CHAPTER-I

INTRODUCTION

1.1 Background of the Study

According to World Health Organization, drug is defined as "any substance that when taken in to the living organism, may modify one or more of its functions"(NGN2007).

Drug Abuse refers to the regular use of drugs for other than the accepted medical purpose and to the extent that results in physical and psychological harm to user or used in a way that detrimental to society. The five stages of substance abuse in youth are curiosity, experimentation, regular use, psychological or physical dependency using drugs to feel 'normal' (Sturat Goil 2005).

The total number of the drug users in the world is now estimated at about 185 million equivalents to 3% of the global population, 4.7% of the populations are aged between 15-64 years. There are about 13 million injecting drug users worldwide, 78% of them in developing countries (1998-2003). Some 3.3 million are living in south and south East Asia, 3.2 million are in Eastern Europe and central Asia and 2.3 million are in the East Asia and the Pacific (UN 2004).

World Drug report shows that the drug use at the global level in 2006/2007, is 6,475 million people, world population aged 15-64 years is 4,272 million non drug using population aged 15-64 years is 4,064 million (95.1%), annual prevalence of drug use is 208 million people (4.8%) and monthly prevalence of drug use is 112 million. This shows that the problem of drug abuse in the world is increasing day by day. Cannabis is the most commonly used drug in the world. In 2006, United Nations office on drug and crime estimates that 166 million people or 3.9% of the global population age 15-64 years used cannabis. The total number of cannabis users has increased steadily over the 1997/98-2006/07 period. The estimated average prevalence rate of cannabis users in south Asia is 3.2% (UNODC 2008). In 2001, 15.9 million or 7.1% of Americans age 12 years and older used an illicit drug users, among adults aged 18-25 years, 18.8% were current drug users (SAMHSA 2003).

Regarding the situation of drug abuse among South Asian Association for Regional Cooperation (SAARC) countries, Pakistan, the second largest country in the region with an estimated population of 149.1 million, have increasing trend of drug abusers. According to the National Drug Abuse Assessment study conducted by government in 2001 there are an alarming 500000 chronic heroin users, including drug injectors (15%) or 60,000 in Pakistan. It is estimated that (0.06%) of the population is infected with HIV/AIDS have been attributed to injecting drug use. In SriLanka, approximately population is 20 million, there are estimated 300,000 drug dependents, (2%) or 6000 persons are injecting Drugs users (IDUs) (UNODC-2005).

In Bhutan, estimated population to be between 0.7 million to 2.3 million, 47% are between the age group of 15-49 years. The extent of substance abuse and estimated number of drug dependent in Bhutan is not known, no significant drug injecting is reported, there are an estimated 30-100 IDUs in Bhutan and so far no case of HIV/AIDS has been detected among them. Maldives, having approximately 339,330 populations, 35-40% of population falls between 16-35 years. Health report 2004 shows that 45,739 people screened for HIV, no IDUs found HIV positive (UNDP/UNODC).

India, the largest country in the SAARC region with the second largest populated country in the world, has about 1.15 billion people. According to latest survey, there are estimated 73-54 million persons dependent on drugs, of which 62.46 million are addicted to alcohol, 8.75 million to cannabis, 2.04 million opiates users, and 0.29 million users of sedative hypnotic. Nationwide, figures for prevalence of IDUs are however not available, about 14.3% of those seeking treatment have reported that they are having injecting drugs in street, about 43% are IDUs. At the end of 2003, 2.2% of total HIV infections are because of injecting drug use (UNODC-2008). Drug abuse has emerged in Nepal since 1960s with cannabis abused by hippies. Injecting is reported to have emerged in early 1990s with the widespread use and availability of burenorphine in injects able form.

In Nepal, almost 50% or 12.4 million of the total estimated population (25.7 million) falls in the age group of 15-49 years. There are estimated 70,000 drug abusers in Nepal, although drug consumption is more visible among males, there are also female

dependent users. The most communal used drugs are cannabis, heroin, cough syrup, nitrazepam, tables, phensedyl and tidigesic (UNODC, 2007).

In the 1990s, use of opiates, especially heroin is increased among women substance users in different cities in the world. Majority of the female substance users are single, educated and employed, and they have started using substances quite early. Women substance users are also known to start having sexual relations at a younger age and to share injecting equipment. Women suffer from low self-esteem and face rejection from families and communities and must also deal with drug user "experts" who are often males. Furthermore, substance use problems are treated as medical problems, without giving attention to social issues, and some substance abuse services have a more punitive than supportive approach (UDODC, 2010).

Injecting Drug Use (IDU) has emerged as an important route in the HIV transmission dynamics in India. Though the current number of IDUs in India is 200,000, the HIV prevalence among IDUs is very high. The Surveyillance data for 2008-2009 shows declining HIV infections among female sex workers but Injecting Drug Users (IDUs) and Men Who Have Sex with Men (MSM) are more vulnerable to HIV with increasing trends in many states (NACO, 2010). Of the nine districts reporting > 15% HIV prevalence among IDUs in the country seven districts are in the three high prevalence (NACO, 2008).

According to the survey conducted by Central Bureau of Statistics there are 46,309 hard drug users in Nepal. Among them 42954 are males and 3356 are females. In this Survey the people using only cigarette, cannabis, and alcohol are not included. The number of female drug abusers is highest is Kathmandu valley i.e. 1878, Kaski-318, Jhapa-145, Sunsari-332, Rupendehi-133, Chitwan-191, Morang-50, Parsa-89, Makawanpur-19 and other areas 200. 76% drug abusers have started taking drugs before 20 years of age. Out of 3356 drug abusers, 2047 (61%) are injecting drug users (MoH, 2007).

1.2 Statement of the Problem

The number of drug abusers in the world is increasing day by day. In Nepal approximately two lakhs drug abusers are found. Among them 35000 are injecting drug users and approximately 40% of them having HIV positive. The number of drug abuser in Nepal is increasing by 10-15% annually. It is also revealed that school and colleges are the breeding grounds for drug mafias (Acharya 2007).

Drug addiction is rapidly growing and it has been a major challenge to the Nepalese society. There are an estimated 70,000 drug users in Nepal (UN, 2007). Moreover, according to the latest National Action Plan (NAP) 2007-2011 estimation 8,00,000 youths are potential abusers and these groups will also be affected by HIV. The primary cause of spread of HIV among IDUs in South Asia is intravenous drug use. From such high risk groups the virus is now spreading to the so called "general population" through sexual transmission (UN 2005-2007). In Nepal also, drug users are one of the Most At Risk Population (MARPS) and the prevalence of HIV is higher than other MARPS. Recent integrated bio behavioral Surveys indicate that the prevalence of HIV among IDUs to be 51.6% in Kathmandu, 31.7% in eastern Terai districts, 11.7% in western Terai districts and 21.7% in Pokhara valley (New ERA/SACTS, 2005). It is found the HIV prevalence amongst injecting drug users was only 2% in early 90s.

The number of people living with HIV in Nepal is 75000 and death due to AIDS is 5100, the main risk group of HIV infection is found that drug users are more than female sex workers. So, it has been clear that mortality rate due to drug abuse is also high. Drug abuse creates a lot of social problems like loss of properties, loss of social prestige, dignity and creation of family tensions, frustration, failures, pain, sorrows, cries, tears and numerous other emotional problems, the cost of which remains unmeasured. Malnutrition, weight loss, impaired memory and concentration power and many other physical problems have become the outcome of drug abuse so that many physical, social and psychological problems can arise by drug abuse. The international standard states that there should be 70-80% comprehensive service coverage to reduce HIV infection among the MARPS but in 2005 the National coverage of the services for intravenous drug users was only 8.6% in Nepal (UNODC/MOH country report, 2005).

Due to the lack of resources, commitment from the government and donor organizations was not enough according the need and the current coverage was below 20% in 2006 (Sharma B 2007).While considering the situation of Pokhara, there are 6000 drug abusers, among them approximately 1700 are injecting drug abusers (Naulo Ghumti, 2007). The number of drug abusers in Kathmandu valley is higher than in Pokhara valley. The number of drug users is increasing at alarming rate so it is not only the problem of our country but also the real problem of the world today.

It is very difficult to know about female drug users and affecting factors to abuse them and how they differ from those of men. It is difficult, however, to get a full picture of women's involvement in drug use, since international, national and local studies on the prevalence of substance use and associated problems do not often address female issues. This is consistent with the historical focus on men in the field of drug user.

Lack of resources, lack of awareness and negative attitudes to women's substance use may contribute to the scarcity of gender-related epidemiological data and other research on women's substance use problems. In addition, methodological problems contribute to women not being included in some research studies and/or the absence of female physiology are more complex than male. Lack of information about women and female injecting drug users is particularly research found in United States of America, with some also from Australia, Brazil, Germany and the United Kingdom of Great Britain and Northern Ireland (UN-2004).

