are the only providers of service of drug addicts to cope with drug abuse. But the only efforts of NGO cannot do much. This calamitous problem of drug abuse cannot be efficiently overcome unless the various agencies such as government and non-governmental organization in the different disciplines are prepared to co-operate and co-ordinate their efforts depending upon the aspects in which they can become most effective.

Punarivan Kendra is the only non-governmental organization of its kind in Dharan working among drug addicts and their problems.

1.1.2 Background of the Punarjivan Kendra (PJK)

Dharan is large municipality and one of the most drug affected area situated in the eastern part of Nepal. The population of Dharan is about
68,000. The population of the city like other towns in Nepal is mixed of
different ethnic groups mainly Limbu, Rai, Gurung, Magar, Tamang,
Newar, Chhetri, Brahman, Muslims, etc. A recent survey of Punarjivan
Kendra shows that the total number of drug users in Dharan are 5000.
The drug users are from 14 - 25 years old. The socio-economic status of
drug users are middle and low class. Tedigesic (Bupronorphine) is the
choice of drug amongst drug addicts, which is injected in the body. Other
drugs are tablets like Nitrazepam, Diazepam , Proxivan are also
extensively used by drug addicts. Some addicts take large quantities of
cough syrup. Ganja, which is locally produced is also popular amongst
drug addicts. The primary mode of drug use is injection. About 70 per
cent of drug users are Injecting Drug Users (IUDs). The drugs come from
India through Jogbani, Kakarvitta, Vantabari which are the border cities
of both India and Nepal. The survey shows that 90 per cent injecting drug
users use tedigesic by common needles. Thus, there is high risk for
transmission of HIV through the needle. According to the rapid
assessment survey conducted by Punarjivan Kendra with the assistance
from National Centre for AIDS & STD Control (NCASC), total of 39 per
cent drug users are HIV positive, total of 61 per cent Hepatitis C, total of
2 per cent had Hepatitis B. The most serious concern is the case of HIV
where the infected person develop AIDS. This indicates how serious the
problem is in Dharan. But still, very few studies about this social problem
in Dharan are carried out.

Kirat Yakthung Chumlung (KYC) is one of the very few social
organization who works with this problem in Dharan. Kirat Yakthung
Chumlung (KYC) established a Day Care Centre called Punarjivan
Kendra (PJK) in February 26, 1996. Punarjivan Kendra developed
treatment and rehabilitation centre in December, 1997. PJK is the only social organization that works for treatment and rehabilitation of drug addicts as well as the prevention of this social problem. PJK developed as a community based organization where 18 NGOs, CBOs and GOs have been interrelated. It has an advisory board, management committee which is on the chairmanship of the Dharan Municipality. PJK is going to extend harm reduction, public awareness and excess drinking minimization programme on the Dhankuta, Terthum and Panchthar.

a) Financial Resources of Punarjivan Kendra
The Kirat Yakthung Chumlung, Community Contribution, Volunteer, Donor, Government Agencies are the financial resources of Punarjivan Kendra.

b) Objectives of Punarjivan Kendra
The following are the objectives of the Punarjivan Kendra:

i) To provide treatment and rehabilitation facility for drug addicts and to make them useful and productive citizens.

ii) To create public awareness against drug abuse and HIV/AIDS.

iii) To prevent HIV/AIDS/HBV/HCV/STD or drug related harm.

c) Main Activities of Punarjivan Kendra
The following are the main activities of the Punarjivan Kendra:

i) Public awareness programme
   - Parents meeting
   - Student class (visiting students in their schools)
   - Organizing parents groups against drug abuse and HIV/AIDS
- Door to door campaign
- Publishing materials/brochures.

ii) HIV/AIDS prevention programme among IDUs
- HIV/AIDS/STD and safer sex education
- Pre-post, Detox and family counselling service
- Primary health care service
- Preventive material distribution
- IEC material distribution

iii) Training and research programme
- Peer-education training
- Teacher's training
- HIV/AIDS training
- Counselling training
- Research and Survey

iv) Drug Treatment Programme
- Therapeutic Community Model
- Acupuncture/Cold turkey Detoxification
- Counselling service
- Group dynamics
- Work-Therapy
- Psycho Therapy
- Inventory Programme
- Follow-up programme
- Family counselling service
- Social, moral and civic education
- Twelve step classes
- Yoga and meditation
d) Drug Treatment and Rehabilitation Concept

i) Tough and Ragged approach
   - The treatment programme involves comprehensive daily activities, maintenance of high discipline.

ii) Psycho-social approach
   - Psychological aspect deals with behaviour modification, attitude, values, perception and problem solving
   - Sociological aspect deals with dynamic of family relationship, norms and sanction of society, basic human needs, moral and social.

e) Treatment and Rehabilitation Plan

   - Admission to the centre either through police arrest under Narcotic Drug Control Act 2033 and also through voluntary admission.
   - Cold Turkey is used for detoxification.
   - Structured daily activities are used in order to maintain behaviour and attitude.
   - The treatment period is interrelated with their problem.

The Following tables shows the preventive strategies of Punarjivan Kendra.
Table No. 2
Preventive Strategies of Punarjivan Kendra

<table>
<thead>
<tr>
<th>Programme level</th>
<th>Objective</th>
<th>Method</th>
<th>Focus group</th>
<th>Programme</th>
</tr>
</thead>
</table>
| Primary         | Education/Awareness    | School/Community based education | 1. General Public  
2. Drug addicts | Public awareness |
| Secondary       | 1. Education/awareness | 1. Education programme  
2. Referral service  
3. Vocational training | 1. Youth at risk  
2. General public | 1. Outreach for education, counselling  
2. Socio-cultural involvement and activities  
3. Vocational training |
|                | 2. Individual contact  |                             |                              |                                  |
| Tertiary        | 1. Individual service  | 1. Outreach programme  
2. Treatment & Rehabilitation | Drug addicts | 1. Treatment and rehabilitation programme  
2. Service delivery outreach programme  
3. Harm reduction programme |
|                | 2. Education/awareness |                             |                              |                                  |

Source: Punarjivan Kendra.

f) Daily Activities of Drug Treatment (Activities within the Centre for Clients)

The following is the time schedule for the client who reside at the centre

5.30 a.m.  - Getting up
6.00 a.m.  - Prayer and Yoga
7.00 a.m.  - Tea
7.30 a.m.  - Work therapy (all the clients are divided into groups and each groups have to perform their daily duty like gardening, cooking, cleaning rooms)
9.00 a.m.  - Lunch
10.00 - 11.00 a.m.  - Writing Feeling
11.00 - 12.00 a.m.  - Individual Counselling
12.00 - 2.00 p.m.  - Group Dynamic (discussion about their problem in group and getting suggestion from therapist)
2.00 - 3.00 p.m.  - Tea - Snack
3.00 - 4.00 p.m.  - Peer Education/N.A meeting
4.00 - 5.00 p.m.  - Free time (Table Tennis, Chess, TV, Caremboard, Playing Card run by their own)
5.00 - 7.00 p.m.  - Work therapy
7.00 p.m.  - Dinner
8.00 p.m.  - Inventory class
9.00 p.m.  - Free time
10.00 p.m.  - Go to bed.

g) Organizational Structure of Punarjivan Kendra (PJK)
The following is the organization structure of Punarjivan Kendra

![Organizational Structure of Punarjivan Kendra](image)

Source: Mr. Bijay Limbu, Programme Manager of Punarjivan Kendra
h) **Target Group of Punarjivan Kendra**

The following are the target population of the Punarjivan Kendra:

- Drug Addicts
- Community
- Youth at risk

1.2 **Statement of the Problems**

The drug problem is not a recent phenomenon in the world. People have used, or misused one kind of drug or another throughout the ages. Individuals have used drugs as a celebration of life and as an escape from life. The current international trend to discourage drug abuse is based on the belief that enslavement to drugs deprives society of the most valuable contribution the individual can make, that of an intelligent, fully functioning human being, motivated and able to make a contribution to life in the community. World Health Organization (WHO) report on the world health situation speak of up to 50 per cent of teenagers are 'exploring drugs' and of increasing evidence of the abuse of heroin and psychoactive drugs, describing it as a dynamic factor. Young generation is the future of the nation. But if this young generation become victim of drug addiction, them it is misfortune for any country.

The pattern of drug addiction in the world has changed over the last two decades. Nepal is caught in the web of this changing international phenomenon. Not only are narcotics readily available in Nepal but the social acceptance of alcohol and Ganja, Bhang and its rising consumption amongst young Nepalese youth present a separate but related set of
problems which complete the complicated substance abuse picture. These soft drugs are not physically addictive, but rather become psychologically addictive. Psychological dependence to a drug bring about a false feeling of well being and a person needs to maintain this drug taking habit to continue in this somewhat euphoric state. A danger in this kind of preoccupation with 'soft drug' involvement exposes a Nepalese youth to an environment in which hard drug readily available and introduces a companionship with drug takers. These are often two ingredients that can lead to shift from one form of drugs to another.

The drugs scene is one of the rapid change in recent years. The most pronounced increase in drug abuse has been reported for synthetic drugs. Children and adolescents are constantly experimenting with new substances, while offering a great variety of method in taking them. Thus, there is justifiable concern that with clandestine manufacture of these substances spreading, and entirely new derivatives (designers drugs) with unknown pharmacological activity profiles appearing in the illicit market, the severity of adverse reactions to synthetic impurities or to the new drugs themselves may increase considerably. In the absence of any clinical testing of these new substances, users are passively offering themselves up as pharmacological guinea pigs (World Drug Report 1997). Due to the vast range of availability of drugs, from natural to synthetic drug, polydrug abuse has become the order of the day. Users restrict themselves less to one preferred drug; they smoke, inject, sniff, pop (take pills), inhale, drink and eat whatever drug is available in whatever shape or form and in whatever degree of purity paying little concern to the inherent risk. Thus multiple drug abuse, often in
combination with alcohol is becoming the rule rather than the exception and characterizes today’s substance abuse practices.

In fact, illicit drug use in any form is associated with harmful consequences, drug injection is commonly regarded as the most dangerous mode of administration. One of the principle reason for this is that, it’s association between unsafe injecting practices and the possibility of the transmission of HIV/AIDS and the wider diffusion of these diseases by sexual contact. Sharing of needles is very common among injecting drug users. Many, such addicts, though they realized the danger involved, still continue with the unsafe technique when in hurry because of withdrawal symptoms. In Nepalese context, by 1996, there were nine cases of Injecting Drug Users (IDUs) that were found to be HIV positive and than mode of transmission has been reported to be heterosexual. By October 1997, the number of HIV positive has risen to 863 out of which 128 belonged to Injecting Drug Users (IDUs) group (Shakaya, 1997). Amongst 30,000 drug users in Kathmandu Valley, 15,000 are injecting drug users and 40 Per cent of these IDUs are today already infected with HIV/AIDS (The Kathmandu Post, 12 October 2001). The association between unsafe drug injecting practices and the HIV transmission has currently became a major concern in many parts of the world.

The mounting problem of drug addiction in younger generation is posing a serious threat to our family integration, social and economic stability and the progress of our nation. The most promising part of our society is degenerating. A sub-society of young escapists and fanatics with perverted values and antisocial behaviour is crippling along the way of
new generation, often hindering the path of promising youth. What seems to be a problem of few westerners on 'Freak street' has become a Nepalese problem and must be recognized as such. So it is a high time to take some positive steps to curb drug abuse in Nepal. Otherwise, in no time it will follow the escalating pattern that already has been seen in the western countries. In fact, drug addiction is treatable and recovery is possible. There are many treatment and rehabilitation centre for drug addict which work with drug addict and drug related field, especially in Kathmandu valley. Along with these, Punarjivan Kendra (PJK) situated in Dharan, is the only local non-governmental organization, that provides treatment and rehabilitation facilities as well as prevention programme. Therefore, the problem of present study is stated as “The Effectiveness of Prevention and Rehabilitation Programme run by Punarjivan Kendra on Drug Addicts” of Dharan. In other words the problem of the present study is to find out the status of the application of prevention and rehabilitation programme and assess its effectiveness.

1.3 Objectives of the Study

The main objective of the study is to explore the effectiveness of prevention and rehabilitation programme of PJK on drug addicts of Dharan. And the following are the specific objective of this study:

a) To explore the existing situation of drug addiction in Dharan.

b) To identify the socio-demographic characteristics of drug addicts in Dharan.

c) To explore the benefits achieved by the clients of PJK.

d) To investigate drug history of addicts who is admitted at the centre for residential treatment.
1.4 Research Questions

This study seek to answer the following questions:

i) Why the young people become attracted to drug and become addicts?

ii) What are the socio-demographic characteristics of drug addicts in Dharan.

iii) To what extent the treatment and rehabilitation facilities are provided by Punarjivan Kendra.

iv) To what extent the clients are benefited by prevention and rehabilitation programme run by Punarjivan Kendra.

1.5 Significance of the Study

Drug addiction is becoming a critical social problem in Dharan. Mainly the younger generation are becoming the victim of this problem. The fight against this problem cannot be done by imposing punishment. It is psychological weakness and need to be treated by psychological readjustment of the emotional factors that led the individual into drug addiction. The researcher believes that the present study will contribute significantly in the following areas:

i. This study will explore the existing situation of drug addiction in Dharan.

ii. The finding of this study will provide useful insight for better dealing with the drug related problems.
iii. The solution, recommendation of this study will urged the curriculum developer for the inclusion of drug education in the school curriculum.

iv. This study will be helpful to those who are doing research work associated with drug abuse.

v. The issues of this study will serve as guidelines for health planners, health policy makers, community health workers to formulate plan and policies and improving the levels of knowledge and awareness towards this problem.

1.6 Limitation and Delimitation of the Study

Every study has its own limitations due to the limited time and economic constraints. This study area is limited in Dharan Municipality of Sunsari District and delimited in the following areas:

a) The respondents (drug addicts) for the study include only the outreach service holder of Punarjivan Kendra.

b) The respondents (drug addicts) are delimited to the 15 - 30 years age groups.

c) The case study was conducted with the inpatient/clients of Punarjivan Kendra.

d) The study may not reflect the health pattern of drug addicts in depth.

e) The study has not covered the social and economic cost of drug abuse.

1.7 Definition of Terms Used

Bhang: Beverage or substance made by crushing and rubbing of the leaves and seeds of cannabis plant.
Cannabis: is the Latin word for hemp; mild hallucinogen and widely grown in Nepal.

Chasresh: is the form of cannabis resin. It is mostly smoked with tobacco or in cigarette.

Detoxification: is a part of treatment which aims at withdrawal from physical dependence on addictive drugs.

Dhaturo: a hallucinogen and native of Nepal; it is related to the belsadonna plant (Dhatura)

Drug Abuse: Use of any drug in a manner that deviates from approved social or medical patterns.

Drug Culture: Group of people whose patterns of behaviour involve and are supportive of recreational use of drugs.

Drug Dependence: is a state psychic and physiological resulting from the interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis.

Drug Misuse: When a drug is taken for the intended use but not in the proper quantity, frequency, strength and/or manner.

Drug Psychoactive: is one that is capable of altering mental functioning. It is synonymous with the word 'drug' and includes narcotic drugs as well as psychotropic substances.

Drug Tolerance: A stage when a person become regular user of a drug, a chemistry of this body changes and the effect of every dose of the drug
gradually decreases. Then a person requires more and more dozen of the drug for the same effect.

**Drug:** Any substance that, when taken into the living organism, may modify one of more of its function.

**Epidemic:** Appearance of an infections disease or condition that attacks many people at the same time in the same geographical area.

**Fix:** To inject drug like Tedigesic and Brown Sugar.

**Follow-up:** Measures to keep in contact with treated persons and to collect information systematically on their drug-free status and other activities for research or evaluation purposes.