Most of studies depend on male drug user in developed countries, In Nepal we could find some researches or studies about male drug user and it is rare in case of female. Thus, to identify why people (especially females) are involved in drug abuse, what are the main factors associated with drug abuse which factors compel people to take drugs in Pokhara are the curiosities of the researcher. If the factors why people become drug users can be explored, why most of studies were targeted to male drug users it may be helpful to lunch out prevention program for female IDUs in Pokhara valley, so I am interested for this topic.

Based on the Statement of the Problem, following Research Questions are formulated:

- Why people (especially females) are involved in drug abuse?
- What are the main factors associated with drug abuse?
- Which factors compel people to take drugs in Pokhara?

1.3 Objective of the Study

1.3.1 General Objective

The general objective of the study is to find out the factors associated with female drug abuse/user in Naulo Ghumti Pokhara.

1.3.2 Specific Objectives

The specific objectives of the study are:

- To identify the relationship between social factors and drug abuse.
- To identify the individual factors associated with drug abuse.

1.4 Rational/Significance of the Study

Drugs such as cannabis and alcohol were traditionally used in Nepal for centuries. Use of these drugs as part of the cultural norm did not create any major social problem during that period. However, the types of drugs used have been shifted from cannabis to synthetic opiates and other chemical substances since the last few decades. The mode of drug use has also changed from smoking/ingesting to injecting. The injecting of drugs has become one of the major causes of HIV infections. So, drug abuse has become vast growing problem in Nepal and drug-control is a big challenge for the government. The Ministry of Home Affairs and other Non-governmental Organizations have been working rigorously to overcome this situation. But, lack of reliable information on size and characteristics of drug users was bottleneck in formulating effective plans/programs and implementation.

Much of the available research have focused on the male injecting drug users, male rehabilitation center, male focus voluntary testing, counseling centre and social integration for male factors related on male drug users.

On the background of ever increasing number of drug abusers in the world, factors associated with drug abuse among female injecting drug users was thought as relevant topic to be studied.

1.5 Operational Meaning of the Terms

Female Drug Users (FDUs): Women who have used drugs such as heroin or brown sugar or other medically used drugs for pleasure (for other than medical reasons) FIDUs have also been referred as 'women drug users' in this report.

Female Injecting Drug Users (FIDUs): Female Drug Users (FDUs) who had injected drugs at least once in the past one month for other than medical reasons.

Daily injectors: Female Injecting Drug Users (FIDUs) who injected drugs at least once a day in the past one month for other than medical reasons.

Stress: The stress in this study is referred to the cause of using drugs, as mentioned by the respondents, such as poor academic achievement, love tragedy, unemployment, job frustration and family tension.

Social Factors: The social factors in this study is referred to the factors that influence to take drugs such as peer pressure, broken home, lack of love and affection from parents, lack of attention of parents and lack of knowledge / information as mentioned by the respondents.

Lack of knowledge/information: is referred to the lack of knowledge/information of the respondents about dependency upon drugs and its effects on physical and mental health that lead them to use drugs.

Individual Factors: is referred to the factors associated to use of drug , individual factors such as curiosity, pleasure seeking and search for the identity that lead to drug abuse as mentioned by the respondents.

Search for the identity: is referred to the respondents who used drugs to feel themselves smart, strong, courageous and unique as other elder drug users as mentioned by the respondents.

Boy Friends: Partners with whom, women drug users had sex in exchange for money or drugs.

Drop in Centre (DIC): Drop in center is a key service delivery mechanism which is a one step of service centre for IDUs, that provides comprehensive and holistic harm reduction services to the community.

1.6 Limitations of the Study

- This research does not represent all components of female Injecting Drug User.

- This study will be carried out for the partial fulfillment of the requirement for the master degree of arts in Sociology. Therefore, detailed research is not be possible due to insufficient time financial and human resource.

- This study is carried out only in Pokhara valley especially on female IDUs attaining in Naulo Ghumti, Pokhara. Therefore associated factors of drug abuse may not be generalized in any other cases and spaces.

1.7 Organization of the Study

This dissertation is organized in to six chapters. First chapter is related to introductory part, which starts with the background information and includes statements of the problem, objectives of the study, rational of the study, limitation of the study and organization of the study.

Second chapter is review of the literature. In this chapter various books, related previous studies, articles and reports related to present study are reviewed.

In chapter three, research methodology adopted for the study is discussed. The methodology chapter is further divided into research design, sampling and sample size, rationale for the selection of study, source of the data, data collection method data processing , reliability and validity and ethical consideration are include.

Chapter four particularly deals with the brief introduction of the study area. This includes geographical location, population, ethnicity, natural resources and brief introduction of Naulo Ghumti.

The fifth chapter is a core chapter of the study. The chapter deals with the socio demographic status of the female injecting drug users and factors associated the female injecting drug abuser of the study area which is supplemented by the data collection from the field.

Chapter six provides brief summary of the whole study, conclusion of the study, finding and recommendation of the harm reduction of female injecting drug user.

CHAPTER-II

LITERATURE REVIEW

2.1 Theoretical Overview

2.1.1 Theoretical Overview on Drug Abuse

In many cases, addiction theorists have now progressed beyond stereotyped disease conceptions of alcoholism or the idea that narcotics are inherently addictive to anyone who uses them. The two major areas of addiction theory those concerning alcohol and narcotics have had a chance to merge, along with theorizing about overeating, smoking, and even running and interpersonal addictions. Yet this new theoretical synthesis is less than meets the eye: It mainly recycles discredited notions while including piecemeal modifications that make the theories marginally more realistic in their descriptions of addictive behavior. These theories are described and evaluated in this chapter as they apply to all kinds of addictions. They are organized into sections on genetic theories (inherited mechanisms that cause or predispose people to be addicted), metabolic theories (biological, cellular adaptation to chronic exposure to drugs), conditioning theories (built on the idea of the cumulative reinforcement from drugs or other activities), and adaptation theories (those exploring the social and psychological functions performed by drug effects).

While most addiction theorizing has been to one dimensional and mechanistic to begin to account for addictive behavior, adaptation theories have typically had a different limitation. They do often correctly focus on the way in which the addict's experience of a drug's effects fits into the person's psychological and environmental ecology. In this way drugs are seen as a way to cope, however dysfunctional, with personal and social needs and changing situational demands. Yet, these adaptation models, while pointing in the right direction, fail because they do not directly explain the pharmacological role the substance plays in addiction. They are often considered even by those who formulate them as adjuncts to biological models, as in the suggestion that the addict uses a substance to gain a specific effect until, inexorably and irrevocably, physiological processes take hold of the individual. At the same time

their purview is not ambitious enough (not nearly so ambitious as that of some biological and conditioning models) to incorporate non narcotic or nondrug involvements. They also miss the opportunity, readily available at the social-psychological level of analysis, to integrate individual and cultural experiences.

Global Biologic Theories of Addiction: Peele and Brodsky (1975), also described interpersonal relationships as having addictive potential. The thrust of their version of interpersonal addiction, however, was exactly the opposite of that in Liebowitz (1983) and Tennov (1979): Peele and Brodsky's aim was to show that any powerful experience can form the object of an addiction for people predisposed by combinations of social and psychological factors. Their approach was antireductionist and rejected the deterministic force of inbred, biological, or other factors outside the realm of human consciousness and experience. Their work signaled a burst of addiction theorizing in areas other than substance abuse, the bulk of which paradoxically sought to analyze these phenomena at a biological level. The result has been the proliferation of biologic theories to account both for the range of compulsive involvements people form and for the tendency some people show to be addicted to a host of substances.

Smith (1981), a medical clinician, has posited the existence of an "addictive disease" to account for why so many of those who become addicted to one substance have prior histories of addiction to dissimilar substances (cf. "The Collision of Prevention and Treatment" 1984). It is impossible to explain as Smith attempts to do how innate, predetermined reactions could cause the same person to become excessively involved with substances as disparate as cocaine, alcohol, and valium. In examining the generally strong positive correlations among tobacco, alcohol, and caffeine use, Istvan and Matarazzo (1984) explored the possibilities both that these substances are "linked by reciprocal activation mechanisms" and that they may be linked by their "pharmacologically antagonistic . . . effects". The evidence here is rather that substance abuse exceeds biological predictability. The fact of multiple addictions to myriad substances and no substance-related involvements is primary evidence against genetic and biological interpretations of addiction.

Nonetheless, neuroscientists put forward biological theories of just this degree of universality.

Milkman and Sunderwirth's (1983) neurological model of addiction is not limited to drug abuse (as nothing in Dunwiddie's account would so limit it). These authors believe that addiction can result from any "self-induced changes in neurotransmission," where the more neurotransmitters that are involved "the faster the rate of firing," leading to the "elevated mood sought by cocaine users, for example". This account is actually a social-psychological one masquerading as neurological explanation, in which the writers introduce social and psychological factors such as peer influence and low self-esteem into their analysis by suggesting "that the enzyme produced by a given gene might influence hormones and neurotransmitters in a way that contributes to the development of a personality potentially more susceptible to . . . peer group pressure". Both Dunwiddie's and Milkman and Sunderwirth's analyses cloak experiential events in neurological terminology without reference to any actual research that connects biological functioning to addictive behavior. These models represent almost ritualistic conceptions of scientific enterprise, and while their analyses are caricatures of contemporary scientific model building, they come unfortunately close to mainstream assumptions about how the nature of addiction is to be interpreted.

Exposure Theories: Biological Models

The Inevitability of Narcotic Addiction: Alexander and Hadaway (1982) referred to the prevailing conception of narcotic addiction among both lay and scientific audiences that it is the inevitable consequence of regular narcotics use as the exposure orientation. So entrenched is this viewpoint that Berridge and Edwards (1981) while arguing that "Addiction is now defined as a disease because doctors have categorized it thus". Refer readers to an appendix in which Griffith Edwards declared "anyone who takes an opiate for a long enough period of time and in sufficient dose will become addicted". This view contrasts with conventional beliefs about alcohol that would reject the same statement with the word "alcohol" substituted for "an opiate."

Underlying the exposure model is the assumption that the introduction of a narcotic into the body causes metabolic adjustments that require continued and increasing dosages of the drug in order to avoid withdrawal. No alteration in cell metabolism has yet been linked with addiction, however. The most prominent name in metabolic research and theory, Maurice Severs, characterized efforts during the first sixty-five years of this century to create a model of addictive narcotic metabolism to be "exercises in semantics, or plain flights of imagination" (cited in Keller 1969: 5). Dole and Nyswander (1967; cf. Dole 1980) are the modern champions of heroin addiction as a metabolic disease, although they have provided no explicit metabolic mechanism to account for it. Endorphin theorists have suggested that regular use of narcotics reduces the body's natural endorphin production, thus bringing about a reliance on the external chemical agent for ordinary pain relief (Goldstein 1976b; Snyder 1977).

Endorphins and Nonnarcotic Addiction

Although unsubstantiated in the case of narcotic addiction, endorphin-related explanations have proved irresistible to those considering other addictive behavior. In particular, discoveries that food and alcohol as well as narcotics can affect endorphin levels have prompted speculation that these substances create self-perpetuating physical needs along the lines of those the narcotics supposedly produce. Weisz and Thompson (1983) summarized these theories while noting that "At this time there is not sufficient evidence to conclude that endogenous opioids mediate the addictive process of even one substance of abuse". Harold Kalant (1982), a distinguished neuroscientist, was more conclusive in his rejection of the idea that alcohol and narcotics could act according to the same neurological principles. "How do you explain . . . in pharmacological terms," he queried, that cross-tolerance occurs "between alcohol, which does not have specific receptors, and opiates, which do".

To date, the most active speculation by clinicians about the role of endorphins has been in the area of compulsive running and exercising (cf. Sacks and Pargman 1984). If running stimulates endorphin production (Pargman and Baker 1980; Riggs 1981), then compulsive runners are presumed to undergo narcotic-like physical states to which they become addicted. Research on the relationship between endorphin levels, mood swings, and running motivation has failed to turn up regular relationships (Appenzeller et al. 1980; Colt et al. 1981; Hawley and Butterfield 1981). Markoff et

al. (1982) and McMurray and his colleagues (1984) reported that exercising subjects treated with the narcotic-blocking agent naloxone reported no differences in perceived exertion and other physiological measures from those not treated. Addicted running defined by inflexibility and insensitivity to internal and external conditions, running until the point of harming oneself, and being unable to quit without experiencing withdrawal is no better explained by endorphin levels than is the self-destructiveness of the heroin addict (Peele 1981).

Cigarette Addiction

Schachter (1978) has been the most vigorous proponent of the case that cigarette smokers are physically dependent on nicotine. They continue to smoke, in Schachter's view, in order to maintain habitual levels of cellular nicotine and to avoid withdrawal. Interestingly, Schachter (1978; Schachter and Rodin 1974) has proposed that different types of factors determine obesity and smoking: the former is due to an inbred predilection while the latter is due to an acquired constraint (avoidance of withdrawal). This is the same distinction drawn in traditional theories of alcohol and narcotic addiction. The distinction is necessary in order to defend biological causality in the case of excessiveness both in activities that are common to most people (eating and drinking alcohol) and activities that only some indulge in (smoking and narcotics use).

As with alcohol and narcotic use (see below), there is no prima facie reason why destructive eating and smoking habits need necessarily be dictated by separate classes of factors. Indeed, studies Schachter (1978) and his students conducted with cigarette smokers replicated results of Schachter and Rodin's (1974) work with the obese. For example, both smokers (while not smoking) and the obese were more distractible and more sensitive to negative stimuli like pain than were nonsmokers or normal-weight people. Both smokers and the obese apparently found their habits allayed anxieties and cushioned them against unpleasant stimulation. Furthermore, the apparent uniformity in the addictive use of cigarettes that Schachter's model suggests is illusory. Different smokers consume different amounts of tobacco and inhale different levels of nicotine; Best and Hakstian (1978) found such variations to reflect different motivations and settings for smoking and to suggest different circumstances under which smokers can quit.

Alcohol Dependence

As narcotic addiction theorists have been forced by the recognition of individual variations in addiction to postulate innate neurochemical differences among people, alcoholism specialists have increasingly put forward the claim that alcohol problems are simply a function of excessive drinking. It might be said that conceptions of alcoholism and narcotic addiction not only are meeting on common ground but are passing each other going in opposite directions. The change in emphasis in alcoholism is in good part a result of the desire of psychologists and others to achieve rapprochement with disease theories. It has led controlled-drinking clinicians to assert that a return to moderate drinking is impossible for the physically dependent alcoholic. Intriguingly, behaviorists have thus adopted Jellinek's (1960) formulation of the disease theory of alcoholism, in which he claimed that true (gamma) alcoholics could not control their drinking due to their physical dependence. (In his 1960 volume Jellinek was ambiguous about the extent to which this disability was inbred and irreversible, the traditional claims made by AA.).

The concept of alcohol dependence has been elaborated by a group of British researchers (Edwards and Gross 1976; Hodgson et al. 1978). In the same breath, it attempts to replace the disease theory (whose defects are more broadly agreed upon in Great Britain than in the United States) while rescuing important disease notions. The alcohol dependence syndrome resembles the disease of alcoholism in conceiving of drinking problems as a condition that can be identified in isolation from the drinkers psychological state and situation and as one that endures beyond the alcoholic's active drinking. Severity of dependence is assessed purely in terms of how much people habitually drink and the physical consequences of this drinking (Hodgson et al. 1978), without regard for their reasons for drinking or cultural, social, and other environmental factors. Thus, those who are heavily dependent are thought to have a stable condition that makes their return to moderate drinking unlikely.

The alcohol-dependence syndrome suffers from the tension of acknowledging the complexity of alcoholic behavior. As its supporters note, "the control of drinking, like any other behavior, is a function of cues and consequences, of set and setting, of psychological and social variables; in short, control, or loss of it, is a function of the way in which the alcoholic construes his situation" (Hodgson et al. 1979: 380). Within

this framework, Hodgson et al. regard withdrawal symptoms to be a strong cue for alcoholics to return to heavy drinking. However, the appearance of withdrawal in alcoholism is itself variable and subject to drinkers' subjective constructions. Moreover, such symptoms are regularly overcome by alcoholics in their drinking careers and in any case are limited in duration. Avoidance of withdrawal simply cannot account for continued drinking. There is a more basic objection yet to the alcohol dependence concept. In his critique of "the concept of drug dependence as a state of chronic exposure to a drug," Kalant (1982) remonstrated that dependence concepts have "ignored the most fundamental question why a person having experienced the effect of a drug would want to go back again and again to reproduce that chronic state". Whereas speculation about human drug dependence has been influenced greatly by generalizations from animal research the alcohol-dependence syndrome has had to fly in the face of animal research.

It is difficult to get rats to drink alcohol in the laboratory. In his seminal research, Falk (1981) was able to induce such drinking through the imposition of intermittent feeding schedules that the animals find highly uncomfortable. In this condition, the rats drink heavily but also indulge in excessive and self-destructive behavior of many kinds. All such behavior including drinking depends strictly on the continuation of this feeding schedule and disappears as soon as normal feeding opportunities are restored. Thus, for rats that had been alcohol-dependent, Tang et al. (1982) reported "a history of ethanol overindulgence was not a sufficient condition for the maintenance of overdrinking".

On the basis of animal research, at least, alcohol dependence seems to be strongly state-dependent rather than a persistent characteristic of the organism. Rather than being contradicted by human behavior, this phenomenon may be even more pronounced for humans. The supposed biological basis of drinking behavior in the alcohol dependence model is thus unable to deal with major aspects of alcoholism.

Control of Alcohol Supply

Sociological theory and research has been the main counterpoint to disease theories of alcoholism (Room 1983) and has made decisive contributions in depicting alcoholism as a social construction, in discrediting the idea that drinking problems can be

organized into medical entities, and in disproving empirical claims regarding such bedrock disease notions as inevitable loss of control and reliable stages in the progress of alcoholism. Yet some sociologists have also been uncomfortable with the idea that social beliefs and cultural customs affect levels of drinking problems (Room, 1976). In place of such sociocultural interpretations of alcoholism, Sociology as a field has now largely adopted a supply-of-alcohol perspective based on findings that alcohol consumption in a society is distributed in a unimodal, lognormal curve (Room, 1984).