**Heroin:** Popularly called smack, brown sugar or even white powder. It is analgesic in nature and is derived from opium.

**Hippies:** Individuals following a way of life based on renunciation of material things and believing it possible to achieve deep insight into life through use of drug.

**HIV Positive:** It is such a condition in which human immunodeficiency virus is seen through blood test.

**Outreach Programme:** The programme in which services are provided to target group in their own setting such as street.

**Pandemic:** A disease affecting the majority of the population of large region, such as HIV/AIDS.

**Pull:** To take Brown Sugar in the form of smoke.
Punarjivan Kendra (PJK): Non-political and non-profit making community base organization in Dharan. PJK provide treatment and rehabilitation facilities for drug addicts.

Rehabilitation: is a part of treatment which is concerned with the restoration of physical and mental health as well as the enhancement of capacity for socio-economic function or assuming social and productive role in community.

Shoot: To inject drug.

Trip: The experiences of high resulting from drug use.
CHAPTER TWO

REVIEW OF RELATED LITERATURE

Literature review is the most important component of the previous research from which the researcher gains the other's experiences. Also, it helps to gain insight on particular research issues, which assists in formulating the research problem and acknowledging the previous efforts made by the scholars and researchers. It can be a strong bridge between the previous and the present efforts to carry out the fundamental assumptions, without which a research work can never be original. Similarly, literature, studies on drugs field has been reviewed on various grounds to provide its relevant concepts, and its significance in the world on Nepalese context. Overall, the purpose of this chapter is to review briefly the different existing view of experts on this field and to lay out a framework for the present study.

This review chapter presents a discussion on the importance of the role of NGO and its origination in Nepal in drug field, techniques applied in the prevention, treatment and rehabilitation of drug addicts.

2.1 Related Literature

Thapa, Kamal (1988:27:110-117) has mentioned about the emergence of NGOs in the fight against drug abuse in Nepal. It is only since 1975 that cases of drug addiction began to draw public attention. By the end of the 1986, the number of people in drug addiction has been estimated to be
about 25,000 in entire Nepal. Several volunteers organizations have come forward with their own initiation in preventing the drug problem. But some concrete step in an organized way have been taking place only since 1984, when Nepal Youth Organization set up a committee called Drug Abuse Prevention Committee to concentrate on the work related to the prevention of drug addiction in Nepal. This committee conducted a national seminar on the prevention of drug abuse in 1985 and hosted the Seventh International Conference of NGOs on drug dependence in Kathmandu from September 23 - 27, 1985. Some 230 participants representing different NGOs of Asia, Europe, Africa, Australia assembled in Kathmandu to deliberate on the ways and means of improving NGOs role in attaining the objectives of drug free youth for participation, development and peace. A year later, this committee developed into a full-fledged and a autonomous organization called Drug Abuse Prevention Association Nepal (DAPAN). DAPAN is an umbrella organization pioneered solely to the particular cause of drug problem. It is affiliated to the Social Service Nepal Co-ordination Council (SSNCC) and function within the periphery of Health Service Co-ordination Committee Nepal. Youth Organization, Nepal Jaycess and Nepal Medical Association are the pioneer organization of Nepal in combating against this greatest social threat of today. Social Service Centre run by the Jesuit society and Godavari Alumni Association are also among the frontline organizations in this field. Later on, many organizations were established to cater to the needs of society in this regard such as Nepal Association for Drug Abuse Prevention (NEADAP), Social Action Volunteers (SAV), United Mission to Nepal (UMN) Youth Against Drug (YAD) etc. Many treatment and rehabilitation Centres were opened. Navajivan Ashram,
Freedom Centre, Youth Vision, Aashra Sudhar Kendra, Richmand Fellowship (for both male and female) are some of the treatment and rehabilitation centre. Most of these organizations are involved in multidisciplinary activities with their own interests, targets and groups, concerns and priorities. The significant roles they have played during their initial days are highly commendable.

Pokhrel, Tika Prasad (1999:19:48-52) has deliberated about the role of NGOs in drug control, networking and information exchange. According to him, NGO movement started quite late in Nepal. There were altogether 372 NGOs till 1991. Their number, however increased extensively during last eight years. There are at present 9500 local NGOs and 94 International NGOs affiliated with the Social Welfare Council (SWC) and still there are few more NGOs who have yet to come within the umbrella of SWC. Among these NGOs, there are quite a few NGOs involved directly into drug related programmes in Nepal. Their numbers are about 60 and their activities are mainly concentrated on awareness creation against drug abuse and rehabilitation.

With regard to the role of NGOs in drug control, he viewed that NGO can play role in all the four aspects of drug control i.e. control in consumption, production, trafficking and rehabilitation. Control in consumption and rehabilitation is largely on matter of education, persuasion and socialization. They could be achieved only through the personal contact, high level of patience, timeless efforts and also it could be achieved only in the informal environment. These role could be expected from the NGOs which work in a more informal environment.
NGOs can play direct role in demand reduction. But in other aspects, such as production, processing and trafficking, the government should take the lead role in the matter of controlling them. In these connection, the NGOs can have limited roles like the role of acting as a pressure group and passing on the information to the general public.

All of these tasks, however could not effectively be done without having a strong networking experiences and information sharing among the NGOs and other stakeholders within and outside the countries. NGOs should also have a close contact with the government agencies working in this field. Government agencies should act as a supportive agency and provide necessary facilities to such NGOs. Likewise, NGOs should act as supplementary to the government agencies, then only the NGOs along with the government agencies could be effective in the field of addressing the drug abuse.

Subbba, Chaitanya (1988:26) had suggested that prevention through awareness, education and action is fundamental to reduce demand for drugs. Such preventive measures are considered as effective means for long-term success towards preventing drugs abuse and related crime. HMG is relying on Non-Governmental Organizations (NGOs) in this fields. Both government and NGOs are doing its best in creating awareness and disseminating information to the public. Nepal police, through its radio programmes and periodicals, is disseminating information relating to the hazards of drugs abuse. Mass media owned by the government are giving wide coverage on the events of drug offences. Nepal Television is devoting its time to produce programmes in creating
awareness and disseminating informations to the people. A few education materials have been produced by NGOs such as DAPAN, Nepal Medical Association (NMA), St. Xavier Social Service Centre and Jana Chikitsalya. Due attention and emphasis are given to the development of positive values and skills among risk groups. Distributions of posters, pamphlets, organizing rallies and talk programmes, workshops, seminars are conducted by Nepal Youth Organizations, Nepal Scout, Nepal Jaycess, Friend's Club, Jana Chikitsalya and some other clubs in different part of the kingdom.

It is mentioned in World Drug Report (1997:31:203) that the purpose of drug abuse prevention is to communicate a message which discourage individuals who have not taken drugs from doing so. The most important elements to be considered in developing programmes are the target groups to whom the message is carried out, the style and the content of the message and the vehicle or medium used to communicate that message. The effectiveness of the drug prevention message is judged by how it affects knowledge, attitude and behaviours, and each requires a different message input. Ideally helping people to build up self-esteem should be an integral part of drug prevention programme.

Likewise any drug prevention programme must take into account the social and cultural concern of given target groups, if they are to be effective. Ethnic minorities have different strengths and vulnerabilities from the rest of the population and these must be addressed through drug prevention message which respect and reinforce the culture and its prevailing norms.
According to Quejas, Sofia Q. (1981:20:53-63) as the complexity of drug abuse suggests deeper problems, prevention workers should resort to a variety of approaches either utilized singly or in combination, within realistic limits of financial and technical capabilities, operational resources and time. The principle approaches to drugs abuse prevention widely used to carry out preventive programme in the Philippines are: Education, Information, Alternatives and Interventions. But it varies from one country to another depending upon the operational concepts, the target groups, the drug being used, and on the specific needs of the communities which are either low or high risks areas in the problem or drug abuse.

In this regard, it has been further stressed that the error of adopting foreign policies without adequate testing and evaluating as to suitability must be avoided.

Silveria, D.X. (1994:23:253-258) has suggested that AIDS prevention is closely integrated with drug demand reduction programmes because of the link between injecting drug use and transmission of HIV. Primary prevention is the only known means of stopping the spread of HIV virus. So the prevention programme should meet the following three criteria:

i) The target population must believe that AIDS is a real threat.

ii) Specialized services must be available to encourage drug users to change their risky behaviours.

iii) Social network must exist, or be created, which reinforced the desired behavioural changes.
The HIV/AIDS Pandemic (1994:33) published by World Health Organization deliberates on the accounts of the Harm Reduction Approach. Proponents of the harm reduction believe that drug policies based on abstinence are bound to fail because they ignore the root causes of the problem. The transmission of HIV and other blood-borne infections through sharing drug paraphernalia, the resource to crime in order to pay for the dependency, the uncertain quality of drugs purchased on the street and the social marginalization of the consumers are all cited as factors which necessitate a better integration of drug users and the provision of assistance to them, including drug if necessary. If it is done so, it is claimed that the crime level will fall, cities will become less violent, dependent drug users will be healthier and more integrated into the society and thus more likely to return to a productive life. The ultimate objective of the harm reduction approach is the overall reduction to a minimum of the harm caused by the drugs, and also of the harm perceived as being caused by the illegal status of drugs. These principles were incorporated into the 'Frankfurt Resolution' a declaration signed by representatives or city counsellors of nine European cities in Frankfurt in 1990. But some of the countries still objects to implement this. Objection have been raised on the grounds that syringe/needle exchange may encourage drug users to inject or to inject more frequently, or that, at the very least, they do not discourage injections practices. But evaluations are mixed in this regard. Syringe and needle exchange have been strongly supported by most health care professionals not just for their perceived efficacy in reducing blood borne diseases but because they are means of bringing drug users into contact with health agencies, who may ultimately
be persuaded to take advantage of some forms of counselling, primary healthcare. Likewise, The World Health Organization also warned that in areas most affected—Cambodia, Myanmar, Thailand and a few states in India, the death rate of adults will rise 40 per cent and as for most moderately - affected Asian countries, annual death among adults will increase by 5 per cent in the coming decade due to AIDS. The WHO said that AIDS epidemic in virtually all of Asia is concentrate on sex workers and injecting drug users. So it has called an Asian nations to focus on drug addicts and prostitutes in the battle against AIDS. It is said that in Myanmar, Thailand, Nepal and China's Yunnan Province and Manipur in India, about 50 per cent or more of the injecting drug users are infected with HIV virus. In a report released in Manila, the WHO called on Asian countries to 'aggressively' implement HIV Prevention programmes for drug addicts, including the controversial practice of providing clean needles to ensure safe injection practice among them and promoting condom use among prostitutes. The report further said that some government in Asia are against providing clean needles because it would encourage the larger drug abuse problem.

Maharjan Shivahari, et al (1994:15) have commented on the increasing number of people injecting heroin and opiates in many Asian countries, and the explosions epidemic of HIV infection among injecting drug users. They have also pointed out the urgent requirement for strategies to prevent further spread of HIV among Intravenous Drug Users (IDUs). The activities of the Lifesaving and Lifegiving Society (LALS) in Dillibazar, Kathmandu, Nepal is presented in their report. The involvement of LALS in various programmes such as distribution of
preventive materials e.g., sterile water, bleach, condoms for HIV prevention and the provision of sterile needles in exchange for contaminated needle is mentioned in document. It also highlights on the risks of HIV infection through injection and sexual contact.

Dr Kunwar, D.R.B. (1981:13:1-6) presented a paper ‘Treatment Techniques of Drug Dependence in Nepal’ at the First National Seminar and Workshop on Drug Abuse and Addiction. In that paper, he briefed on the various types of treatment methodologies practiced all over the world such as Cold Turkey, Substitution Therapy, Traditional Methods, Saturation Method, Modified-Chemo-Narco Therapy. He also mentioned his own experience of providing treatment to heroin addicts at the year of 1976. Further, he also mentioned about the method of treatment used in Nepal, about the nursing care complication during treatment, advantages and disadvantages of treatment. According to him, the success rate of treatment has been over 95 per cent as far as the initial treatment of medical detoxification is concerned. But the treatment of drug addict go beyond the medication. The real battle of social and occupational rehabilitation is rather crucial. He emphasized that the medical detoxification only give added confidence to both the patient and the treatment team because after that, the patient lost his intense craving for drug and generally shows no psychological stigma of drug. This will pave the way, if given the better chance for further socio-occupational rehabilitation and regular follow up would definitely give high degree of success. In his opinion, the failure of treatment can be attributed mainly to the poor-economic background in many cases.
Stanley, Einstein (1980:25:775-779) has commented on treatment, as being the essential phase which paves the way for more meaningful and ongoing rehabilitation programme. Attention to immediate physical complications and psychological disorder is needed. The goals for treatment must be set and considerations given to appropriate screening techniques, suitable technology, staff, defined roles, appropriate site, policies, built in evaluation, follow-up and reasonably well defined criteria for goal achievement. The key issues are: appropriateness of approaches, accessibility to clients, cost effectiveness, harmony with cultural and social factors, effective referral links, good record-keeping for research, follow-up and evaluation.

Medical intervention constitutes different phases in its treatment programme depending upon types of drugs abused by the clients and the objective of the treatment. The process of detoxification, relief of the withdrawal symptoms with different medication, and maintenance treatment for the intervention of both immediate crisis or for long term therapy is essential (Russel and Hersov, 1983:8).

Abstinence based treatment begins with detoxification, the process by which the drug is eliminated from the human organism. Detoxification may be carried out on a more gradual basis, with substitute pharmaceuticals. Detoxification is carried out by using methadone, chlorpromazine and procyclidine or hypnotics during withdrawal stage and gradually tailing off the medicaments. This method is used in Hong Kong and Malaysia. Substitution with small doses is effective in achieving a drug free state safety, quickly and with minimum discomfort. Medication
always carries the possibility of substituting dependence on another drug. Methadone always carry the possibility of substituting dependence on another drug i.e. some persons become addicted to methadone itself. It is like giving beer to whisky drinkers. There is also danger of being life threatening and other undesirable side effects. Problems with medication arise with the complications associated with addiction such as debility, dehydration, anorexia, and toxaemia from infections. Other complications like hypersensitivity, paralytic ileas, choking, aspiration, pneumonia, deep vein phlebothrombosis or sudden circular collapse is common. Lastly, it is costly and call for the need of highly expert medicinal care and a high degree of devotion and expertise as team on the part of everybody concerned. (Vogel, 1949:30:909-914).

According to Galanter (1993:9:28-36), psychological approaches have been applied with increasingly good results for both individual or group. Psychological treatment is applied to drug abusers of different age groups according to the nature and severity of the problem. To this date, various form of psychotherapy like network therapy, music therapy, dance therapy have been used. Furthermore in some innovative programme of treatment, along with mediation for detoxification and withdrawal programmes, different approaches like Gestalt, Behaviour Modification, Existentialist, Freudian Analysis are applied. Apart from these, basic counselling therapies like rational emotive, reality therapy, rational-behaviour therapy, group therapy and basic social skill development programmes are also introduced.
An examination of alcohol and drug literature has revealed 35 separate treatment processes, broadly categorized as either disease model behavioural or general psychotherapy process. A national survey of 123 treatment experts' view on treatment process was conducted to determine whether certain process would be considered as most important in the treatment of drug problems. Disease model and behavioural experts tended to differ strongly on their process into a traditional disease framework. (Morgenstern and McCrady, 1992:11:79).

Donovan (1990:6:79) had suggested in this regard, as for the prerequisite for progress, appropriate assignment and most cost effective treatment should include.

i) More communication between researcher and clinicians with findings from basic research being integrated into clinical practice.

ii) Flexibility in treatments that are available.

iii) A clear definitions of who is an addiction specialist and

iv) Integration within the addiction treatment communities.