Since a large proportion of the alcohol available is drunk by those at the extreme end of this skewed curve, increases or decreases in alcohol availability are believed to push many drinkers above or below what might be considered a heavy and dangerous drinking level. Alcohol supply policy recommendations thus include raising taxes on liquor to lower overall consumption. The alcohol supply model is most certainly not a biological theory and does not itself lead to theoretical derivations about alcohol metabolism. Yet as Room (1984: 304) has pointed out, it can be rationalized with the disease-theory view that those at the extreme of the curve have lost control of their drinking. In fact, the model fits best with the alcohol-dependence syndrome, where alcoholic behavior is conceived principally to be the result of excessive consumption.

Exposure Theories: Conditioning Models

Conditioning theories hold that addiction is the cumulative result of the reinforcement of drug administration. The central tenet of conditioning theories is that (Donegan et al. 1983: 112): a substance is used at a level considered to be excessive by the standards of the individual or society and that reducing the level of use is difficult in one way of saying that the substance has gained considerable control over the individual's behavior. In the language of behavior theory the substance acts as a powerful reinforce: behaviors instrumental in obtaining the substance become more frequent, vigorous, or persistent. Conditioning theories offer the potential for considering all excessive activities along with drug abuse within a single framework, that of highly rewarding behavior. Originally developed to explain narcotic addiction (cf. Woods and Schuster 1971), reinforcement models have been applied to most popular psychoactive drugs and to nondrug addictions like gambling and overeating (Donegan et al. 1983). Solomon (1980), in a broadly influential approach calls the opponent-process model of motivation, has extended conditioning principles to every

pleasurable and compulsive activity. The complex processes that characterize learning also allow increased flexibility in describing addictive behavior. In classical conditioning, previously neutral stimuli become associated with reactions brought on in their presence by a primary reinforce. Thus an addict who relapses can be conceived to have had his craving for the addiction reinstated by exposure to the settings in which he previously used drugs (S. Siegel 1983).

The Myth of the Universal Reinforce

The Inherent Pleasurableness of Narcotics Conditioning theories leave open one critical question: What is a reinforcing activity? The assumption in narcotic addiction is usually that the drug provides an inherent, biologic reward and/or that it has strong reinforcement value due to its prevention of withdrawal pain (Wikler 1973). This assumption is part of a wide range of theories of addiction (cf. Bejerot 1980; Dole 1972; Goldstein 1976a; McAuliffe and Gordon 1974; Wikler 1973). Indeed, the belief that narcotics are irresistible to any organism that, once having tried them, has free access to drugs is the epitome of the exposure model of addiction. The body of work thought best to demonstrate the truth of this belief is the observation that laboratory animals can readily be induced to ingest narcotics and other drugs. No less a biological determinist than Dole (1980) has now declared that "most animals cannot be made into addicts.... Although the pharmacological effects of addictive substances injected into animals are quite similar to those seen in human beings, animals generally avoid such drugs when they are given a choice".

If the behavior of laboratory animals is not locked in by drug action, how is it possible for human beings to become addicted and lose the possibility of choice? One proposal to account for the feverish pursuit of drugs and other human involvements has been that these experiences bring in ordinate pleasure, or euphoria. The idea that pleasure is the primary reinforcement in addiction is present in several theories (Bejerot 1980; Hatterer 1980; McAuliffe and Gordon 1974) and most especially has a central role in Solomon's (1980) opponent-process model. The ultimate source of this idea has been the supposedly intense euphoria that narcotics, particularly heroin, produce, a euphoria for which normal experience offers no near counterpart. In the popular image of heroin use and its effects, euphoria seems the only possible inducement for using a drug that is the ultimate symbol of self-destructiveness.

Some users describe euphoric experiences from taking heroin, and McAuliffe and Gordon's (1974) interviews with addicts revealed this to be a primary motivation for continuing to use the drug. Other research contests this notion vigorously. Zinberg and his colleagues have interviewed a large number of addicts and other heroin users over several decades and have found the McAuliffe and Gordon work to be extremely naive. "Our interviews have revealed that after prolonged heroin use the subjects experience a 'desirable' consciousness change induced by the drug. This change is characterized by increased emotional distance from external stimuli and internal response, but it is a long way from euphoria" (Zinberg et al. 1978: 19). In a Survey of British Columbian addicts (cited in Brecher 1972: 12), seventy-one addicts asked to check their mood after taking heroin gave the following responses: Eight found the heroin experience to be "thrilling" and eleven found it "joyful" or "jolly," while sixty-five reported it "relaxed" them and fifty-three used it to "relieve worry."

Applying labels such as "pleasurable" or "euphoric" to addictive drugs like alcohol, barbiturates, and narcotics seems paradoxical, since as depressants they lessen intensity of sensation. For example, narcotics are ant aphrodisiacs whose use frequently leads to sexual dysfunction. When naive subjects are exposed to narcotics, usually in the hospital, they react with indifference or actually find the experience unpleasant (Beecher 1959; Jaffe and Martin 1980; Kolb 1962; Lasagna et al. 1955; Smith and Beecher 1962). Chein et al (1964) noted the very special conditions under which addicts found narcotic effects to be pleasurable: "It is . . . not an enjoyment of anything positive at all, and that it should be thought of as a 'high' stands as mute testimony to the utter destitution of the life of the addict with respect to the achievement of positive pleasures and of its repletion with frustration and irresolvable tension" (Shaffer and Burglass 1981: 99). Alcoholics' drinking does not confirm any better to a pleasure model: "The traditional belief that alcoholism is maintained primarily as a function of its rewarding or euphorigenic consequences is not consistent with the clinical data" as "alcoholics become progressively more dysphoric, anxious, agitated and depressed during chronic intoxication" (Mendelson and Mello 1979b: 12-13).

Adaptation Theories

Social Learning and Adaptation: Conventional conditioning models cannot make sense of drug behavior because they circumvent the psychological, environmental, and social nexus of which drug use is a part. One branch of conditioning theory, social-learning theory (Bandura 1977), has opened itself to the subjective elements of reinforcement. For example, Bandura described how a psychotic who continued his delusional behavior in order to ward off invisible terrors was acting in line with a reinforcement schedule that was efficacious despite its existing solely in the individual's mind. The essential insight that reinforces gain meaning only from a given human context enables us to understand (1) why different people react differently to the same drugs, (2) how people can modify these reactions through their own efforts, and (3) how people's relationships with their environments determine drug reactions rather than vice versa.

Social-learning theorists have been especially active in alcoholism, where they have analyzed how alcoholics' expectations and beliefs about what alcohol will do for them influence the rewards and behaviors associated with drinking (Marlatt 1978; Wilson 1981). Yet it has also been social-learning theorists who have launched the alcohol-dependence syndrome and who seem to feel subjective interpretation is far less important than the pharmacological effects of alcohol in causing drinking problems (Hodgson et al. 1978, 1979). This lacuna in their theorizing is most noticeable in the inability of modem social-learning theorists to make sense out of cultural variations in drinking styles and experiences (Shaw 1979). Whereas McClelland et al. (1972) offered an experiential bridge between individual and cultural conceptions about alcohol behaviorists have regularly rejected this kind of synthesis in favor of direct observations and objective measurements of alcoholic behavior (embodied by Mendelson and Mello 1979b).

In another area of social-learning theory, Leventhal and Cleary (1980) proposed "that the smoker is regulating emotional states and that nicotine levels are being regulated because certain emotional states have been conditioned to them in a variety of settings" (391). In this way they hoped to "provide a mechanism for integrating and sustaining the combination of external stimulus cues, internal stimulus cues, and a variety of reactions including subjective emotional experience with smoking" (393).

In other words, any number of levels of factors, from past experience to current setting to idiosyncratic thoughts, can influence the person's associations with smoking and subsequent behavior. In creating a conditioning model as complex as this one in order to account for behavior, however, the authors may have been putting the cart before the horse. Instead of conceiving of cognition and experience as components of conditioning, it seems easier to say that addiction involves cognitive and emotional regulation to which past conditioning contributes. In this view, addiction is an effort by an individual to adapt to internal and external needs, an effort in which a drug's effects (or some other experience) serve a desired function.

Social-Psychological Adaptation: Studies that have questioned users about their reasons for continued drug-taking or that have explored the situations of street users have revealed crucial, self-aware purposes for drug use and a reliance on drug effects as an effort to adapt to internal needs and external pressures. Theoretical developments based on these investigations have focused on the psychodynamics of drug reliance. Such theories describe drug use in terms of its ability to resolve ego deficiencies or other psychological deficits—rought on, for example, by lack of maternal love (Rado 1933). In recent years theorizing of this sort has become broader: less wedded to specific child-rearing deficits, more accepting of a range of psychological functions for drug use, and including other substances besides narcotics (cf. Greaves 1974; Kaplan and Wieder 1974; Khantzian 1975; Krystal and Raskin 1970; Wurmser 1978).