World Drug Report (1997:32) has explained the traditional form of treatment for drug addicts. Traditional healing methods are described as 'non-orthodox, therapeutic practices based on indigenous cultural traditions which operate outside official health care system' and are particularly widespread in Asia and Africa'. Ritual and symbolic procedures involve incantations, invocations and various forms of spiritual and physical purification. Herbal emetics and laxatives are used to drain or purge the body of addictive substances, followed by intake of, or bathing in, consecrated fluids and by massage and physiotherapy.
Religious rites of confession pledge and sacrifice are performed to signify the liberation of an individual from the scourge of addiction.

In Malaysia, Chinese Taoist practitioners and Hindu Ayurvedic Healers offers residential treatment from one to several weeks duration. Drug abuse treatment based on Islamic precepts is also available in Malaysia and consists of internal purgation and external cleaning followed by spiritual didactic counselling. Islamic religious leaders in the Arab world provide spiritual counselling within mosque grounds after detoxification has taken place. In Cairo, Saudi Arabia, group therapy follows prayer sessions with joint worship and recitation of the holy scriptures. Yoga and other traditional practices such as homeopathic medicine, acupuncture and transcendental medication have also been adopted by western practitioners. Sometimes, eastern and western practices are combined, as in Hong Kong, methadone maintenance is provided on a short term basis, and then traditional treatment is provided in Buddhist temple. Treatment is given in the temple grounds.

According to Ling (1992:14:22-26), the variety of therapeutic approaches in the treatment of drug abuse indicate the fact that treatment of drug addicts is complex. Drug addiction does not only create physical or psychological craving by malfunctioning system of body and mind, it has also the wide spread effect in man's life. Therefore, drug abuse and dependence is not the presence of any one discipline of professional group. The drug problem touches upon somatic as well as psychological, social and ethnic questions. This fact also indicates that any meaningful attempts at control, prevention and treatment should involve therapeutic
techniques of different perspective. Such diversity of problems indicates that drug problems do not represent single or unitary phenomenon. Therefore multi-nodular approach is more appropriate to avoid one-sidedness in the therapy.

The Resources book on measure to reduce illicit demands for drug published by the United Nation Division of Narcotic Drug, (1979:28:70) has defines "rehabilitation as the process of helping individuals to establish a state in which they are physically, psychologically and socially capable of coping with the situations encountered, thus enabling them to take advantages of the opportunities that are available to other people in the same group in the society." Rehabilitation, therefore should form a crucial aspect of society's attempts at helping drug dependent persons to change their lifestyle. Thus re-entry, readjustment and independent functioning of recovered former drug dependent persons is the final goal of rehabilitation.

United States Department of Health, Education and Welfare (1973:29) mentioned that the concept of rehabilitation of drug dependent person is based on premise that they are capable of change and positive social adaptation. It implies change from a status that has strongly negative connotation. The process aims at acquiring new social and coping skills. This involves two important ingredients: the will to give up drug oriented lifestyle and developing the means to do so. The former depends upon the addicts and the latter on to society. It is essential to view rehabilitation in the context of personal evolution over a period of time. The primary
objective of rehabilitation is to provide catalytic situations and to mobilize the abovementioned two important ingredients.

International Labour Organization (1977:10:73) in ‘Study on measure to reduce illicit demands for drug’ has stated that social reintegration as the part of the rehabilitation process aimed at the re-adaptation of a drug-dependent person, with respect to society, by helping him or her to participate in and meet the demands of the family, community and occupation. Employment is an essential feature of the reintegration process, but one must consider the global psycho-social needs of the ex-addict in setting goals. These needs included contacts with family, friends, suitable living accommodation, suitable leisure activities, etc. Therefore, a variety of necessary supporting services such as residential programmes and half-way houses, foster families, Drop-in centres, self-help groups should be included.

A Study of New York opiate addicts (Suffet and Brotman, 1976:7) proposed employment as an essential marker in successful rehabilitation and identifies minority race, poor educational and clinical record as social disabilities, which act against recovery.

Shahandeh, Behrouz (1985:21) has mentioned in his handbook, the complex nature of drug and alcohol abuse, it outline the infrastructure and administrative support services required for the rehabilitation services; it deals with the important factors which can influence policy development of such services, the importance of involving the community at all stages of planning and implementing rehabilitation programmes is stressed and
many examples of successful and varied approaches to resolve the rehabilitation problems of addicted persons throughout the world are provided.

Abdullah, Dato Adnan Bin Haji (1981:1:105-110) in his paper entitled 'The Social Welfare Approach in the Treatment and Rehabilitation of Drug Dependent' gives an accounts for the Malaysian government approach in rehabilitating the drug dependents. The Welfare Ministry’s in conjunction with the Ministry of Health has undertaken it’s responsibility by setting up of rehabilitation centres and maintaining the referral and supervisory service, including after-care. The philosophical assumption that is adopted in the centres is that the drug dependent himself is the key factor to his own rehabilitation. For his own cure, he/she must play an active part as he himself would have to play this part in his life outside. He highly encouraged for the active involvement of family and community. He also mentioned that the total abstinence is not the only criteria of successful rehabilitation. Other criteria such as ability to hold a job, increasing responsibility towards family and absence of criminal activities need also be considered along with abstinence. Furthermore, he added that treatment and rehabilitation needs flexibility and should include varieties of treatment and rehabilitation modalities to cater for the varying needs of the heterogeneous drug addict population.

2.2 Related Study

Bhandari and Subba (1992:4) conducted a survey entitled 'Students and Drugs in Nepal' among the students of grade 9 and 10 in high schools and
intermediate level students from three major cities: Kathmandu, Lalitpur, Pokhara and Biratnagar. A total number of 6218 (64 per cent male and 30 per cent female) were interviewed. The primary purpose of the survey was to provide an accurate picture for school and campus population in each of three important and geographically dispersed cities in Nepal by collecting scientifically sound, reliable and valid data on drug knowledge, use and awareness. It was concluded regarding exposure and reaction to anti-drug messages that mass media such as newspaper, radio, television and video films were seen as the major channels transmitting anti-drug messages to the society. Males over females were more aware of mass media. And two third of the respondents reported that anti-drug messages had brought positive change and only 6 per cent reported that it had adversely affected the respondents. The recommendations made regarding the anti-drug messages were:

a) Anti-drug campaign through mass media has produced a very positive change among the students. Hence, it is recommended that awareness raising programmes at the mass level be enhanced and expanded throughout the country and the content of the message be examined by a team of professionals before it is disseminated to the masses. Ill-prepared and ill-designed anti-drug information may even bring negative impact among its target groups.

b) Teenagers should be the prime target of the prevention education of drug and substance use, including tobacco and alcohol.

c) Preventive education should be directed at parents and teachers, who can reach young potential users effectively and efficiently.
Nepal (Joshi), Prabha (2052:18) submitted research report entitled “An Opinionnaire Survey of Head Master and Experts Regarding the Inclusion of Drug Education in Secondary School Curriculum”, which has three main objectives: to find out the attitudes of head master of secondary schools about drug education, to find out the opinion of head master of secondary schools and experts regarding the inclusion of drug education in secondary school curriculum and to provide a model content on drug education for secondary level. The research was conducted at the schools of Lalitpur and Kathmandu Municipality and related experts by using random sampling method. Questionnaire schedules was the main research tools. The major finding of the study were as follows:

i) 96 per cent of the Headmasters and all experts were unanimous with regard to the need for the inclusion of drug education in secondary school curriculum.

ii) It was found that integrated type of curriculum was preferred the most by both headmaster and experts.

iii) All headmasters and experts were of the opinion that the content of the drug education would have positive impact in creating social awareness against drug abuse.

Mc Gettigon, Kevin (1988-1989:16) submitted research paper entitled ‘Nepali Alcohol and other Drug Abuse Recovery Options’. It is a qualitative research work of descriptive nature based on the author’s interviews with counsellors, doctors, practitioners, healers and social workers engaged in anti-drug abuse programmes, including his observations in Kathmandu treatment centres in 1989. The primary objective of this study was to cover all aspect of alcohol and other drug
abuse recovery options available in Nepal and an exchange of information between the people helping drug addicts in Nepal.

His major findings were as follows:

1) The study has listed 14 centres or groups who provide some kind of treatment services to the patients of drug and alcohol addiction.

2) The study also gives brief overviews of organization, such as DAPAN, NEADAP, SAV, UMN, Freedom centre, engaged in the treatment of drug dependence in the country.

3) The recovery options outside the valley, according to the report, include medical doctors, health workers, and local healers (Jhankri and Village, Lamas.)

Sinha, Rebecca (2045:24) submitted a research report entitled “Factros Resulting Drug Addiction in School Age Children”. It is a descriptive study in Kathmandu and Lalitpur Districts. A snowball sampling technique was used. The objective of this report was to examine factors associated with drug addiction in school age children of 10-15 years old. A total of 25 drug addicted children including both sexes from Kathmandu, Lalitpur districts were taken for the study. A semi-structured questionnaire was used.

The major findings are as follows:

i) Higher incidence of drug addiction (48 per cent) found at the age of 15 years and males were more prone to drug addiction (76 per cent) than females (24 per cent). The reason for taking drugs were due to curiosity and inquisitiveness.
ii) Only 20 per cent addicted children were treated and remaining 80 per cent were not treated.

On the basis of the findings, following suggestions regarding prevention, treatment and rehabilitation were made:

i) In order to prevent drug addicts from using it, the most important and significant roles are played by the parents. Mass awareness campaign should be organized to create social awareness among parents.

ii) Treatment services should be provided to the addicts as soon as possible. And there should be referral system too.

iii) Rehabilitation programme should be conducted to reintegrate addicts into the society.

2.3 Proposed Conceptual Framework

The above review of literature indicated that NGO have unique contribution to make in drug related problem, especially in demand reduction side. The main objective of the study is to explore the effectiveness of the prevention and rehabilitation programme run by Punarjivan Kendra on drug addicts of Dharan. In fact, no model of conceptual framework related to present study is found. On the basis of the related literature and experience, a set of research paradigm was constructed in order to accomplish the study objective.
The above conceptual framework depicts the researcher concept of the outcome of prevention and rehabilitation programme. The expected outcome produced is the effectiveness of prevention and rehabilitation programme of Punarjivan Kendra.

The following are the main four components of the framework which are a) Input b) Process c) Outcome and d) Feedback.

a) Input
Various factors such as organizational objectives, human and financial resource, facilities and supportive agencies are considered for the study. It is supposed that organizations are set up with definite goals which represent variety of objectives. The organizational objectives provide guidelines for the financial and human resources. The financial and human resources are the important factors for any organizational
structure. The human resources, if used effectively and fairly, can contribute towards the goal of the organization. The financial resources usually determine the services and facilities of the organization. No organization can function properly in isolation of financial resources. There should be co-operation, co-ordination and net-working within the NGOs, INGOs and GOs at the local, national and international levels.

b) Process
The process involves the strategies of the organization in order to meet the objectives being sought by the organization. In fact, it mediates between the input and outcome of the organizational structure. Since the demand reduction strategies involved the eradication of drug abuse from the society through prevention, treatment and rehabilitation of drug addicts, the organizational strategies in this study are prevention, treatment and rehabilitation strategies along with the provision of training, seminar and workshop. It is supposed that for effective prevention and rehabilitation programme, the treatment and rehabilitation programme should be carried out hand in hand.

c) Outcome
Outcome is caused by the input and process component of the organizational structure. The expected outcome in this study is considered the level of awareness on target groups, decline in risk behaviours amongst drug addicts and reintegration of drug addicts into the society.

The three components of the research paradigms are interrelated and doesn’t exist in isolation. The organizational strategies are designed as
per the requirements of the organizational objectives and an outcome depends upon the input and process of the organizational structure.

At the end of the every financial year, the overall success, obstacles, benefits and limitations of the programmes implemented are known. There will be feedback for the future determination of the programme.

Therefore, the present study reveals the holistic approach in the treatment and rehabilitation programme that has been adopted by the concerned organizations and centres, along with the preventive strategies for drug demand reduction.
CHAPTER THREE

METHODOLOGY OF STUDY

The present study is descriptive in nature. The study intended to explore the effectiveness of prevention and rehabilitation programme run by Punarjivan Kendra on drug addicts. The following methodological procedure has been applied in the course of study.

3.1 Population of the Study

In order to obtain the necessary information related to the effectiveness of prevention and rehabilitation programme run by Punarjivan Kendra on drug addicts, different sources were used.

The study was based on both primary and secondary data. In order to obtain the primary data, various study population were used by applying different research tools. The drug addicts (current users who are outreach service holder and clients who are admitted at the centre) are population of this study. Apart from them, the parent of drug addict, peer, teacher, police were also taken for the study population as key informants. They are directly or indirectly involved with the prevention and rehabilitation programme of Punarjivan Kendra. Besides, information were also collected from secondary sources like annual report of Punarjivan Kendra, other research works, books, journals, periodicals, newspaper, brochure etc.
Punarjivan Kendra keep contact with drug addicts in two ways. One way is from their outreach programme in which drug addicts are met in the street by the outreach worker of Punarjivan Kendra. In another way, the drug addicts are admitted for residential treatment programme. The drug addicts, contacted through their outreach and residential programme were considered as the major source of data.

In this study, only the drug addicts who are in regular contact with the outreach programme of the PJK at the time of this study were concerned. The total number of population is the total number of drug addicts, contacted by outreach programme at the time of this study. The number were approximately 450 at the time of this study. The drug addict who is admitted at the centre for residential treatment was contacted by the researcher after getting permission from the programme manager of PJK. As for key informants like peer, local NGO and government agency, they were recommended by the programme manager of PJK. Only one from each of them as for example only, one peer, one local NGO personnel and one personnel from government agency were taken for the study. They were selected on the basis of their interest and involvement with the prevention and rehabilitation programme of PJK.

3.2 Sampling Procedure

The number of drug addicts who are regular outreach service holders were approximately 450 at the time of this study. It is not possible for the researcher to contact all of them. Therefore, the respondents were selected by using purposive sampling technique. Purposive sampling was
used because drug addiction is considered a sensitive issue. The drug addicts themselves and their parents do not want to disclose about their addiction. So it is very difficult to identify the drug addicts. Even if they are identified, the main problems is that, they do not talk openly about their addiction. But the drug addicts have opened up with outreach worker. Thus by the purposive sampling the researcher could approach the right respondents who could provide the needful information. It was intended to contact with 25 per cent of the total study population but due to the nature of the study it was not possible. Study of drug abuse needs a lot of methodological considerations. Normally, people do not talk openly on such things, especially if they themselves are involved in it. Parents do not want to disclose that their son/daughter are drug addicts and the drug addicts also do not want others to know about their addiction because of the feelings of losing their social status. So not all the drug addicts are willing to fill the questionnaire. The researcher could make contact with 76 drug addict which makes 17 per cent of the total study population. Quantitative informations were collected from those 76 drug addicts ‘Outreach service holders’.

The rule of Punarjivan Kendra does not allow the outsiders to meet directly with their clients who are admitted at the centre for residential treatment. But after explaining its importance to the programme manager to accomplish the research objective, the researcher was allowed to meet one client and the selection of the client was done by the programme manager of PJK. The case study was conducted with the client in order to obtain qualitative information.
Unlike the drug addicts who are directly related to the study, the parents, teacher, police, peer groups, member of the social organization and authority in government agency are indirectly involved with the prevention and rehabilitation programme of PJK. So the researcher did not strictly follow that all are covered in the study. Though all were approached, the researcher could only meet with the ex-addict, the executive co-ordinator of Under Privileged Children Association (UPCA) and Youth Development Officer of Dharan Municipality, which are taken as key informants. Each represent the peer group, the local NGO and the government body respectively. Qualitative informations were obtained from those key informants. The types and the number of respondents are given in the following table.