Social-Psychological Adaptation: approaches were developed in response to the clear-cut finding that very few of those exposed to a drug, even over extended periods, came to rely on it as a life-organizing principle. What they failed to explain adequately is the great variability of reliance on drugs and addiction in the same individuals over situations and life span. If a given personality structure led to the need for an specific kind of drug, why then did the same people wean themselves from the drug? Why did others with comparable personalities not become wedded to the same substances? What was obvious in the case of narcotic addiction was its strong association with certain social groups and lifestyles (Rubington 1967). Efforts to incorporate this level of social reality led to higher-order theories that went beyond

purely psychological dynamics to combine social and psychological factors in drug use (Zinberg 1981).

Such social-psychological theories addressed the function of drug use in adolescent and post adolescent life stages as a way of preserving childhood and avoiding adult conflicts. They also dealt with the availability of drugs in certain cultures and the predisposing social pressures toward their use (Gay et al. 1973). Finally they presented the impact of social ritual on the meaning and style of use that a person in a given setting adopted (Zinberg et al. 1977). What ultimately limited these theories was their lack of a formulation of the nature of addiction. While nearly all of them minimized the role of physiological adjustments in the craving and response to withdrawal that signify addiction (Zinberg 1984), they provided little in the way of basic mechanisms to account for the dynamics of addiction.

The Requirements of a Successful Theory of Addiction

A successful addiction model must synthesize pharmacological, experiential, cultural, situational, and personality components in a fluid and seamless description of addictive motivation. It must account for why a drug is more addictive in one society than another, addictive for one individual and not another, and addictive for the same individual at one time and not another (Peele 1980). The model must make sense out of the essentially similar behavior that takes place with all compulsive involvements. In addition, the model must adequately describe the cycle of increasing yet dysfunctional reliance on an involvement until the involvement overwhelms other reinforcements available to the individual.

Finally, in assaying these already formidable tasks, a satisfactory model must be faithful to lived human experience. Psychodynamic theories of addiction are strongest in their rich explorations of the internal, experiential space of their subject matter. Likewise, disease theories while seriously misrepresenting the nature and constancy of addictive behavior and feelings are based on actual human experiences that must be explained. This last requirement may seem the most difficult of all. One may wonder whether models built on social-psychological and experiential dynamics make any sense when confronted with the behavior of laboratory animals or newly born infants.

2.1.2 Theoretical Overview on Gender

Over the years several major theories have been proposed to explain gender development. The theories differ on several important dimensions. One dimension concerns the relative emphasis placed on psychological, biological, and sociostructural determinants. Psychologically-oriented theories tend to emphasize intrapsychic processes governing gender development (Kohlberg, 1966). In contrast, sociological theories focus on sociostructural determinants of gender-role development and functioning (Epstein, 1988). According to biologically-oriented theories, gender differences arising from the differential biological roles played by males and females in reproduction underlie gender-role development and differentiation (Buss, 1985; Trivers, 1972).

A second dimension concerns the nature of the transmission models. Psychological theories typically emphasize the cognitive construction of gender conceptions and styles of behavior within the familial transmission model. This model was accorded special prominence mainly as a legacy of Freud's emphasis on adoption of gender roles within the family through the process of identification. Behaviorist theories also have accorded prominence to parents in shaping and regulating gender-linked conduct. In theories favoring biological determinants, familial genes are posited as the transmission agent of gender differentiation across generations (Rowe, 1994). Sociologically-oriented theories emphasize the social construction of gender roles mainly at the institutional level (Lorber, 1994). Social cognitive theory of gender-role development and functioning integrates psychological and socio structural determinants within a unified conceptual framework (Bandura, 1986; 1997). In this perspective, gender conceptions and role behavior are the products of a broad network of social influences operating both family and in the many societal systems encountered in everyday life. Thus, it favors a multifaceted social transmission model rather than mainly a familial transmission model.

The third dimension concerns the temporal scope of the theoretical analyses. Most psychological theories treat gender development as primarily a phenomenon of early childhood rather than one that operates throughout the life course. However, rules of gender-role conduct vary to some degree across social contexts and at different periods in life. Moreover, socio cultural and technological changes necessitate

revision of pre-existing conceptions of what constitutes appropriate gender conduct. Gender role development and functioning are not confined to childhood but are negotiated throughout the life course. While most theories of gender development have been concerned with the early years of development (Freud, 1916/1963; Kohlberg, 1966) or have focused on adults (Deaux & Major, 1987), socio cognitive theory takes a life-course perspective. Therefore, in the following sections, the analysis of the socio cognitive determinants of gender orientations will span the entire age range. Nor is the theory restricted predominantly to cognitive or social factors. Rather cognitive, social, affective and motivational processes are all accorded prominence. Before presenting the socio cognitive perspective on gender development, the main psychological, biological and sociological perspectives on gender differentiations are briefly reviewed.

In contrast to equity feminism, Sommers coined the term "gender feminism" to describe what she contends is a gynocentric and misandric branch of feminism. Gender feminists typically criticize contemporary gender roles and aim to eliminate them altogether. In current usage, "gender feminism" may also describe feminism which seeks to use legal means to give preference to women in such areas as domestic violence, child custody, sexual harassment, divorce proceedings, and pay equity.

Gender feminism characterizes most of the body of modern feminist theory, and is the prevailing ideology in academia. She argues that while the feminists she designates as gender feminists advocate preferential treatment and portraying "all women as victims", equity feminism provides a viable alternative form of feminism to those who object to elements of gender feminist ideology.

Similarly, Nathanson and Young use the term "ideological feminism" to describe a dualist school of thought rooted in Marxist theory. Marxism's concept of perpetual conflict between working-class proletariat and capitalist Bourgeoisie has been replaced with feminist theory that posits perpetual exploitation of women by men, or by a patriarchal power structure. "In short, the names have been changed but not the ideology." Additionally, Nathanson and Young contend that ideological feminism is "profoundly anti-intellectual". Directly or indirectly, many ideological feminists have repeatedly argued that women are psychologically, morally, spiritually, intellectually

and biologically superior to men. This was more explicitly expressed in the late nineteenth century and early twentieth century than it was again in the 1980s. That mentality is now pervasive – not only in academic circles but also in popular culture as well, where it will no doubt endure far longer.

2.1.3 Female Drug Abuse

Drug use among women is being increasingly recognized, many related issues have not been studied nor addressed when developing responses to drug use and/or HIV/AIDS prevention and treatment for vulnerable groups. This is partly due to the limited number of women drug users and the largely subordinate position of women users in the drug subculture. Drug use further weakens the disadvantaged position of women, especially in societies with a high degree of gender inequality. It also increases their vulnerability to intimate partner violence, to drug peddling and/or sex work required to sustain their drug habit and with that the risk of health consequences. The stigma and subsequent social isolation is more severe for women compared to male drug users, which often holds them back from reaching out for help. Research indicates that women are likely to suffer worse health consequences than men as a result of drug use. However, most prevention and care programs for drug users do not reach female drug users because the services are more male-centric.

The situation of the female drug user is more dreadful as there have been very little services available for them. Women may be more biologically and physiologically vulnerable to the HIV virus than men. In addition, social norms, traditional roles and their subordinate position in the social hierarchy leave many women in Nepal with little power to manage their health. All of the above are exacerbated by abuse, coercion, violence, trafficking and poverty, conditions that disproportionately affect women and girls. Women and girls have unequal access to education services which increases their vulnerability to HIV and other diseases and infections. In addition, studies suggest that women become dependent on drugs more quickly than their male counterparts because of their greater physical and psychological vulnerabilities (NCASC).

Sex trade becomes a common source of income for women drug users which results in stigmatization and discrimination as well as making them more vulnerable to HIV/AIDS and other blood borne diseases. Women who are not involved in the sex trade are very often largely dependent on their partners for the procurement and use of drugs. As many women stay 'underground', they remain very hard to reach both in terms of service delivery and in terms of Surveyillance. From the anecdotal evidence available it is clear that female IDUs with a male partner will often share injecting equipment to reinforce relationships and strengthen bonds with their partners. Most HIV transmission among women comes from unprotected penetrative sex but research shows the link to injecting drugs is on the rise. Generally, women's drug use is increasing worldwide. Although the number of female injecting drug users (IDUs) involvement in sex work is high, compared to the total number of sex workers or drug injectors, they can contribute disproportionately to the HIV/AIDS epidemic (NCASC).

Over the years, as a result of social and economic development, women now play new roles in addition to their traditional roles as wives and mothers. The stresses and strains of rapid change have contributed to an increase in the levels of drug abuse in most societies, including women. The factors responsible for the increase in drug abuse among women are related to the roles and responsibilities of women in each society. The real extent of the impact of drugs on women is only gradually gaining the attention of policy of policy makers dealing with matters related to substance abuse and drug trafficking.

Women in general are centrally involved as sexual partners of male IDUs, as careers of people with HIV/AIDS, STI, tuberculosis and other blood borne diseases. The links between drug use, HIV and gender in developing regions are not yet well understood and needs further exploration. It is clear, however, that the problems surrounding HIV and gender are greatly compounded when drug use is an added factor (MOH/UNDC).