Table No. 3
Types and the Numbers of Respondents

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Types of respondents</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Drug addicts from the outreach programme (Outreach service holder in the street)</td>
<td>76</td>
</tr>
<tr>
<td>2.</td>
<td>Drug addict who is admitted in the centre for residential treatment (Case Study)</td>
<td>1</td>
</tr>
<tr>
<td>3.</td>
<td>Peer (ex addict), member of social organization, authority from government agency (Key Informants)</td>
<td>3</td>
</tr>
</tbody>
</table>

3.3 Tools and Instruments

The researcher used different tools to the different respondents for the purpose of data collection.
The structured questionnaire was administered to the drugs addicts who are outreach service holder of Punarjivan Kendra. Broadly, the questionnaire was developed to cover the two broad areas as follows:

Section A: Socio-demographic Characteristics

Section B: Variables related with Drug Addiction

Each section constitutes the varying number of questions to obtain the necessary information for the research objectives. The questionnaire is presented in Appendix -I.

To collect the necessary data, the researcher made the interview

The case study was conducted to one of the client admitted at the centre for residential treatment. The model of interview schedule is presented in Appendix II.

The interview schedule was administered to the peer educator (ex-addict), member of social organization and authority of Dharan Municipality. The uniformity was maintained by asking same questions to each of the key informants. The questions cover the area like the cause of drug addiction in Dharan, the liaison between their organization and PJK, and their opinions and suggestions on the programme of Punarjivan Kendra. The model of interview schedule is presented in Appendix III.

3.4 Validation of the Instruments

Different reference materials were reviewed before developing the questionnaire and interview schedule. The researcher submitted the prepared tools to the Health and Physical Education Department for getting feedback. The researcher, then, revised the tools in accordance
with the guidance and suggestions provided by the department. Then the revised tools was administered to the clients of Freedom Centre as tryout after getting permission from the concerned authority of Freedom Centre. The tool was improved further on the basis of the feedback by the tryout. The tool was finalised after the approval of Health and Physical Education Department and Punarjivan Kendra.

3.5 Data Collection Procedure

In order to collect the necessary data, the researcher made the working schedule. According to the schedule, the researcher visited the Punarjivan Kendra with authorized letter from the Health and Physical Education Department and explained the nature and purpose of the study. The researcher requested with the authorized person of Punarjivan Kendra for help to collect the necessary data. The programme manager of PJK suggested the researcher to visit the site with the outreach worker to be familiar with the drug addicts before collecting data. Thus the researcher made several visits at site with outreach worker. During such visits, the researcher got chance to be familiar with several drug addicts (outreach service holder). Thereafter, the researcher briefed about the nature and purpose of the study and made request with the drug addicts to fill the questionnaire. Each of the respondents were personally approached by the researcher during data collection. Researcher also gave assurance to every respondent that their response would be kept secret and only used for study purpose. The data were collected within two months.
After finishing this schedule, the researcher started to work on another schedule. The researcher asked for permission with programme manager to meet with the clients to conduct case study. Though, PJK did not allow the outsider for any purpose to meet with their clients, the programme manager provided one of their client.

As for interviewing peer educator, member of social organizations and authority from government agency, the names of the concerned persons were provided by the programme manager of PJK. The researcher, then, made contact with each of them over the telephone. Each of them were interviewed by the researcher on different time as per their appointment.

3.6 Statistical Treatment

On completion of data collection, a quick and careful re-check of all the questionnaire was carried out and master table was prepared on different headings. No special statistics were done for analysing but simple statistical methods like frequency count and percentage distribution were applied.
CHAPTER FOUR

ANALYSIS AND INTERPRETATION OF DATA

This chapter intends to present the analysis and interpretation of data in an organized form. Since different research tools were administered to different respondents in order to obtain the necessary information regarding the effectiveness of the prevention and rehabilitation programme of PJK, an attempt was made to analyse in accordance with the nature of data collected. This chapter is divided into four main sections which are as follows:

1. Responses of drug addicts who are contacted through the outreach programme of PJK (Outreach Service Holders).


3. Information collected from key informants such as peer educator (ex-addict), personnel from local NGO and government agency (Dharan Municipality)

4. Analysis of Case Study

4.1 Responses of Drug Addicts who are contacted through the Outreach Programme of PJK (Outreach Service Holder)

In this section, all the data collected were arranged in master table to count the frequencies and percentage distribution and they were analysed under the following heading.

a - Socio-demographic characteristics

b - Variables related with drug addiction
4.1.1 Socio-Demographic Characteristics

Many researches have been conducted in the past on the socio-demographic characteristics of drug addicts, especially in Kathmandu valley. Drug addiction is inextricably interwoven with the socio-demographic characteristics of the respondents. The information provided is important to estimate the prevalence of the use of drug among respondents by gender, age, education, marital status, occupational status, ethnicity/caste, pattern of drug use and social relationship. The following sub-headings are included in this heading.

a) Distribution of the Respondents by Age Groups
Adolescent and young people constitute the larger number of drug addicts population because at such age they are less able to evaluate the dangers and judge the likely consequences of their behaviours. Their lack of caution may make them more vulnerable to become the victim of drug. Most of the research findings on drug a field revealed that the majority of the drug addicts are unmarried males and between the age-group 15-30 years. The following figure provide the distribution of drug addicts by age group.
Figure No. 3
Distribution of Respondents by Age - Group

- 15-19: 14.47%
- 20-24: 21.05%
- 25-29: 28.95%
- 29 and above: 35.53%
A majority of the drug addicts are at the age range between 20 - 24 years age group (35.53 per cent) which is shown in above figure no. 3 and second happened to be the age group 15 - 19 years which is 22 (28.95 per cent). The drug addicts between the age group 25 - 29 years are 16, which is 21.05 per cent and the number of drug addicts are 11 (14.47 per cent) at the age group 29 years and above.

This figure indicates that young people belonging to the age group 20-24 years constitutes the larger number of drug addicts. This findings substantiates the finding of Bhandari (1988). In his report, the majority of the drug addicts were at the age range between 20-25 years. But the Bhandari's report also revealed that the second highest number of drug addicts are at the age range 25 - 30 years. The figure shows that the second highest number of drug addicts are at the age range 15 - 19 years. Overall it indicates that the drug addiction in the past few year has much affected the age group 20 - 30 years but in the recent years it has much affected the younger generation amongst 15 - 24 years age group.

b) Drug Addiction by Marital Status

Marriage is an important social institution, which allows a man and women for sexual relations in the society. Mazumdar defines marriage as “approved union of male and female, or as a secondary institution devised by society to sanction the union and mating of male and female for purpose of a) establishing a household b) entering into sex relations c) Procreating and d) Providing care for the offspring.”
On the other hand, it is well accepted that the prevalence of HIV among drug addicts population is high. These groups may transmit this infection to their spouses if they are married or living with spouses. So, it is important to find the marital status of the respondents population. The figure no. 4 indicates the marital status.
Figure No. 4
Drug Addiction by Martial Status

- 30.07%
- 2.45%
- 67.48%

Options:
- Unmarried
- Married
- Divorce
The data presented at that figure no. 4 shows that the highest number of respondents 55, which makes 72.37 per cent are unmarried and 21 of them which make 27.63 per cent are married. Out of them 2.60 per cent are already divorced.

Figure no. 4 indicates that the percentage of unmarried addicts is extremely high compared to married one. This finding substantiates the findings reported by Bhandari (1988).

c) Distribution of Respondents by Ethnic/Caste Group

Population of Nepal is composed of various caste and ethnic group. Census of 1991 listed more than 60 caste and ethnic group residing in Nepal. Ethnicity is an important factor to determine the social cohesion and organizational basis in the community.
Figure No. 5
Distribution of Drug Addicts by Caste and Ethnic Group

<table>
<thead>
<tr>
<th>Caste/ Ethnic Grouping</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rai-Limbu</td>
<td>59.21</td>
</tr>
<tr>
<td>Gurung /Magar /Tamang</td>
<td>13.16</td>
</tr>
<tr>
<td>Newar</td>
<td>15.79</td>
</tr>
<tr>
<td>Brahmin /Chhetri</td>
<td>7.89</td>
</tr>
<tr>
<td>Underprivileged groups</td>
<td>3.95</td>
</tr>
</tbody>
</table>
The distribution of addicts according to ethnic grouping is presented in figure no. 5 shows that the largest number of drug addicts 45 (59.29 per cent) are from Rai/Limbu groups, followed by Newar, Gurung/Magar/Tamang, Brahmin/Chhetri and underprivileged group. The drug addicts from Newar groups is 12 (15.79 per cent), which stood second position and 10 from Gurung/Magar/Tamang group which stood third position. The figure indicates that the problem of drug addiction has highly affected Rai-Limbu group. It has least affected Brahmin/Chhetri and underprivileged group.

Most of the research conducted in Kathmandu valley revealed that the majority of drug addicts is from Newar group. It is so, because Newar is predominant population in Kathmandu Valley. In same way majority of drug addicts in Dharan belongs to Rai/Limbu groups because Rai/Limbu is the pre-dominant population residing in Dharan. This findings also confines the finding reported by Khalil Ahmed (1999). According to his report, the problem of drug abuse is mainly wide-spread among Rai/Limbu and Magar/Gurung/Tamang community.

d) Distribution of Respondents by Religion
Religion is very important aspect of human's life. Religion, culture, tradition and society have strong influence to control human behaviour. In this study the respondents were divided into four religious groups and they are 1) Hindu, 2) Buddhist, 3) Christian, 4) Others.
Figure No. 6
Distribution of Respondents by Religion

- 85.53%
- 9.21%
- 5.26%

- Hindu
- Buddhist
- Christian
The figure no. 6 indicates that the highest percentage (85.53 per cent) of drug addicts are Hindu followed by Buddhist and Christian. In Nepal, 89.5 per cent people of the total population are Hindus (CBS 1981). So high percentage of drug addicts is also prevalent among Hindus which is natural.

In Hindu mythology, there has been the mention of various intoxicants like, 'Somras', 'Ganja' and 'Bhang'. The Hindu worship lord 'Shiva' who is described as a deity and very fond of Ganja and 'Dhatura'. It may be the reason why there is tradition among hindu to lake 'Ganja' and 'Bhang' on the day of Shivaratri. It indicates that the use of Ganja, Bhang are embedded in Hindu religion. The traditional use of 'Ganja' and 'Bhang' is not the threat but the real threat is the practice of abuse including hard drug like brown sugar and other synthetic drug by the young people.

e) Educational Status of the Respondents

Education is the main variable which changes he person's behaviour in every aspect of life. In this study, the educational level is categorized into
i) Primary Level (up to class 5)   ii) Lower Secondary and Secondary Level (Class 6 to 10) and   iii) Collage Level.
Figure No. 7
Education Status of the Respondents

☐ Primary level (up to class 5) ☐ Lower or Secondary level (6 to 10) ☐ Collage level
The data displayed at the figure no. 7 shows that all the respondents are literate. The majority of the respondents 65 (85.53 per cent) have attained secondary level educational and only 7 (9.21 per cent) have attained college level education. It indicates that chance of academic achievement is less after being hooked to drug. Some of them managed to complete school level but failed to pursue higher level of education at campus level because of their addiction.

Normally, the age of most student of class 5 onwards are 14, 15, and 16 years. In other words, they are teenagers and peer pressure is very influential at such age, which make them very prone to getting into drugs.

f) Employment Status of the Respondents

Unemployment and drug abuse can forge a particularly vicious circle. Some unemployed may turn to drug out of frustration or boredom and thereby risk compounding their marginalized status and jeopardizing their future employability. The following figure shows that employment status of the respondents.
Figure No. 8
Employment Status of Respondents

- 14.47% Unemployed
- 85.53% Employed
The above figure no. 8 showed that the higher number of respondents 65 (85.53 per cent) are unemployed. The figure indicates that the chance of getting into drug is less likely among employed youth than the unemployed youth. The previous research conducted in Kathmandu valley also showed that most of the drug addicts were unemployed. According to the Mayor of Dharan, about 75 per cent of people in the city are jobless. This status of unemployment seemed to be very destructive for the youth as many of them start taking drugs to pass the time and have fun.

g) Occupation of Respondent's Family by Ethnic/Caste Group

Respondents were asked about the occupational background of their parent. In this study, occupation is categorized into i) Army (British & Indian) ii) Civil servant iii) Farmer iv) Businessman and v) others.

Table No. 4

Occupation of Respondent's Parent by Ethnic/Caste Group

<table>
<thead>
<tr>
<th>S N</th>
<th>Occupation</th>
<th>Number of Respondents</th>
<th>Ethnic Grouping</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No</td>
<td>Percent</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Army (British/India)</td>
<td>35</td>
<td>46.05</td>
</tr>
<tr>
<td>2</td>
<td>Civil Servant</td>
<td>7</td>
<td>9.21</td>
</tr>
<tr>
<td>3</td>
<td>Farmer</td>
<td>10</td>
<td>13.16</td>
</tr>
<tr>
<td>4</td>
<td>Businessman</td>
<td>8</td>
<td>10.53</td>
</tr>
<tr>
<td>5</td>
<td>Others*</td>
<td>16</td>
<td>21.05</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>76</td>
<td>100.00</td>
</tr>
</tbody>
</table>

*Note: No Particular Jobholders.
The above data at table no. 4 displays that the highest number 35 (46.05 per cent) of respondents' parent have served in Army (British and Indian Army). Only 10 (13.16 per cent) of respondents father are farmer, 7 (9.21 per cent) of the respondents father are civil servant and 8 (10.53 per cent) of respondents' father are in business.

With regard to ethnic grouping, the highest number 30 (85.72 per cent) of Rai/Limbu are in Army followed by Gurung/Magar/Tamang. The other cast grouping like Newar, Brahmin, Chhetri and Under-privileged are not in army. It shows that drug addiction has chiefly affected Rai/Limbu, Tamang/Magar/Gurung community.

In the context of the occupation, most of Rai/Limbu are army. The original place of most of these social groups are hilly regions of the north-eastern Nepal. Mostly, the male members from these community go to abroad as member of British and Indian Army. This makes the economic situation of most of the families belonging to this communities improved drastically. Migration to the city like Dharan, Itahari is most common. The upliftment of the economic condition is the positive result but it leaves in its wake a socio-economic and cultural upheaval amongst these community. The lack of male member specially father in the family, lack of proper parental guidance, exposed to different cultures like migration from village to city and then to European and some developed Asian countries like Hong-Kong, Singapore in short span of time may result in cultural shock, easy availability of pocket money
and generation gap between parent and sibling are the disharmony in the life of these community, which may result in drug abuse.

4.1.2 Variables Related with Drug Addiction

The variables included in this heading is directly related to the use, mode and type of drugs uses, social relationship of drug addicts and the response of drug addicts regarding treatment. This heading includes the following sub heading.

a) Reasons for Drug Abuse by Respondents

Drug addiction is seen with contempt in society. Nevertheless a large number of people have been the victims of drug addiction. Each individual have their own reason for being drug addict. In this study, the respondents were asked about the reason for taking drugs.

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Reasons</th>
<th>Respondent of Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Out of Curiosity</td>
<td>10</td>
<td>13.16</td>
</tr>
<tr>
<td>2</td>
<td>Fun/enjoyment</td>
<td>12</td>
<td>15.79</td>
</tr>
<tr>
<td>3</td>
<td>Forget Problems</td>
<td>7</td>
<td>9.21</td>
</tr>
<tr>
<td>4</td>
<td>Remove tension/ anger/Frustration</td>
<td>4</td>
<td>5.26</td>
</tr>
<tr>
<td>5</td>
<td>Peer influence</td>
<td>35</td>
<td>46.05</td>
</tr>
<tr>
<td>6</td>
<td>Unemployment</td>
<td>6</td>
<td>7.89</td>
</tr>
<tr>
<td>7</td>
<td>Out of Boredom</td>
<td>2</td>
<td>2.63</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>76</td>
<td>100.00</td>
</tr>
</tbody>
</table>
The above data displays that the highest number of respondents 35 (46.05 per cent) take drug because of peer influence. Some 12 of them thought for enjoyment is the cause for initial drug use. The reason for taking drug out of curiosity was perceived by 10 (13.16 per cent) and 7 of them (9.21 per cent) take drug to forget problem. Unemployment as the reason of taking drug was perceived by 6 (7.89 per cent). The above table indicates that peer influence is the primary reason for taking drugs. Other reasons such as out of curiosity, for fun and enjoyment, out of Boredom, unemployment, remove tension/anger/frustration are also taken into consideration.