Empirical Review of FIDUs

The drug user Survey undertaken in Nepal in 2007 estimated that 7.2% of the drug using population were women and recognized that their issues differ from those of male drug users. Efforts have been made in the past few years to address their needs

by setting up female specific drop in centers (DICs) and extending support for free treatment of substance dependence.

Recognizing the need for a more comprehensive study on women drug users and related aspects, UNODC, in partnership with the Ministry of Home Affairs and the National Centre for AIDS and STD Control, Government of Nepal conducted the study titled "Profile, Drug use pattern, Risk Behavior and Selected bio-markers of Women Drug Users from Seven Sites in Nepal". The study aimed to understand the profiles, substance use patterns and risk behaviors of women drug users based on one-to-one interviews and selected bio markers related to Sexually Transmitted Infections (STIs), including HIV. A total of 393 women, including 323 injecting and 70 non injecting drug users, were interviewed across seven sites in Nepal, namely Kathmandu, Lalitpur, Kaski, Rupandehi, Chitwan, Sunsari and Morang, all being located within the two designated HIV epidemic zones in Nepal (UNODC/NCASC-MOH Report 2008).

Drug use among females is highly alarming which has been going unnoticed by the government as well as the communities. Thus, female who use drugs are two times vulnerable to HIV/AIDS,STI, respiratory infections and other blood borne infection as well as double stigmatized and discrimination. Millions of dollars have been invested to build the capacity of drug users. However the bitter truth is female drug users have been excluded most of the time from such events and opportunities. There have been advocacies regarding the equal opportunities and there again female part has been excluded and ignored by everybody. Narconon Nepal has estimated that about 24,000 female substance users exist in Nepal whereas we have no actual demographic data in the Home Ministries or in our drugs users' network organization. Out of 24,000 female drug users 80% of female drug users have multiple sexual partner and most of them are infected and because of the orthodox society they were kicked out from their house and they stayed in slum area with their partner, not only for shelter but the truth is hardly they eat food. Because of smoking and drug using habit they are more vulnerable to lung infections. Sad but true, these events show that female has always been excluded from such opportunities in regard to male parts. There has been no proper intervention from any part of the NGOs, INGOs, government or society, even the drug users' community, in favors of females' drug users. Still government, INGO

and NGO didn’t focus in their mental health problem, substance users they complain that they have gone through frustration, depression, anxiety, illusion, hallucination, delusion and suicidal tendencies. But still there is no implementation in the service provided to them, as well as government, INGO and NGO didn’t focus in their mental health problem.

By this time it has been clear that the female drug users are in desperate need for drug treatment with other related services like psychological support and to launch this program we need to awake our government, INGOs and NGO by providing clear evidence about the mental health problem and other physical problem in substance users, (Meena Panday, Naya Goreto 2010).

2.2 Review of the Previous Study

A study on alcohol and drug use among street children in Nepal stated that main source of drugs for drug users was found to be drug seller that are 35.3%, friends (35.3 percent) , pharmacy 11.8% and from other sources (17.6 %) (Dhital 2001). A study found that peer pressure and culture were the dominant factors to influence the drug use behaviors, showed that 50 percent of IDUS started to take drug due to peer pressure, 29 percent due to self curiosity and 17 percent due to tension and frustration (Rai 2000).

Researches show that the risk periods for drug abuse are during in children's lives. The first big transition for children is when they leave the security of the family and enter school. Later, when they advance from elementary school to middle school. They often experience new academic and social situations, such as learning to get along with a encounter drugs for the first time. When they enter high school they face additional social, emotional and educational challenges and exposed to greater availability of drugs, drugs abusers and social activities involving drugs, these challenges increase the risk of taking drugs. Similarly, when young adult leave home for college and work their risk is increased (NIDA 2002).

Dr. Mohit Ahmad states that the causes of drug abuse are complex and there is always in interaction of many biological, psychological, socioeconomic and cultural causes.

The main causes are availability of drugs, immigration, unemployment, and parental attitude, absence of love, group pressure, and enjoyment (Mohit 2002).

A study conducted in Kathmandu valley among injecting drug users found that more than three quarters of the respondents were found to use drugs for the sake of enjoyment, only 11.5% mentioned the pressure from friends prompted them to use drugs, fewer were those who said that it was due to stress. It also revealed that the cause for using parental drug was to enhance 35.6% for pleasure and 30.8% due to curiosity. For them it was the person's internal forces, rather than any external reason which played role in the use of drugs. This study also found that all the respondents were male ranged from 17-40 years, majority were in the age group of 26-30 years, majority were single, Hindu and Newars, closely followed by Chhetri. Unemployed (37.2%) were the largest occupational group. More than 60% had completed their high school / monthly income of the family was ranged from Rs 2,000-1, 50,000, for majority it was in the range Rs 10,000-59,000 more than 75% were drug users for more than 5 years. More than two thirds had their expenses in between Rs 100-300 daily (Ojha S.P. et al 2002).

Niraula and Pun concluded in their study that the main cause of drug abuse is self curiosity (40%), 20% due to family problem, 14% due to peer pressure, 9% due to entertainment, 7% due to financial problem, 6% due to failure in love affair and 4% due to search for identify. The majority of them 7.4% started to take drug between the age of 15-20 years (Niraula and Pun 2002).

A Survey was conducted on 'Injecting and Sexual Behaviours of Male Injecting User in Kathmandu Valley'. Its overall findings indicated that most of the respondents perceived that peer pressure was the main reason for initiating drug use, they thought that if they did not take drugs they would be ridiculed or avoided by friends. Some started after conflict with family members; someone considered them as hero and gang fighter after taking drug. Some reported that he started to improve his memory power for securing a better outcome in his exams. Most of the respondents (57.14%) had initiated non injecting drug when they were aged between 15-19 years. Similarly 50.79% respondents had started injecting drugs when they were age 15-19 years. Among those who initiated taking drugs in their 20s more of them initiated injecting

than non injecting drugs probably because of the initiating of non injecting drugs during adolescence. More than one third of the respondents switched from non injecting drugs to injecting drugs within one year following the starting of non injecting drugs such as phensidyle and other tablets, about one fifth respondents shifted to injecting drugs after 2-3 months of taking non injecting drugs (CREHPA 2002).

According to the study conducted of Maskey its outcome revealed that peer pressure and self curiosity were the dominant factor to influence the drug use behaviours and pattern of IDUS. He found that out of seventy respondents 44.28% started to take drug due to peer pressure and other 44.28% started due to self curiosity and the remaining (4.42%) started due to the tension and frustration (Maskey 2002).

It was found that some of the reasons of taking drug as reported by the clients were friends influence, poor relation with parents at home, frustration in study, unhappy material life, lack of affection from spouse and lack of interest in day to day life, and as an alternative to alcohol. This was particularly true for village people who were drinking alcohol regularly and were not able to give it up so choose to smoke cannabis in place of alcohol. This study also showed that majority of alcohol users were adolescents or adults (86%), unmarried (53.7%), unemployed and 32.7% had got school level education, Hindu (67.4%), Gurung (33%) and all were male (Upadhaya 2002.)

A study conducted in Pokhara shows that the main reason for initiating drug was peer pressure (38%), relaxation (20%), curiosity (12%), family tension (10%), educational failure (10%), tragedy (6%) and sexual satisfaction (4%). The main causes of relapse of the respondents was found due to friends and companionship, family tension, physical and mental dependency that is 29%, 21%, 13% respectively. The other reasons were problem of belief, unable integrating in society / family, unemployment and poor self control. The majorities of them were Gurung (34%), Hindu (48%), and male (98%). The mean age was 23.9 years, 62% were between the age group of 21-25 years, 4% were illiterate, 50% of them had got secondary level education. Most of them (66%) were married, unemployed (34%), from nuclear family (62%), and got drugs from friends (31%). The majority of the respondents' fathers' occupation was

army (30%). Most of the respondents (46%) monthly family income was Rs 5000-15000, most of them (34%) spend Rs 200-300 daily 44% respondents were on the age group between 16-19 years when they started drug (Sharma 2002).

Researchers have long recognized the strong correlation between stress and drug abuse, particularly relapse to drug use. The conclusion made after the study are:

- Stressful events may influence profoundly the use of alcohol or other drugs. Stress is a major contributor to the initiation and continuation of addiction to alcohol or other drugs, as well as to relapse or a return to drug use after periods of abstinence.

- Children exposed to severe stress may be vulnerable to drug use. A number of clinical and epidemiological studies show a strong association between psychological stressors early in life (e.g. parenteral loss, child abuse) and substance abuse in adulthood (Hanson Glen R 2002).

It was also found that majority of the IDUS (28.75%) were Newar, 23.75% were Chhetri, 13.75% were Tamang, 12.5% were Gurung, 10% were Brahmin, and other remaining were Rai, Tibetian, and Sheikh (Muslim caste). The majority of the respondents (33.75%) were at the age group of 20-25 years, second largest (28.75%) were age group 25-29 years. Most of the respondents (66.26%) were unmarried. Majority of the respondents (25%) were unemployed, the second largest did business and others worked in factory, service holder, student, laboring in the street, driver, tourist guide respectively. No one was illiterate; majority of them (56.25%) got secondary level education and 5% got informal education. Most of the informants (65%) were of nuclear family. The majority of them (80%) started drug below the age of 19 years and majority (51.25%) used ganja in the first time and most of them (35%) paid below 100 Rs for injecting in a day, only 5% paid 500-600 per day. Majorities (43-75%) of their parents were service holder, 37.5% were businessman, 7.5% were farmer and others were worker and drivers (Karki 2004). It was found that among 50 respondents the majority or (82%) were between the age group of 19-21 years, most of them were Rai, unmarried and male (Rai 2003). Most of the drug addicts were between 15-25 years of age and children whose fathers were abroad (Bhadgaule 2003).

A study in eastern Nepal showed that estimated number of total IDUS in eastern Nepal was about 2200 from more than 150 locations, majority of the IDUs were youth, larger percentage (61.5%) IDUS belonged to the age group 20-29 years 11% were below 20 years of age, 28% respondents belonged to the age group of 30-45 years. The median age of IDUS in the sample was 25 years. More than half (53 percent) IDUS were unmarried, about 37 percent were currently married and living with spouse. The average age at marriage was 20 years. Only 5 percent of IDUS were illiterate, about 15 percent had received primary level education, 7.1 percent had received secondary level education, 9 percent had received SLC and above educations which show that most of them had received secondary level education (FHI 2003).

It is found that majority of the respondents (45.74%) were in the age group of 22-24 years. The median age of the IDUS was 22 years. Nearly two-third of the IDUs had injected drugs when they were below 20 years. Most of them (56%) were Mongolian, unmarried (66.7%) have received secondary level education, born and live in Pokhara valley. The average duration of injecting drugs was 3.7 years. Median age at the first drug injection was 19 years (New ERA / SACTS 2003).

According to the Survey conducted in Biratnagar it was found that the main reasons for injecting drugs reported by IDUS were curiosity, desperation or feeling boring, love tragedy, job frustration, peer pressure and financial problems. The median age at which they started non injecting drugs was reported to be about 13 years indicating the half of the respondents initiated non injecting drugs before reaching 13 years of age. Out of 16 informants, about one third (5) had begun using non injecting drugs when they were 15-19 years old. One respondent claimed that he begun when he was just 9 years old. On the other hand the median age when they started injecting drugs was 21.6 years. This indicated that in an average it took eight years time to switch from oral drugs to injecting drugs. It was found that encouragement and pressure from friends and senior IDUS and curiosity were the main reasons given for initiating drugs (CREHPA 2004b).

"Neuroscience of psychoactive substance use and dependence summary" showed that the risk factors of drug abuse are environmental and individual. The environmental factors are: availability of drugs, poverty, social change, peer culture, occupation,

cultural norms, attitude, policies on drugs, tobacco, alcohol, etc. The individual factors includes genetic predisposition victim of child abuse, personality disorder, family disruption and dependence problems, poor performance at school, social deprivation, depression and suicidal behavior (WHO 2004).

A study conducted on "Injecting and Sexual Behaviors of Injecting Drugs users in Jhapa, Nepal" found that the main reasons for injecting drug use were curiosity, peer pressure, financial problems, love tragedy and sharing habits while using oral drugs. Among 21 respondents there were 17 males and only 4 were females. The average age at initiating drugs was 21 years for both male and females. The average age at initiating or switching over from non injecting substance among male was 21.3 years and it was almost the same for females. Switching over from non injecting to injecting drugs has been rapid and within a very short span of time of 1-2 years for one third of males. While equivalent number of informants mentioned that they have switched over to injecting drugs after a span of six years for remaining male the time was three was three to five years. They have used 25 different type of drugs in Damak and 28 in Kakadbhita (CREHPA 2004c).

According to NIDA, in more than 20 years of drug abuse research it identified the important risk factors for drug abuse. They are-chaotic home environments particularly in which parents substance or suffer from mental illness, ineffective parenting especially with children with difficult temperaments or conduct disorders, lack of parent child attachment and nurturing, inappropriately shy or aggressive behaviors in the classroom, failure in school performance, poor social coping skills, affiliations with peers displaying deviant behaviors, perception of approval of drug using behaviors in family work, school, peer and community environment (NIDA 2005).

People take drugs to feel good, to feel better, and to do better and curiosity, other risk factors are early aggressive behaviors, poor social skills, lack of parenteral supervision, peer substance use, drug availability and poverty (NIDA 2008.) IBBS Survey 2006 showed that the HIV prevalence among the IDUs in Pokhara has been tremendously decreased from 22 percent to 7 percent (IBBS 2006, Gyawali 2007).

There is strong relationship between genetic and environmental influences and initiation and progression of substance use (Tom Fowler and et al 2007).

According to the Survey conducted by Ministry of Home it is found that there are altogether 46,309 drug abusers in Nepal excluding the user of cigarette, alcohol, cannabis only. Among them 76 percent are below 30 years of age and 73 percent start drug before reaching 20 years of age. Among the drug users in Nepal 14 percent are the students of school and college. Similarly about half of them (49 percent) are the students of class 6-10 and 22 percent are above S.L.C. It is also found that among them 83 percent drug users have started drugs because of peer pressure. Other reasons revealed from this study are curiosity, family environment (stress) and carelessness of parents. Similarly, 21 percent have received drug from their friends and 19 percent get from drug seller (MOH 2007).

2.3 Conceptual Framework

The conceptual framework for this study is based on the three dimensions detouring the life FIDUs. Various factors interplay with each other, leading a normal life woman to convert herself as a drug user, such factors are demographic factors (age, ethnicity, marital status, age at drug use), economic factors (income of family members, occupation, spouse's employment status, alternative income source), stress (poor academic achievement, poor economic status, love tragedy/teenagers /modernism/freedom, unemployment/job frustration, family tension), social factors (peer pressure, broken home/ conflict, lack of love and affection from parents, lack of attention of parents/structural change, lack of knowledge/information and individual factors (curiosity, pleasure seeking, search for identity, beauty/ heroisium) interplay of these factors reinforce a woman to enter in injecting drug use.

2.3.1 Research Variables

2.3.1.1 Dependent Variable: Drug Abuse

2.3.1.2 Independent Variables

Stress

- Poor academic achievement/Economic status
- Love tragedy/Teenagers/Modernism/Freedom

- Unemployment
- Job frustration
- Family tension

Social Factors

- Peer Pressure
- Broken home/ Conflict
- Lack of love and affection from parents
- Lack of attention of parents/Structural change
- Lack of knowledge / information