Previous research findings such as findings reported by Shrestha (1999) and Bhandari (1988) also revealed the peer influence is the main reason for drug use.

b) Duration of Drug use by Age Group

It is the established fact in drug field that the longer drug addicts are indulged in illicit drug use, it is more likely for them to be exposed to various undesirable situations like social marginalization, involvement in crime an anti-social activities, vulnerable to the diseases like AIDS, hepatitis B and other STD.
Table No. 6
Duration of Drug Use by Age - Group

<table>
<thead>
<tr>
<th>S. N</th>
<th>Duration (Year)</th>
<th>Respondent Number</th>
<th>Age Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>15-19</td>
<td>20-24</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No</td>
<td>Per cent</td>
</tr>
<tr>
<td>1.</td>
<td>Below one year</td>
<td>5</td>
<td>2</td>
<td>40.00</td>
</tr>
<tr>
<td>2.</td>
<td>1 - 2</td>
<td>15</td>
<td>5</td>
<td>33.33</td>
</tr>
<tr>
<td>3.</td>
<td>3 - 4</td>
<td>15</td>
<td>9</td>
<td>60.00</td>
</tr>
<tr>
<td>4.</td>
<td>5 - 6</td>
<td>22</td>
<td>5</td>
<td>22.72</td>
</tr>
<tr>
<td>5.</td>
<td>7 - 8</td>
<td>8</td>
<td>1</td>
<td>12.50</td>
</tr>
<tr>
<td>6.</td>
<td>8+</td>
<td>11</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>76</td>
<td>22</td>
<td>28.95</td>
</tr>
</tbody>
</table>

According to the table, the highest number of respondents which is 22 (28.94 per cent) have been taking drugs since 5 - 6 years. And out of those 22 respondents, 12 of them belongs to (20 - 24) years age group, 5 of them belong to (15 - 19) years age group.

The number of respondents are equally distributed for the duration of drug use (1 - 2) years and (3 - 4) years. Out of 15 respondent who have been taking drugs for (3- 4) years, 9 of them belongs to (15. - 19) years groups and 4 of them belong to (20 - 24) years age group.

Out of 11 respondents who have been taking drugs for more than 8 years, 5 of them belong to (25 - 29) years age group and another 5, respondents belong to age group 29 years and above.
Out of 5 respondents who have been taking drugs for less than one year, 2 of them belong to the age group (15 - 19) years and another 2 respondents belong to age group (20 - 24) years.

Overall, the table indicates that the drug addiction is highly prevalence in the (15 - 24) years old group and they have been taking drug for the last 3 - 6 years.

c) Number of Drugs Used by Respondents

Multiple drug use is emerging as a new trend in drug use pattern. Different drug are used either at the same time or consecutively or haphazardly as dictated by whim, ability and market forces. The following tables shows the number of drugs used by respondents.

Table No. 7(a)
Number of Drugs Used by Respondents

<table>
<thead>
<tr>
<th>Users by number of drugs use</th>
<th>No of respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mono Drugs user</td>
<td>6</td>
<td>7.89</td>
</tr>
<tr>
<td>Poly drugs user</td>
<td>70</td>
<td>92.11</td>
</tr>
<tr>
<td>Total</td>
<td>70</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Above table shows that very few respondents 6 (7.89 per cent) consume one drug. The number of respondents 70 (92.11 per cent) consume more than one drugs. It shows that the majority of drug addict use more than one drugs or they are poly drug user. The following table shows the number of drugs consumed by poly drug users.
Table No. 7(b)
Number of Drugs Used by Poly Drug Users

<table>
<thead>
<tr>
<th>Number of drugs used by poly drugs users</th>
<th>No of respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two drugs</td>
<td>13</td>
<td>18.57</td>
</tr>
<tr>
<td>Three drugs</td>
<td>22</td>
<td>31.43</td>
</tr>
<tr>
<td>Four drugs</td>
<td>15</td>
<td>21.43</td>
</tr>
<tr>
<td>More than five drugs</td>
<td>20</td>
<td>28.57</td>
</tr>
<tr>
<td>Total</td>
<td>70</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The above table indicates that amongst poly drug users, 22 (31.43 per cent) of them out of 70 consume three drugs. 20 (28.57 per cent) consume more than five drugs. 15 (21.43 per cent) of them consume four drugs and 13 (18.57 per cent) of them consume two drugs. It is mentioned in the World Drug Report that users in the most risk prone category often compound the consequences of ecstasy use by mixing it with other drugs or with alcohol and these cocktail with unknown adulterants have potentially devastating effects which the consumer cannot possibly predict.

d) Frequency of Drugs Used by the Age Groups of the Respondents

In this study, the respondents, were asked to name the drugs used by them. The following table presents the frequencies of drugs used in each age grouping.
Table No. 8
Frequency of Drugs Used by Age Group

<table>
<thead>
<tr>
<th>S. N.</th>
<th>Age grouping</th>
<th>Number of respondent in each age grouping</th>
<th>Names of the drugs used</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>15 - 19</td>
<td>22</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>2.</td>
<td>20 - 24</td>
<td>27</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>27</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>23</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>3.</td>
<td>25 - 29</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>4.</td>
<td>29 and above</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>76</td>
<td></td>
</tr>
</tbody>
</table>

Above table shows the trend of multi drug use. The consumer of tedigesic, nitrazepam and Ganja user is higher than proxyvan and brown sugar user in all age group.

Nitrazepam is consumed by 20 out of 22 in (15 - 19) age grouping followed by Ganja and Proxyvan.

Nitrazepam is consumed by 27 out of 27 in (20 - 24) age grouping followed by tedigesic and phencidyl.

Tedigesic is consumed by 15 out of 16 in the age - group (25 - 29) followed by nitrazepam and phencidyl.

Tedigesic is consumed by 8 out of 11 in the 29 and above years respondents followed by nitrazepam and phencidyl and Ganja.
Majority of the respondents consumes nitrazepam in all age group and tedigesic is consumed highly by the respondents belonging to the age group 25 years and above.

Proxyvan and Ganja is highly consumed in the age group 15 - 24 years than in the age group 25 years and above.

e) Mode of Drugs use by Respondents

Since the drug addicts are experimenting with more and new substance, they also employ greater variety of method in taking them. In this study, the mode of drug use were categorized as i) Oral only ii) injection only iii) smoking only iv) Injection + oral v) injection + oral + smoking v) Oral + smoking.

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Mode of drug use</th>
<th>Respondent Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Oral only</td>
<td>14</td>
<td>18.42</td>
</tr>
<tr>
<td>2.</td>
<td>Injection only</td>
<td>6</td>
<td>7.89</td>
</tr>
<tr>
<td>3.</td>
<td>Smoking</td>
<td>1</td>
<td>1.32</td>
</tr>
<tr>
<td>4.</td>
<td>Injection + oral</td>
<td>33</td>
<td>43.42</td>
</tr>
<tr>
<td>5.</td>
<td>Injection + oral + Smoking</td>
<td>21</td>
<td>27.63</td>
</tr>
<tr>
<td>6.</td>
<td>Oral + Smoking</td>
<td>1</td>
<td>1.32</td>
</tr>
</tbody>
</table>

| Total | 76                | 100.00             |

The data presented in table shows that more than half of the respondents administer drug by more than one way.
According to this table, majority of the respondents 33 (43.42 per cent) takes drug through both intravenously and orally. About 21 (27.63 per cent) of them use drug through orally, smoking and intravenously. Some 14 (18.42 per cent) of them take drug through oral administration.

f) Syringe use practice of respondents

While illicit drug use in any form can be associated with harmful consequences, drug injection is considered the most dangerous method of administration. It is because the association between drug injection and HIV transmission. Most of the studies have shown that sharing needles among the group is common practice among injecting drug users. The use of blood contaminated injecting equipment by which the virus is injected directly into the blood or body tissue may carry higher risk of disease like HIV/AIDS. Thus this HIV/AIDS has added a new dimension to the risk of drug taking.

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Syringe use practice</th>
<th>Respondent Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Always use new syringe</td>
<td>23</td>
<td>38.33</td>
</tr>
<tr>
<td>2.</td>
<td>Reuse own syringe number of times</td>
<td>18</td>
<td>30.00</td>
</tr>
<tr>
<td>3.</td>
<td>Share syringe in group</td>
<td>19</td>
<td>31.67</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>60</td>
<td>100.00</td>
</tr>
</tbody>
</table>

According to data in table, the highest number of respondents 23 (38.33 per cent) always use new syringe. Some 19 (31.67 per cent) of them share
syringe in group and 18 (30.00 per cent) of them reuse their own syringe number of time.

Above table shows that around one-third of the total respondents expose themselves to high risks by sharing needles.

g) Social Relationship and the Response of Drug Addict Regarding Treatment.

Use of drugs is considered as illicit activity and the family and community have negative attitudes towards drug addicts. Following question were asked to measure the social relationship and their response about treatment.

Table No. 11
Responses of Respondents Regarding Social Relationship and Treatment

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Questions</th>
<th>Respondent Number</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes (Per cent)</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Do your family members know you as drug addicts?</td>
<td>80.26</td>
<td>100.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No (Per cent)</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Do you think your family can help you making free of addiction?</td>
<td>88.16</td>
<td>100.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Have you ever thought of going for treatment?</td>
<td>78.95</td>
<td>100.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Do you know anybody who got treatment?</td>
<td>81.58</td>
<td>100.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Was the treatment successful?</td>
<td>33.87</td>
<td>100.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1. Regarding the question, "Do your family member know you as drug addicts, the highest number 88.26 per cent of respondents gave positive response and some 19.74 per cent gave negative answers. It shows that the majority of the family of drug addict know about his addiction and only few of the addict's family are unknown about his addiction.

2. Also the table indicates that 88.16 per cent of respondents agreed that their family can help to make free of addiction and some 11.84 per cent of respondents showed their disagreement.

3. It is found that 78.95 per cent of respondents favoured the treatment while 21.05 per cent of respondents do not favoured treatment. It means that the majority of the respondents want to go for treatment to quite drug.

4. It is revealed that the highest number of respondents (81.58 per cent) know the persons who have gone for treatment and some 18.42 per cent of respondents haven't known any such person.

5. The table also indicate that 66.13 per cent of respondents claimed that the treatment was not successful and only 33.87 per cent claimed the treatment was successful. It indicates high number of failure of treatment.

h) Reasons for the Failure of Treatment

The following table presents the respondents' opinion on the reasons for the failure of treatment.
Table No. 12
Reasons for the Failure of Treatment

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Reasons for the Failure of Treatment</th>
<th>Respondent Number</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Lack of will power</td>
<td>10</td>
<td>24.39</td>
</tr>
<tr>
<td>2.</td>
<td>Same environment and peer group</td>
<td>16</td>
<td>39.02</td>
</tr>
<tr>
<td>3.</td>
<td>Unemployment</td>
<td>4</td>
<td>9.75</td>
</tr>
<tr>
<td>4.</td>
<td>Continued distrust from society and family</td>
<td>2</td>
<td>4.89</td>
</tr>
<tr>
<td>5.</td>
<td>Due to family misbehaviour</td>
<td>7</td>
<td>17.07</td>
</tr>
<tr>
<td>6.</td>
<td>Treatment was not complete</td>
<td>1</td>
<td>2.44</td>
</tr>
<tr>
<td>7.</td>
<td>Don't know</td>
<td>1</td>
<td>2.44</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>41</td>
<td>100.00</td>
</tr>
</tbody>
</table>

According to the data on the above table, the highest number of respondents 16 (39.02 per cent) think that the reason behind the failure of treatment is involvement with the same friends and environment through which he has originally trapped in drug addiction. It indicates that the recovering addicts who has just come out from treatment centre should avoid, as far as possible, the same peer group and environment.

Some 10 (24.39 per cent) of them think that the lack of will power on the part of drug addict is the reason behind unsuccessful treatment.

Some 7 (17.07 per cent) of them think the family behaviour towards drug addict is the reason behind the failure of treatment and 4 (9.75 per cent) of them stated unemployment as the reasons for unsuccessful treatment.
and some 2 (4.89 per cent) said that continued distrust from family and society is the reason behind the failure of treatment. Only 1 (2.44 per cent) of them reported that the treatment was not successful because treatment was not completed by drug addict.

4.2 Achievement of Punarjivan Kendra in the Year 1999, 2000 and 2001

The analysis has been done on the basis of the objectivewise activities, its target and achievement in three consecutive year 1999, 2000 and 2001. The data was obtained from the annual report of PJK in the year 1999, 2000 and 2001 respectively. The following are the objectives of Punarjivan Kendra.

1. To Provide treatment and rehabilitation facility to drugs addicts.
2. To conduct awareness programme on drugs and HIV/AIDS
3. To conduct harm reduction programme in order to prevent HIV/AIDS among drug user.
4. To conduct training and research programme.

4.2.1 Treatment and Rehabilitation Programme of PJK

Treatment and rehabilitation programme is one of the major programme of Punarjivan Kendra. The following table present the number of clients admitted in the centre for treatment.
Table No. 13
Treatment and Rehabilitation Programme of PJK

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of clients admitted</th>
<th>Under treatment (per cent)</th>
<th>Self discharge (per cent)</th>
<th>Refer to Mental hospital (per cent)</th>
<th>Negative discharge (per cent)</th>
<th>Rehabilitated (per cent)</th>
<th>Detoxified (per cent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>28</td>
<td>43.00</td>
<td>10.00</td>
<td>7.00</td>
<td>18.00</td>
<td>22.00</td>
<td>100.00</td>
</tr>
<tr>
<td>2000</td>
<td>27</td>
<td>34.00</td>
<td>11.00</td>
<td>44.00</td>
<td>100.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>24</td>
<td>25.00</td>
<td>-</td>
<td>33.34</td>
<td>41.66</td>
<td>100.00</td>
<td></td>
</tr>
</tbody>
</table>

According to the above table, 28 clients were admitted in the year 1999. Out of them, the entire clients (100 per cent) were detoxified and 22 per cent were rehabilitated.

The number of clients admitted in the year 2000 were 27. Out of them all of them were detoxified and 44 per cent of them were rehabilitated.

In the year 2001, 24 clients were admitted and 100 per cent of them were detoxified and 41.66 per cent of them were rehabilitated.

Rehabilitation is very complex process and it involves reintegration of drug addicts with family and society remaining free of drug abuse. The relapse incidence is high in drug addiction. But the above table shows that as each passing year, the per cent of rehabilitated clients has been increased.
4.2.2 Public Awareness Programme of Punarjivan Kendra

Public awareness programme is the primary strategy of demand reduction. Public awareness programme is one of the major objective of Punarjivan Kendra. Various activities are carried out under this programme like student classes, teacher training, community meeting and door to door campaign in order to raise awareness on drugs and HIV/AIDS to different group like student, parents, and other at-risk group in the community. The activities are either school based or community based.

Both private and government schools are included in this programme. Mainly, the students of class 8 and 9 are the target of this programme because they are more vulnerable to the perceived attraction of drug taking. In the students classes, they are given information on drugs, dangers associated with drugs, how drugs affects the body and mind and its relation to the problem of HIV/AIDS. At the parent meeting, parents are given education on drugs, parent education on treating the youth and coping with drug problem. PJK has conducted public awareness programme with the support from M-S Nepal and Drug Abuse and Demand Reduction Project (DADRP). The following table shows the activities carried out under public awareness programme.
Table No. 14
Public Awareness Programme of Punarjivan Kendra

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1999</td>
</tr>
<tr>
<td></td>
<td>Target</td>
<td>Achievement</td>
</tr>
<tr>
<td>To conduct public awareness on drugs and HIV/AIDS</td>
<td>Student Class</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Parent Meeting</td>
<td>-</td>
</tr>
</tbody>
</table>

According to the table, the activities carried out under public awareness programme are a) Student Class and b) Parent Meeting.

According to the annual reports of PJK in the year 1999, it was first time ever that PJK has conducted any programme out from Dharan. Public awareness programme was conducted in Damak. Damak is another drug affected city in the eastern part of Nepal. The students of class 8 and 9 and other groups at the community were made target of this programme. It was estimated that about 1600 students and 60 families were benefited by that programme.

In the year 2000, the target was set to educate 40 students from Dharan but 44 students got education on drug and HIV/AIDS. The students from Inaruwa were included along with students of Dharan in the year 2000.
In the years 2001, altogether 300 students were made target but 305 students were involved.
With regard to parent meeting, the target was set to gather 1000 parent in the year 2000. Altogether 1450 parents were gathered and participated in the programme of PJK. Likewise, PJK has set the target to participate 150 parents in 2001, but 1250 parents participated. The number of the participation of the parents was high because the programme of M-S Nepal and DADRP was included in that programme.

Over all, the activities were successfully accomplished. The number of students and parent's participation in the public awareness programme of Punarjivan Kendra indicates that the activities of PJK has been positively received by the community. It is important that awareness on drugs and HIV/AIDS on different levels and with different target groups is to be properly implemented as it normally leads to some prevention. Only treatment of drug abuser successfully is not the solution.

4.2.3 Harm Reduction Programme of PJK

Harm reduction process still draw controversy in many parts of the world. The activities carried out under harm reduction programme is the syringe/needle exchange scheme and preventive material distribution. In other world, syringe/needle is distributed free of cost to the abuser in exchange of used one. As mentioned in World Drug Report (1997), the evaluation of Harm Reduction Programme have met with favour tinged with caution. It has been started with the aim of reducing HIV/AIDS risks associated with injection. Thus in some countries, Needle/Syringe Exchange Services have increasingly gain acceptability in prevention
programmes in the attempt to stem the spread of blood-borne diseases among injecting drug users. But objectives have been raised on the ground that syringe/needle exchange may actively encourage drug user to inject or to inject more frequently, or that at the very least they do not discourage injection.

Lifesaving and Lifegiving Society (LALS), one of the non-governmental organization has been operating the syringe exchange programme and preventive material distribution (condom, bleach, sterile water) for the drug addicts of Kathmandu and Lalitpur since the ninety's. The LAL's volunteer/outreach workers visit a few of the sixty four designated sports around the city from Monday to Friday, exchanging used syringes and Needles for the new ones. The volunteer/outreach workers comprised of two groups of people, of at least three backgrounds: one person with some social background for interaction and promotion, a medical person to address the medical problems and provide counselling to the addicts and ex-addicts. LALS believed that their project is for veteran drug addicts who cannot give up their habit at once. It is not encouragement on the part of project to take drugs, it just developed safer practice if they have to take it.

PJK has started Harm Reduction Programme with the financial support from Save the Children US and technical support from LALS in the beginning. In the later year, PJK has given continuity to this programme and now, it has become one of the major activities of PJK. PJK has not yet operate syringe/exchange scheme, but other activities, like DU's and IDU's contact in the street, education on safe injecting practice, STD,
HIV/AIDS and condom use, counselling, primary health services (treatment and care of abscesses) are carried out under harm reduction programme. The outreach workers routinely visit different spots of Dharan and provide their outreach services. PJK has conducted harm reduction programme with the support from National Centre for AIDS and STD control unit, Teku and District AIDS Co-ordination Committee, Sunsari. The following table presents the activities and its achievement in harm reduction programme in the year 1999, 2000 and 2001.

Table No. 15
Harm Reduction Programme

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activities</th>
<th>Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Target</td>
<td>Achieve ment</td>
<td>Target</td>
</tr>
<tr>
<td>To prevent HIV/AIDS among injecting drug users (Harm Reduction Programme)</td>
<td>DUs and IDUs contact in the street</td>
<td>-</td>
<td>770</td>
<td>1000</td>
<td>1175</td>
</tr>
<tr>
<td></td>
<td>Annonymous Counselling</td>
<td>-</td>
<td>251</td>
<td>400</td>
<td>435</td>
</tr>
<tr>
<td></td>
<td>- Detox Counselling</td>
<td>-</td>
<td>208</td>
<td>50</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>- Pre-post antibody test Counselling</td>
<td>-</td>
<td>301</td>
<td>400</td>
<td>475</td>
</tr>
<tr>
<td></td>
<td>Preventive material distribution</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>- *Condom</td>
<td>-</td>
<td>5968</td>
<td>5000</td>
<td>5201</td>
</tr>
<tr>
<td></td>
<td>- **Bleach</td>
<td>-</td>
<td>1651</td>
<td>3500</td>
<td>3600</td>
</tr>
<tr>
<td></td>
<td>- Sterilized Water</td>
<td>-</td>
<td>3302</td>
<td>7000</td>
<td>7200</td>
</tr>
<tr>
<td></td>
<td>PHC Service</td>
<td>-</td>
<td>270</td>
<td>500</td>
<td>579</td>
</tr>
</tbody>
</table>

Note: *Condom by piece
**Bleach and Sterilized water by bottle.
The above table indicates that the number of DUs and IDUs contact in the street has been increased. In the year 1999, 2000 and 2001 the number of outreach service holders are 770, 1175 and 1051 respectively.

Anonymous counselling is given under three categories. These are i) Detox Counselling ii) Pre-post antibody test counselling and iii) Family Counselling. Detox and Pre-post antibody test counselling is provided to drug addicts.

Detox - Counselling was provided to 251 drug addicts in 1999. 400 drug addicts were made target in the year 2000 and 2001, but it was provided to 435 and 398 IDUs in 2000 and 2001 respectively.

The number of drug addicts who got pre-post antibody test counselling were 208, 51 and 7 in 1999, 2000 and 2001 respectively. The target was same i.e. 50 in both year 2000 and 2001. In the year 1999, 2000 and 2001, family counselling was provided to 301, 475 and 406 family in the community. The target was 400 in both 2000 and 2001.

Preventive materials such as condom, bleach an sterilized water was distributed to drug addicts in order to change their risk behaviour. PJK has distributed 5968, 5201 and 5007 condom in the year 1999, 2000 and 2001 respectively. Condoms were also given to general public. The target was to distribute 5000 condoms in both years 2000 and 2001.
Likewise, 1651, 3600 and 3504 bottles of bleach was distributed to drug addicts in the year 1999, 2000 and 2001. The target was to distribute 3600 bottles in the year 2000 and 2001.

Sterilized water was also distributed to drug addicts. Altogether 3302 bottles of sterilize water was distributed in 1999. Though the target was to distribute 7000 bottles of sterilized water in the year 2000 and 2001, but 7200 and 7008 bottles were distributed in the year 2000 and 2001.

In primary Health Care Service, general health services like treatment and care of abscesses are taken care of in order to maintain their immediate health needs. PHC was provided to 270, 579 and 513 drug users in the year 1999, 2000 and 2001. The target was 500 in the year 2000 and 2001.

From the above table it indicates that many drug addicts have been benefited by this programme as the number of outreach service holders have been increased in each consecutive year. Actually, outreach services has been playing an important role in establishing ‘contact and prevention strategy’. Not all drugs addicts could come for or could afford residential treatment. Only small segment of drug addicts have come for treatment and even then rehabilitated clients is low. The outreach worker of PJK literally 'reach out' to individual or group in their own setting and provide numerous types of services who otherwise might not come forward to ask for help such as people in marginal situations, youth at risk, family. Thus outreach service provides the general platform for early intervention of the problem.
Beside these, Harm Reduction Programme can be viewed as drug component of AIDS prevention programme. The activities under Harm Reduction Programme has literally discouraged unsafe drug use and unsafe sexual practice and persuade those who continue to inject to adopt range of measures by indicating alternatives to the current risk behaviour.

4.3 Information Collected From Key Informants

Due to various constraint, the researcher could not interview all the NGO's personnel and governmental agencies, and all peer educators. The names of the personnel from local NGO and governmental agency and peer educator was recommended by programme manager of PJK. Thereafter, they were personally contacted by researcher for interview. Each of them were interviewed in their own office.

The interview was focused on the topics like the causation of drug addiction in Dharan, their liaison with Punarjivan Kendra, their involvement with the activities of PJK, and their views on prevention and rehabilitation programme of PJK.

4.3.1 Response of Mr. Naraprasad Limbu, Executive Co-ordinator of UPCA (Underrivileged Children Association)

UPCA is one of the local non-governmental organization in Dharan. It was established in the year 1993, and has been working since then for underprivileged children in Dharan, Itahari. Mr. Narprasad Limbu, Executive Co-Ordinator of UPCA has been involved with this
organization from the beginning. He is permanent inhabitant of Dharan. So he is very much concerned about the present drug addiction problem in Dharan.

The causation of drug addiction in Dharan according to him, is very much embedded with the socio-cultural aspect of the community in Dharan. He stated that most of the male members (father) work abroad in British army or industrial worker in countries like Hong Kong, Singapore, Malaysia and United Kingdom. This makes the family economically well off. The children are brought up by mother. ‘The children brought up by mother lack confidence, and they have lack of leadership and decision making power.’ This is the statement given by him. They are provided more pocket money and mothers are unaware of the activities of the children. Then, at such situation, they may be attracted to drug. He further mentioned that they start to take drug from the age of 13 - 14 years. Most of them hooked to drug from class nine onwards.

During the interview, he mentioned that UPCA and PJK share a very cordial relationship. UPCA is one of the member of management committee of PJK and has been paying Rs 5000/- annually as a membership fees. Especially, it provides human resources to PJK by providing training to the staff of PJK and also provide assistance in updating their financial report. Beside this, UPCA has always done advocacy of PJK at the local, regional, national and international level.

He further mentioned that UPCA has been involved in drug education, programme of PJK by providing assistance in running student classes.
Mr. Limbu also expressed his viewpoint on the programme of PJK. ‘I am very much impressed by drug education programme in schools. Because students of class 7, 8 and 9 are high risk groups.’ This preventive measures may stop the new recruitment of drug addicts. In his viewpoint counselling may be very helpful for those who are already hooked to drug addiction.

4.3.2 Response of Mr. Sunil Nepal, Youth Development Officer, Dharan Municipality

As being youth development officer in Dharan Municipality, Mr. Nepal is very much involved with Punarjivan Kendra in all its programme. He is also involved with Drug Abuse Resistance Education (DARE).

According to him, the causation of drug addiction in Dharan, in some extent is to be blamed on the social structure of Dharan. Fathers being away from home, children are mostly brought up by single parent, lack of parental guidance, sufficient money provided at small age are the reasons behind the youth of Dharan attracted to drugs. He also blamed on the present education system, which is unproductive and also the state of unemployment amongst youth. The prevalence of drug addiction start from the age of 13 - 19 and the students of class 8 and 9 are more involved in drug addiction.

He mentioned that Dharan Municipality as local government, provide PJK with financial, technical and moral support in every way possible.
Municipality has provided land to construct their own treatment and rehabilitation building. Until now, Municipality has been paying rent for of PJK.

With regards to the involvements with PJK, he stated that municipality has been involved with PJK in drug demand reduction. Municipality has provided support to PJK in anti-drug awareness campaign, school drug programme in which essay, drawing competition in drug themes were organized and community activities like music competition was held at International Drug day 1999. Recently, Municipality has provided N.A (Narcotic Anonymous) and A.A. (Alcoholics Anonymous) information to PJK.

Mr. Nepal expressed his viewpoint that treatment along with follow-up and N.A. has been very effective for long term success of treatment. He further mentioned that preventive measures should be emphasized.

4.3.3 Peer Educator (Ex-addict)

Former drug addicts are trained to provide peer education. They are provided training by PJK where they serve as volunteer.

The researcher met peer educator Mr. S. at Punarjivan Kendra. The interview was held at the office room of programme manager. He has been just out of residential treatment programme and in follow-up phase. He is also one of the active member of N.A. group. Being drug addict himself, he shared most of his own experiences.
According to him, the reason behind prevalence of drug addiction in young people is due to strong peer influence. ‘I am from economically well of Marwari family but I started to take drug because of my friends.’ This is his statement. The initiation of drug taking starts from class 7 - 8.

He mentioned that he is involved with various programmes of PJK. He provides peer education class to the residential clients and offer them comfort after their detoxification period. ‘Drug addicts need assistance not suggestion’. This is his statement. In peer education class he tells other drug addicts how to be safe from drugs, how to cope with stress. He have several tips for them like not to go out with same circle of friends, least expectation from oneself and others. During such session, he explained them some of his own experiences or whatever he has gained from training.

He is very positive about the prevention and rehabilitation programme of PJK. ‘Take me as example. I was a hardcore drug addict. My family even got me married to keep away from drug. But I have changed after I got treatment from here. I want to help other drug addicts by being peer educator.’ In his viewpoint, counselling and group dynamics is very effective within the centre. And after discharge from treatment centre, follow-up and N.A. is very effective for maintaining drug free state.

The above interview on different key informants provides detail informations about the various programmes of PJK. Above all, they seemed satisfied by the prevention and rehabilitation programme of PJK. In spite of various difficulties and shortcomings such as lack of adequate
financial sources, lack of human resources etc, it has been running various programme. Now drug addicts can choose to be in the hands of professional group of people to come out of drug addiction rather than untimely death.

It is revealed from the interviews that the cumulative effect of several causes is associated with growing number of drugs addicts in Dharan. The major factors seemed to be a socio-economic and cultural conflict, which brings about several emotional problems to the families. There is no job opportunity in Dharan and no adequate recreation activities such as sport club, library to spend time in constructive way. In such condition, youth are easily attracted to drug by their friends in the name of entertainment, fun and time pass.

It also indicates that Punarjivan Kendra shares cordial relationship with other NGO and government body. There is good networking within PJK, other NGOs and Dharan Municipality.

4.4 Case Study of the Residential Clients of Punarjivan Kendra (PJK)

As the part of the qualitative research, case study was conducted with residential client of PJK. Though no outsider is allowed to talk directly with the residential clients. But, after convincing Mr. Bijay Limbu, Programme Manager of PJK, the researcher was allowed to meet one of clients. The selection was done by programme manager and the consent from respondent was taken by him.
RJ (not real name) was selected amongst the residential clients by the programme manager of PJK as respondent for case study because despite coming from stable and middle class family background, he became chronic drug addict. He is also HIV positive. After his HIV positive phase, he has chosen treatment to remain free of drug abuse in order to lead normal and peaceful life.

At the first meeting time, programme manager introduced him to the researcher. Thereafter, the researcher was allowed to meet him as per the requirements. The researcher held several informal conversation and meeting with the client. The researcher also made several queries about him with the other staff personal of PJK. The researcher had made standardized set of questions to use and fall back on, if need be but the researcher hoped that the interview would take its own course. So there are mentioned conversational tone sometime, which may reflect verbal communication more than the written word. The following characteristics of client were considered in the course of case study:

a) Basic Family Background

RJ is 30 years old man. He belongs to middle class family from Bhadrapur. His father works in District Administration Office at Bhadrapur and his elder brother is lawyer. He is third child in the family. He used to live with his parent before coming at Punarjivan Kendra (PJK.)

He changed many schools during his schooling years. He studied up to class three at Therathum and then he came to Dharan and studied there up
to class nine and again went to Chandragari. He finished S.L.C from Chandragari school. He studied up to I. Com. Thereafter, he could not continue his study because of drug addiction. He worked as contractor after he dropped out of collage.

b) Drug Experience

When he was studying at class seven, he used to smoke cigarette and occasionally drink alcohol with friends. His 'mama' (mother's brother) used to run pharmacy. When he was studying at class eight, he and mama's son both started taking phencidyl ('P' - code word). This lasted for two years. He became habitual to drug by then. When phencidyl was banned in market, he then, turned to corex. He also used nitrazepam tablets, to have 'high trip'. When he was at Chandragari, he used to go to Galgalia (Indian border city) to buy drug, especially tedigesic ('td' - code word) with his friends. Tedigesic is banned in Nepal. Now, he has turned to 'fix' tedigesic for trip. He was also using nitrazepam tablet side by side. After many months of tedigesic using, he again turned to another drug, now this time, more expensive and hard drug, brown sugar. He 'pull' brown sugar at the beginning but after months later, he started to 'fix' brown sugar. Then again, he started to 'fix' tedigesic and nitrazepam as a substitute, just to kill sick of brown sugar. But his choice of drug is brown sugar.

There are two reasons for using variety of drugs and method of administration of drugs. First one is: he has developed high tolerance to drug and second one is: money problem. At first, one bottle of 'P' and one nitrazepam tablet could give him enough 'trip' that last for a day. But
later on, even 5 to 6 tablets nitrazepam was insufficient to give him 'trip'. So he switched to tedigesic. At the beginning, small quantities of tedigesic was enough to give him trip for a day but gradually his intake of tedigesic increased. He then started to 'fix' tedigesic, sometimes 7 to 8 bottles. In this way, the same drug of which small quantity was enough become insufficient and the drug addicts have to either increase the dose or switch to another drug or change the mode of taking drug. So the same drug addicts who have started with 'P' end up with taking brown sugar, which is expensive than other drugs. At first, he used to 'pull' brown sugar and one quarter of it was enough. But later on, his dose and frequency of taking brown sugar also increased. Then he switched to 'fix' brown sugar. 'Fixing' has one benefited i.e. it needs small quantity of 'drug' but the trip is more. So, economically, 'fixing' is cheaper than 'pulling'. But even after 'fixing' brown sugar, the dose and frequency increased to maximum, he could no longer afford brown sugar, so he switched back to nitrazepam and tedigesic.

At this stage, his life has become totally disorganized. Being an addict, he could not do his contractor job well. So he began to feel money problem. He used to ask money from every body in his family. He even started to steal money and household goods from home. So his family lost faith on him. Because of money problem, he could not continue 'fixing' brown sugar so he switched again to tedigesic and nitrazepam. But at that time, he used to fix eight bottles (16 ampule) tedigesic at a single 'shoot'. He has now turned into chronic drug addict.

He thinks the reasons for taking drug is 'himself' because he himself choose to be with 'bad company' and starts taking drug with them.
c) Risk Taking Behaviours

He knows about the transmission of STD and HIV/AIDS. But still, he used to share syringe with group, 8 to 10 in numbers. When he is alone, he used a single syringe 3 to 4 time. After every use, he used to clean syringe either with water or spit. He also used to go to red light area (brothel) for sexual activity. Along with this, he was also involved in such activity with his girlfriend. He never used condom with his girlfriend but he used condom with sex workers. But once or twice, he didn't use condom with sex workers because he was heavily 'trip' at that time.

d) Treatment and Relapse Episode

He went to Aashara Sudhar Kendra at Kathmandu for treatment three years back. His family suggested him to go there. But his thirst for drug has not quenched fully. So he used to think at that time, ‘I will use drug after I get discharge from here’ and he did exactly the same. He stayed there for one month only, got himself out without completing the session. He came back to Dharan and resumed his drug taking habit again and also involved in sexual activity.

When he tests his blood at Bhadrapur, he found to have HIV positive. He then again tests his blood at Siliguri for conformation, the result was same. He believed that he got it from his sexual activity with sex worker.

e) Post HIV Positive Period

When he knew about his disease, he became out of control. He used to think ‘I will die soon, so I will die taking drugs’. So he used to take heavy dose of brown sugar, even 10 to 15 gram a day. He even fainted out of
overdose but luckily he survived. One day his cousin came to visit him who was also drug addict and infected with HIV positive. He advised him not to loss hope. He told him ‘we have given our family enough trouble but from now on, we should stop it’.

After that, he decided to quit drug. He tried to do that at home. But he felt sick for one week. So his family took him to hospital and then to Freedom Centre, one of the treatment centre at Kathmandu. There was no vacancy at that him. So his family brought him at Punarjivan Kendra and the rest is history now.

f) Current Situation

He is very happy being at centre. He is now very optimistic about his life. He is now free from drug for the last 5 months back. And most important things is that, it is not out of obligation to the rule of centre but he himself want to be free of drug because he wants to be good son to his parent and leads a normal life, giving them loads of happiness. During his stay at centre, he even went outing for three times and meets the same groups of friends but he did not feel the craving for drug. He even gained 10 kg of his body weight.

He is thinking of getting discharge from centre soon. His family’s constant support and his willingness to accept the treatment and his desire to give his family happiness have certainly help him towards successful rehabilitation.

This case study revealed a brief life history of the client: the family background, the childhood, drug experiences, risk taking factors such as
drug taking pattern and sexual activity, treatment and relapse episode, post HIV positive period to current situation. This life history portrays general picture of drug addicts life, yet it is different from others in many ways. He comes from stable middle class family and he has studied up to I. Com. (college level). He decided to quit drug after he got HIV positive. Generally, it is difficult to get rid of drug without the supervision of professional groups of people. But family support and own motivation of the part of drug addict is also important for drug free status.

4.5 Findings

The following major findings were drawn after analysing and interpreting the data.

4.5.1 Socio-Demographic Characteristics

a) Most of the drug addict were young and unmarried male. Majority of them are from 20 - 24 years age group. And the second highest age group belong to 15 - 19 years.

b) Majority of drug addicts are from Rai/Limbu group, which is 59.21 per cent. The second highest from Newar group (15.79 per cent) followed by Gurung/Magar/Tamang group (13.16 per cent). There are also drug users from the Brahmin/Chhetri and underprivileged caste.

c) The prevalence of drug addicts is higher among Hindu religion than other religion like Buddhist and Christian.

d) All the respondent are literate. Of the literate, majority have educational attainment of secondary level (85.53 per cent). The
educational attainment of primary and college level is negligible with that of secondary level.

e) Majority of drug addicts are unemployed (85.53 per cent). The prevalence of drug addiction is about 6 times higher amongst unemployed youth than that of employed (14.47 per cent).

f) Majority of respondents' father occupation is British/Indian army (46.05 per cent). With regards to ethnic grouping, only Rai/Limbu and Magar/Tamang/Gurung are British or Indian army. As for respondent having the family involved in occupation like civil servant, farmer, businessman, the frequency is less than that of British and Indian army.

4.5.2 Variables Related with Drug Addiction

a) Friends were the main sources of introducing the respondents to drug use. Peer influence is the primary reason behind drug addiction (46.05 per cent). The other reason out of curiosity, for fun and enjoyment, unemployment are also the reason taken into consideration.

b) The frequency of respondent is high (28.94 per cent) for those who have been using drugs for the last 5-6 years. Out of 22 of them, 54.55 per cent belong to age group (22 - 24) years, 22.72 per cent belong to age group (15 - 19) years, 13.64 per cent belong to age group (25 - 29) years and 9.99 per cent belong to age group (29 and above year).

c) Multiple drug use is common among the respondents. Almost 92.11 per cent are using more than one drug. The most used drugs
amongst respondents are nitrazepam, tedigesic and phencidyl and Ganja.

d) With regards to age grouping with the use of different types of drugs, nitrazepam, phencidyl and Ganja is much used in the age group (15 - 19) years than tedigesic. Tedigesic is much used in age group (20 - 29 and above years) along with other drug like nitrazepam, phencidyl. This indicated the transition from oral to intravenous use with increasing age. Brown sugar is least consumed in all age group.

e) Substantial proportion of respondents are polydrug users. So they use variety of way to administer the drug. Single way of administration is rare. Administering drug through both oral and injection is highly practiced than either orally and smoking. It is found that administer through injection dominate "smoke" or "oral" mode of administration.

f) It is found that 38.33 per cent of respondents always use new syringe and 30 per cent reported that they don't share syringe but use single syringe repeatedly and 31.67 per cent disclosed that they share syringe in a group.

g) Most of the respondents’ family know about his addiction (80.26 per cent) and only 19.74 per cent of respondents’ family are unknown about his addiction.

h) The majority of the respondents are thinking of going for treatment (78.95 per cent) and almost 81.58 per cent of them knows other addict friends who have got residential treatment.

i) The frequency of respondent is high (66.13 per cent) for those, respondent who say that their friends treatment was not successful
because they are taking drugs again. It indicates relapse proneness in rehabilitated addicts.

j) All the respondents have their own opinion about the failure of treatment. Those who say back to same peer and environment after coming out from treatment centre as the reason of failure of treatment (39.02 per cent), which is high than the other reason. Substantial number of respondents are in view that continued distrust from family, society, and lack of will power are the reason for failure of treatment.

4.5.3 Achievement of PJK in the Year 1999, 2000 and 2001

Various programmes were carried out in order to meet organizational objectives. In every programme except treatment and rehabilitation programme, the target was achieved.

In the treatment and rehabilitation programme, it was found that 100 per cent of those who were admitted at the centre were detoxified. The number of clients admitted at the centre was 28, 27 and 24 in the year 1999, 2000 and 2001 respectively and 22 per cent, 44 per cent and 41.66 per cent of the admitted clients were rehabilitated respectively.

In public awareness programme, student and parent were the target group. Student classes and parents meeting were held. Students of class 8 - 9 of Dharan, Damak and Inaruwa were provided drug and HIV/AIDS education. The target was set to educated 40 and 300 students in the year 2000 and 2001 but 44 and 305 students have attended the student class.
Parent meeting is one of the important activities of public awareness programme. The target was set to held meeting with 1000 and 150 parents in the year 2000 and 2001 but meeting was held with 1450 and 1250 parents.

In the harm reduction programme, DUs and IDUs were contacted in the street. Other activities such as counselling, primary health care and preventive material distribution were carried out.

The target was set to contact 1000 drug addicts in both years 2000 and 2001. But 1175 and 1051 drug uses were contacted in the year 2000 and 2001 respectively.

Detox-counselling was provided to 251, 435 and 398 drug addicts in the year 1999, 2000 and 2001. The target was to provide detox-counselling to 400 drug addicts in each year.

Pre-post antibody test counselling was provided to 208, 51 and 7 drug addicts in three consecutive years. The target was made to provide pre-post antibody test counselling to 50 drug addicts in each year.

Family counselling was provided to 301, 475 and 406 family in the community.

Preventive material such as condom, bleach and sterilized water was distributed to drug addicts. There is increment in the number of item distributed in each consecutive year.
Primary Health Care service was provided to 270, 579 and 513 drug addicts in the year 1999, 2000 and 2001 respectively.

4.5.4 Information Collected from Key-Informants

Each of the key informants represent different cluster of the society. They are personnel from local NGO, governmental agency and peer educator, who is an ex-addict.

It was found that the causation of drug addiction in Dharan as referred by personnel from local NGO and GO are quite similar. According to them, the causation of drug addiction in Dharan is due to socio-economic and cultural conflicts, unemployment. And according to peer educator, peer pressure is the main reason behind onset of drug addiction amongst youth. There is significant variation between the viewpoint of drug user and non-drug users about causation of drug addiction.

It was found that there is co-operation, co-ordination and information exchange between other local organization and government agency.

4.5.5 Case Study

It was found that multiple causes have attributed to the respondent for starting drug abuse. The indirect causes are the adjustment problem, easy access to and availabilities of drug. The direct cause is the peer influence. This finding about the causation of drug addiction supports the finding of the key informants.
It is found that the trend of multiple drug use and variety of mode of drug taking has a lot to do with accessibility, affordability and economic factor.

It is found that even though, transmission of STD and HIV/AIDS is known, risk-taking behaviour still persists. 8-10 number of peer are gathered for injection and sharing syringe is common. Use of condom is also infrequent. Condom is used with sex worker but not with girlfriend. And when heavy in ‘trip’ condom may or may not be used.

It is also found that the person may turn to suicidal attempt after he got to know of being HIV positive. Therefore, the constant support from family and counselling is very crucial at that time.

It is found that motivation on the part of the drug addict to remain free of drug paved the way for successful rehabilitation along with the efforts of the treatment team and constant support from family. If the family admits the person at the centre by force or referred, than there is high chance of relapse.
CHAPTER FIVE

DISCUSSION

The study was confirmed in Dharan Municipality in order to explore the effectiveness of prevention and rehabilitation programme of Punarjivan Kendra on drug addicts. The study comprised 76 sample of outreach service holder, 3 key informants and 1 case study. Different research tools were applied to different study population. Questionnaire and interview schedule were used as research tools.

The study encountered with different age group ranging from 15-30 years of drug addicts. Most of the drug addicts were between 15-24 years. Unemployed and unmarried were found more prone to drug addiction than married and employed one. The prevalence of drug use has affected most of Rai/Limbu (59.21 per cent), Newar (15.79 per cent), Magar/Gurung/Tamang (13.16 per cent), Brahmin/Chhetri (7.89 per cent) and underprivileged group (3.95). So it can be clearly stated that the prevalence injecting drug use is high among Rai/Limbu and there is also increased tendency for other ethnic/caste grouping toward inclination of drug addiction. It is also common to be high number of Rai/Limbu caste because the Rai/Limbu inhabits in Dharan with majority. The study found drug addicts for Hindu religion (85.53 per cent) with majority than other religion such as Buddhist, Christian.

Some attempts in this study were made to identify the causes of drug addiction in Dharan.
The finding and the key informants’ information indicate multiple causes behind the growing use of drugs in Dharan. It is already mentioned that the majority of drug addicts belongs to Rai/Limbu, Newar, Tamang, Magar/Gurung community. These are the ethnic group of Nepal where traditional use of alcohol still persists. Except Newar community, most of the male member from Rai/Limbu, Tamang/Magar/Gurung community go to abroad as member of British or Indian Army. Most of them also take their children to Hong Kong, Brunei, Singapore a number of times. They become economically well off and then settle in Dharan. The children are exposed to different cultures i.e., to western culture when they are abroad but they have to adjust in eastern culture back in Nepal. They always have to face difficulties in adjusting to new cultures. This brings about social and cultural conflicts.

Both parents presence is must for the growing age of children but father being away from home, children are brought up by mother. The children and youth do not accept the authority of the mother in the same way as they do regarding their fathers. Such parents, though might make good money for the family but they are unable to supervise what the children are doing with the money. Thus this socio-cultural conflicts along with family disharmony provides the strong basis for youngster to indulge in drugs.

The finding indicates that 'peer influence' is the reason for drug taking. Since no single factor can account for the development of drug use or addiction, this peer influence has just ‘trigger off’ the favourable situation. Parent and sibling clearly constitute the primary influence on
the behaviour of a growing child, but as adolescent approaches, these are
fell to recede in favour of the peer group. Some research suggest that the
family influence can remain predominant but only if the family unit is
strong and united. The weaker the family, the greater is the peer group
influences. Thus, most of the youngster in Dharan having to raised up in
weak family and cultural ties, easily influenced by peer group. They start
to take drug offered by their friend in the name of fun and
entertainment/pleasure or to pass time.

There is no job opportunity in Dharan. The Mayor of Dharan estimated
that 75 per cent of the people in the city are jobless. It is natural that
youth get frustrated and indulge in drug use as some respondents
expressed it.

The finding indicates that nitrazepam, tedigesic, phencidyl are the most
used drug in Dharan. Brown sugar is least used in comparison to
tedigesic, nitrazepam and phencidyl. Though all these drugs are strickly
illegal in Nepal but are available in market through different channels.
These drug are reported to be available in Jogbani, the border town of
India in an affordable price. Thus the easy access to and availability of
drugs has also made conducive environment to initiate drug use specially
among young people in urban area like Dharan, Kakarvitta. It is evident
from the low consumption of Brown sugar than tedigesic and other
tablets.

The increased use of tedigesic indicate high number of intravenous user
in Dharan. Intravenous use of drug is considered the most dangerous
because of its link to transmission of HIV/AIDS and other blood borne disease. Intravenous use is also the major factors in the increase in the rate of drug related death. A recent survey of PJK (1999) shows that 70 per cent of drug user are injecting drug users. Amongst IDUs, 45 per cent belong to 15 years of age. The majority of drug addicts as the finding of this study revealed belong to the age group (15-24) years. The prevalence of drug addict belong to (15-24) years age group is higher than that of 25 and above year. It implies that the age of initiation into drug use is appears to be falling.

With regard to the effectiveness of prevention and rehabilitation programme run by PJK on drug addicts, it is not adequate to come to some definite conclusion in this regard. Therefore, the discussion is focused to explain how the objective of PJK should have been effective in prevention and rehabilitation of drug addicts.

Broadly, the objectives of Punarjivan Kendra can be divided into two category.

1. Treatment and Rehabilitation facility for drug addicts and
2. Prevention programme by creating public awareness and by prevention of drug related harm.

Punarjivan Kendra is the only treatment and rehabilitation centre in Eastern part of Nepal. It is specially targeted at drug users. Drug addicts from Itahari, Biratnagar, Damak, Kakarvitta come for treatment. Admission into rehabilitation center is either voluntary or refer by family member or police. The treatment period is interrelated with their problem but the total period of treatment programme is minimum three months.
The treatment involves building up the addict both physically and psychological helping through the withdrawal period and developing confidence to make them useful and productive citizens.

The physical ailments caused by the use of drug are often the root causes of the abnormal behavioural symptoms of drug addiction. A vicious circle is often created; the use of drug causes physical troubles and the addict take drug to get relief from the trouble. The more one uses drug, the more physical ailments are produced and more needs for the drug is created. So it is necessary that the person should be detoxified. Detoxification is done by using Cold Turkey Method. Detoxification only reduce the physical ailments caused by drug and prepare the clients for further steps in the treatment. Post detoxification is followed by therapy techniques of different perspective, such as individual or group counselling, work therapy, group dynamics, inventory class, peer education and twelve steps of narcotic anonymous and along with recreational activities.

After care or follow-up is very important after the person get discharged from the rehabilitation center. Expert say, this period should be given high priority as there is a higher chance of relapse among the users during this period. Mr. Bijay Limbu, Program Manager of PJK stated that the person who regularly follow-up has low chance of relapse than who stop coming for follow-up. Dr. Mohammud Samsuddin, Director of LALS stated that when the family and the society itself is reluctant to treat the users as ordinary person even after the rehabilitation. Such behaviour from family and society makes them to take refuge in drug again. This has been also expressed by some outreach service holders.
The relapse proneness in addicted person after rehabilitation sometime give notion that completely cured or rehabilitation is not possible. This is so because there is trend in thinking that total abstinence from drug is the only criteria of successful treatment. But in order to realize the rehabilitation outcome, other criteria such as ability to hold a job, absence of criminal activities, positive change of attitude toward oneself, family and society, increasing responsibilities towards family need to be considered along with abstinence.

Punarjivan Kendra has conducted prevention programme through creating public awareness and providing education and by preventing drug related harm.

Public awareness programme is targeted at students, parents, and at risk youths, and community people. Prevention through awareness and education is fundamental to reduce the demand for drug. Such preventive measures are considered as effective means for long terms success towards preventing drug abuse.

Prevention of drug related harm is targeted at current drug users. It is also the drug component of HIV/AIDS prevention programme. Specially injecting drug users are more susceptible to HIV/AIDS as sharing of needles among them is common. The essence of prevention of drug related harm is the overall reduction to a minimum of the harm caused by the drug. Through service delivery outreach programme, various activities such as education, counselling, primary health care service, preventive material distribution are carried out.
CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATION

6.1 Summary

The drug problem has become a social problem and has infected a large number of the youth. The use of alcohol and drug in Nepalese society is not a new phenomenon. Consumption of Ganja (Cannabis) is connected with Hindu religion and use of alcohol in Nepal has been existing in time immemorial. But it was regulated by social norms, and does not create social problem in the traditional social structure of Nepal.

Drug use began to be seen as a problem in the early 1970s with the influx of large number of hippies. By then, the consumption pattern rapidly changed and most of the cannabis smokers switched to heroin. Heroin use was in epidemic form in Nepal from 1980s onwards. Since early 1990s, synthetic drug have been widely used by the drug users in Nepal. The mode of administration also change from smoking or ingesting to injecting.

The number of drug users are increasing day by day. The Ministry of Health (1998) estimated that there were more than 50,000 drug users in Nepal excluding those using cannabis, alcohol and tobacco. According to LALS, an NGO working with drug addicts, there are 60,000 drug users in Nepal of which 30,000 are in the Kathmandu valley itself. Out of these 30,000 Drug users, 15,000 are injecting drug users and 40 per cent of
these IDUs are today already infected with HIV/AIDS (Cited in Kathmandu Post, 2001. October 12). Among youth drug addicts, majority are unmarried males are between the age of 15-30 years. These youth addicts come from all kinds of social, economic, religious and ethnic background with different reasons for taking drugs. The major drugs abused in Nepal were cannabis, codine based cough syrup (phencidyl is common), nitrazepam tablets and tedigesic (bupreophine) injections. Heroin (brown sugar) is the second most prevalent drug in Nepal. The problem of drug abuse are localized especially in the urban, semi-urban and along the border of Nepal and India. Most of the drug addicts are found in Kathmandu, Pokhara, Biratnagar, Birgunj, Dharan, Nepalgunj, and Bhairahawa. This is the drug abuse situation in Nepal.

Dharan is the most drug affected area in the eastern part of Nepal. Along with alcohol, drug is a big problem here. Drug addiction here has risen from family concern to serious social concern. Drug abuse problem is not a local problem, it is very hastily spreading on all major cities of the eastern part of Nepal such as Ithari, Urlabari, Damak, Kakarvitta, Badrapur.

In order to combat with drug addiction problem, Punarjivan Kendra (PIK) has been providing prevention, treatment and rehabilitation programme for drug addicts.

The research entitled “The Effectiveness of Prevention and Rehabilitation Programme Run by Punarjivan Kendra” was conducted at Dharan Municipality.
Utilizing both quantitative and qualitative, the study aimed at exploring the effectiveness of prevention and rehabilitation programme on drug addicts of Dharan. It also aimed at finding out causes of drug addiction in Dharan.

The target population was outreach service holder. They are current drug addicts and between 15 - 30 years of age. There were about 450 outreach service holder at the time of this study. Out of them 76 was interviewed which represent 17 per cent of the total outreach service holder till that time. They were selected by using purposive sampling method.

Quantitative information was obtained from the outreach service holder by individual questionnaire and qualitative information was obtained from case history and key informants interview.

Analysis and Interpretation was done by using simple statistical method such as frequency count and percentage distribution.

6.2 Conclusion

From the above discussion of result the following conclusions are drawn
a) It is concluded that the major causes of drug addiction in Dharan is socio-cultural and psychological factors. Psychological factors attributed to parent related causes, family disharmony, lack of appropriate control and guidance and lack of interpersonal relationship. It is, in fact cumulative result of social influences related to family, society and behavioural problems as a whole.
b) It is concluded that the drug use is going up while the age of the initiation into illicit drug use is going down. The majority of the sample of the present study fall in the age group (15 - 24) years.

c) Unmarried and unemployed young people are found more prone to drug addiction.

d) Education is clearly associated with drug use. Increasing prevalence of drug use mean decreasing educational attainment.

e) Most of the drug addicts in the present study were from Rai-Limbu group. But the numbers of other caste and ethnic group such as Newar, Gurung/Magar/Tamang, Brahamin/Chhetri were also found. It implies that is increasing tendency among other caste/groups to abuse drugs.

f) 'Peer influence' were the major source of drug introduction. Availability of drug in affordable price has also made conducive environment to initiate drug among youngster in Dharan.

g) Drug scene in Dharan is dominated by synthetic drugs. Nitrazepam, tedigesic and phencidyly is much used by drug addicts in Dharan. Nitrazepam is the most common drugs amongst all age group. The consumption of tedigesic is more prevalence among long time user than who have recently started using drugs. Brown sugar is least consumed by all age group.

h) The majority of drug addicts in Dharan are poly drug user and the primary mode of drug administration is injection.

i) Risk behaviour still persists among IDUs because one third of the sample population share syringe.
j) Most of the respondents family know about their addiction and majority of respondent think that their family can help them to make them free of drug.

k) The completely cured or rehabilitated addicts is very low. Majority of the respondent think the reason for relapse or unsuccessful treatment is the involvement with the same environment and peer after they are back from rehabilitation centre.

l) The family, relatives and community people along with professional person, all have a key role for supporting them for drug free life.

m) Prevention programme is categorized in two broad categories. One is prevention through drug demand reduction and the other is prevention of drug related harm.

n) Drug demand reduction programme is aimed at general public such as family, parents, community people and at-risk group such as students. Awareness raising, information and education on drug related issues are the main activities under drug demand reduction programme.

o) Prevention of drug related harm is aimed at drug addicts. Counselling, education and primary health care services are provided. Preventive material are distributed. Unsafe drug use and unprotected sex is discouraged. The essence is to reduce harm to a minimum caused by drugs.
6.3 Recommendation

The following recommendations are made:

6.3.1 Recommendation for Punarjivan Kendra for the Further Improvement of its Programme

a) Prevention, treatment and rehabilitation programme on drug addicts should be carried out side by side.

b) An effective drug prevention programme called for need to identify the socio-cultural characteristics and psychographics of people in order to design culturally appropriate and responsive programme.

c) Drug use is not only related to physical dependency but at the same time to the social emotional and physical quality of life. So treatment should not be focused on physical dependency to a substance. Rather, it should be on comprehensive approach enhancing the individual's quality of life society, physically and emotionally.

d) For the better treatment and rehabilitation outcome, provision of services for the treatment and rehabilitation for drug addicts, when ever possible, should be integrated with other health, welfare and economic development programme. Co-ordination, and co-operation among government as well as non-governmental organizations (NGOs) are vital.

e) Most of the drug addicts reported peer's pressure is the reason behind the onset of drug addiction. And they inject the drug with close peers or groups. Thus, peers or friends are key factors which
affect the drug use pattern. Therefore, Punarjivan Kendra should develop the peer based programme.

6.3.2 Recommendations for further study

This study is an academic research for the partial fulfilment of the requirements for a Master of Education (Health Education). The study is based on the field work of purposively sampled population of Dharan Municipality. Thus findings of the field study may not be generalized for other parts of Nepal. Therefore, the following recommendations are made for further study:

a) The present study was limited only with the boundaries of the stated objectives. It is recommended that further study in this area especially for female drug addicts should be carried out.

b) Further study of this nature can be conducted in other parts of Nepal.

c) Health consequences associated with drug use hasn’t been explored in present study. Further studies should be conducted covering this area.


APPENDIX I

Questionnaire for Drug Addicts
Who are Outreach Service Holders of Punarjivan Kendra

Attached is a questionnaire which aims to evaluate effectiveness of prevention and rehabilitation programme of Punarjivan Kendra in Dharan. The information provided by you will be kept confidential and will be used only for research purpose. Thank for your cooperation.

Direction: Please, Read the followings questions carefully and tick answers in the box. You may tick (✓) more than one, if needed.

Date: ___________________________ Ward No.:_________________________

Part - I

1. Sex: □ Male □ Female
2. Marital Status: □ Single □ Married □ Separate/divorced
3. Age (Years) ______
4. Ethnic/Caste Grouping: ______
5. Religion: □ Hindu □ Christian □ Buddhist □ Any others (Mention)
6. Education: □ Literate □ Illiterate
   If Literate
   □ Primary Level (Up to class 5)
   □ Lower Secondary & Secondary Level (Class 6 to 10)
   □ Collage Level (Up to I.A.)
7. Employment: □ Employed □ Unemployed
8. Fathers’ Occupation: □ British Army □ Indian Army
   □ Civil Servant □ Businessman
Part - II

1. What is your reason for taking drug for the first time?
   □ Out of curiosity □ For Fun/enjoyment
   □ Forget Problems □ Peer influence
   □ Remove Tension/anger/frustrations
   □ Unemployment □ Out of Boredom

2. For how long have you been taking drug?

3. Which drugs do you use? Please tick (✓) before the name of drug used.
   □ Tedigesic (Maal, Bullet) □ Nitrazepam (Tab, Goti, Puttam)
   □ Ganja (G) □ Phencidyl
   □ Brown sugar (B.S. Dhulo) □ Proxyvan
   □ any other

4. How do you administer drug?
   □ Oral □ Sniffing □ Smoking □ Injection

5. If you inject
   a) Do you always use new syringe every time?
      □ Yes □ No
   b) if you don’t use new syringe, □ re-use my own syringe □ share syringe with friends.

8. Do your family know about your addiction?
   □ Yes □ No

9. Do you think family can help you to make free from drug?
   □ Yes □ No

10. Have you ever thought about going for treatment?
    □ Yes □ No

11. i) Do you know anybody who got treatment?
    □ Yes □ No
    ii) Was the treatment successful or not?
       □ Yes □ No

If the treatment was not successful,

iii) In your opinion, What is the reason for the failure of treatment?
APPENDIX II

Interview Schedule for the Case Study

A) Basic Demographic information

1. Family Background

Name of household head:
Age:                      Address
Sex:                      Households No:
Occupation:               Village/Town:
Education:                District:
Religion:                 
Cast:                      

2. Household Member:

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<th>S. No.</th>
<th>Name</th>
<th>Relationship to household head</th>
<th>Sex</th>
<th>Age</th>
<th>Educational Attainment</th>
<th>Occupation</th>
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3. Client's Informations:

Name:                      Age:                      Sex:
Marital Status:            Number of children, If married:
Educational Attainment
Name of the School/Collage/University:
Occupation:

B) Drug experience

1. In what situation did you take drug?

2. What drug did you take for the first time?

3. What types of drugs did you use? Name all the drugs.

4. How did you administer drug at the initial day of drug taking and then later?

5. Why did you use different types of drugs?
C) Risk Taking Behaviour
1. How did you prefer to use syringe, either group or alone?
2. Did you know about STDs and HIV/AIDS?
3. What did you know about STDs and HIV/AIDS?
4. Are you involved in sexual activity?
5. Did you use condom every time, if involved is sexual activity?

D) Treatment and relapse episode
1. Have you ever gone for treatment?
2. Was it your decision or your family forced it?
3. What do you think about your relapse after treatment?

E) Post HIV positive period
1. How did you know that you are HIV positive?
2. Did you do by your own initiation or somebody had suggested it?
3. How did you feel after you come to know that you are HIV positive?
4. What made you to come for treatment?

F) Current Situation
1. How do you find the residential programme of Punarjivan Kendra?
2. What is your attitude towards yourself and your family nowadays?
APPENDIX III

Interview Schedule for Key Informants

1. What are the causes of drug addiction in Dharan.
2. At what age, do the drug addiction is initiated?
3. What is the liaison between Punarjivan Kendra with your organization?
4. In which programme of Punarjivan Kendra are you involved in?
5. In your opinion, which programme of Punarjivan Kendra do you think is effective for prevention and rehabilitation of drug addicts.

Thank you for your co-operation