Individual Factors

- Curiosity
- Pleasure seeking
- Search for identity
- Beauty/ Heroism

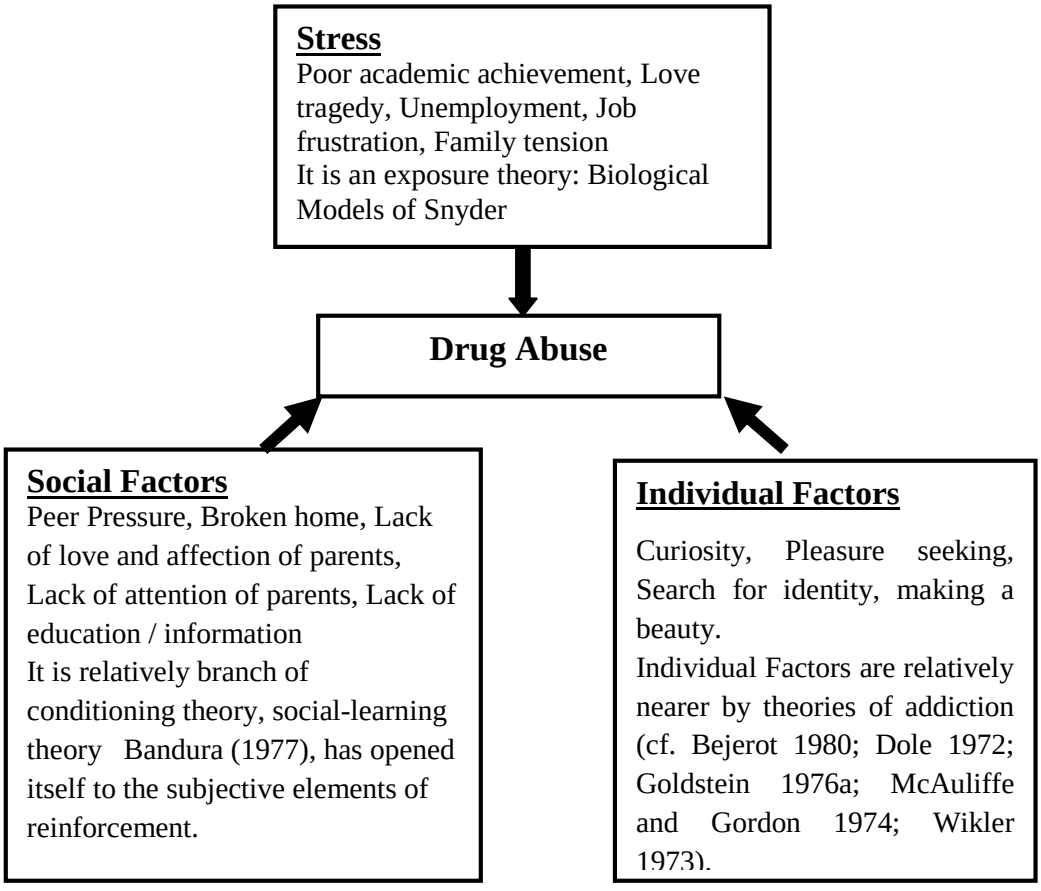

Fig. 1: Conceptual Framework

CHAPTER-III

RESEARCH METHODOLOGY

3.1 Rationale of the Selection of the Study Area

Injecting drug use has been documented in 129 countries, 79 of which also report HIV transmission through contaminated needles, syringes and other injecting equipments. About 13 million people worldwide inject drugs, and about 10% of all new HIV infections globally result from the use of contaminated injecting equipment by injecting drug users. Explosive epidemics have been occurring in many countries of South-East Asia among injecting drug users, namely Indonesia, Myanmar, Nepal, Thailand, and parts of India. Several countries have reported significant numbers of people who inject drugs engaging in commercial sex work, while epidemiological data shows that HIV positive people who inject drugs are infecting their sexual partners through heterosexual route and subsequently to their children.

Although some progress has been made drug abuse creates a lot of social problems like loss of properties, loss of social prestige, dignity and creation of family tensions, frustration, failures, pain, sorrows, cries, tears and numerous other emotional problems, the cost of which remains unmeasured. Malnutrition, weight loss, impaired memory and concentration power and many other physical problems have become the outcome of drug abuse so that many physical, social and psychological problems can arise by drug abuse.

Pokhara lies on an important old trading route between Tibet and India. In the 17th century it was part of the influential Kingdom of Kaski which again was one of the Chaubise Rajaya (24 Kingdoms of Nepal) ruled by a branch of the Shah Dynasty. Many of the mountains around Pokhara still have medieval ruins from this time. In 1752 the King of Kaski invited Newars from Bhaktapur to Pokhara to promote trade. Their heritage can still be seen in the architecture along the streets in Bhimshen Tol (Old Pokhara). Hindus, again, brought their culture and customs from Kathmandu and settled in the whole Pokhara valley. In 1786 Prithvi Narayan Shah added kaski into

his kingdom. It had by then become an important trading place on the routes from Kathmandu to Jumla and from India to Tibet.

Pokhara is highly developed in tourism and modern city of Nepal by adopting western modernism in the Pokhara city. The society of Pokhara has been facing positive and negative impacts of modernism. Mean time the age group of personality carrier development period goes to use drug. Drug addiction is a noted problem in Pokhara city. Solving the drug problem the Ministry of Health, NCASC and UNODC conduct various Surveys and launch different problem now. However most of the studies focus on male drug user, so as to identify why people (especially females) are involved in drug abuse? What are the main factors associated with drug abuse? Which factors compel people to take drugs in Pokhara? Above all are the curiosities of the researcher. If the factors why people become drug users can be explored, why is most of study targeted to male drug users it may be helpful to launch out prevention program for female IDUs in Pokhara valley.

3.2 Research Area

Pokhara Sub-metropolitan city is a tourism city of Nepal. In this city there are various facilities, so people come out leave from every part of countries for various purposes. In Pokhara there are various types of drug users. In the field of male injecting drug user area a little bit studies are made but not in female Drug user. In this research Female Harm Reduction Program Drop in Center Pokhara Sub metropolitan city -8, Shivalaya Chowk and its outreach Spot (Banglung Buspark, Rambazar, Baidam, Lakside, Prithivi Chowk, Naya Gaun, Gharipatan, Deep Kaseri, Bhadrakali) of Naulo Ghumti Nepal are used as research area.

3.3 Research Design

The exploratory research design is used to understand various aspects of the problem or issues of the study, while descriptive research design is used to describe the factor associated for drug abuse, causes and effect of drug abuse. No specific hypothesis has been formulated and no specific variable has been taken as determinant. Descriptive and explanatory research design is used for this research.

3.4 Nature and Source of Data

The nature of data will be both qualitative and quantitative. Primary data of both type are collected by employing research technique i.e. interview schedule, observation, focused group discussion, key informants (peer educator) interview. Interview schedule was the source of generating more qualitative data whereas researcher's DIC and outreach spot observation and key informant interview generate more qualitative data. For making more effective, secondary data are collected from various sources (ie. annual report, monthly plan, client flow chat, logbook etc).

3.5 Universe and Population

3.5.1 Universe: 300 female drug abusers of Pokhara valley are the universe.

3.6 Sample Population

100 female injecting drug users (out of 300, who are recorded in NGN) who are involved in intravenous drug use attending in Female Harm Reduction Drop in Center and its Outreach Spot Shivalaya Chowk , Pokhara Sub metropolitan city -8, of Naulo Ghumti Nepal, during the period of data collection are used as study population.

3.7 Primary Data Collection Tools and Techniques

During the research period primary data are collected directly from the study area. By developing the structure and non structured questions interview are taken with respondents of Female Injecting Drug Users. Another source of primary data is direct observation of outreach Spot, Drop in Center by the researcher. Interview with peer educator, community mobilizer and outreach worker, program coordinator, councilor, paramedical assistant and some case study are other sources of generating primary data.

Sampling Technique: Non probability purposive sampling technique was used.

Data Collection Technique: Interview technique is used for data collection.

Data Collection Tool: Structured interview schedule is used.

3.7.1 Observation

Observation has three components, namely impression, attention and perception and it is one of the important methods of data collection. For this study direct participant observation overt method was used to collect relevant data. Participant observation included establishing rapport with the people and direct collection of primary data from field. Personal observation is crucial for the immediate study of the events. In this study personal observation were made in the field with certain behaviors and different aspect of squatter's life i.e. physical fitness, health status, behavioral condition, and social relationship. Also where female injecting drug user use drug in their vain, their clothes, body language, voice before and after using drug, some of part where they inject are also observed.

3.7.2 Interview Schedule

Interview is fundamentally a process of social interaction and it is one of the primary methods of data collection. This is the flexible and loosely structured format with the questions. In this study interview method was espoused for collecting first hand data. Interview schedule was prepared based on the objective of the research of the study generating both closed as well open-ended question and developed by using the guideline while preparing. Both structured and unstructured interviews were adopted. Interview schedule was checked and verified by the adviser.

Set of questions for interviews were prepared to obtain qualitative data on personal history of the respondent that deals with their socio economic status education and reasons behind use drug.

3.7.3 Case Study

Case studies make the previous history and present status of participants cleared. Some of the selective female injecting drug users were selected for the case study.

3.7.4 Key Informants

For making the research more effective female staff of Naulo Ghumti Nepal, female harm reduction program, who work directly with female injecting drug user, were selected as key informants.

- Parena Gurung-Peer Educator
- Sharmila Gurung-Community Mobilizer
- Kushum Budhatokhi-Outreach worker
- Bin Kumari Gurung –Counselor
- Kamala Rimal- Program Incharge

3.8 Secondary Data Collection

For making more effective research the secondary data were collected basically by means of reviewing related literature and previous research reports. Reports, articles and publications published regarding drug abuse, female drug user annual report of Naulo Ghumti, reports of UNODC, Central Bureau of Statistics (CBS), Nepal, and HOH/NCASC, various websites, other drug related NGO's reports were source of generating secondary data in this study.

3.9 Pretest of Survey

In order to test the schedule prepared, a pre-test (pilot Survey) was carried out. For the purpose, the pilot study was carried out in the respondents having similar characteristics attending in 'Safer Night Program Lakeside, Pokhara and necessary correction were made according to the response. The collected data were checked by the investigator for errors and emission on the same day and ensure the reliability of data. This was more helpful for incorporating new questions or removing unwanted or functionless questions. Furthermore it also helps in measuring the level of questions and respondents.

3.10 Reliability and Validity

- Interview schedule was developed by using the guideline of preparing interview schedule.
- Interview schedule was checked and verified by the adviser.
- Research tool was pre-test and the respondents having similar characteristics attending in safer Night Program lakeside, Pokhara and necessary corrections were made according to the response.
- The collected data were checked by the investigator to ensure the reliability of data.

- Collected data were checked for errors and emission on the same day.
- The data were collected by researcher himself expect some cases (the peer Educator, outreach worker/Community Mobilizer of Naulo Ghumti Nepal).

3.11 Ethical Consideration

Formal permission was taken from the authorized organization i.e. Naulo Ghumti Nepal.

- Objectives of the study were explained to the respondents.
- Informed verbal consent was taken from each respondent.
- All the collected data were kept confidential and anonymous. In some cases we made few photograph after permission of FIDUs.
- Respondents were not influenced by any means to participate in the study.
- The special relationship between the respondents and the researcher was not exploited in anyway.

3.12 Data Presentation and Analysis

In this study quantitative data obtained from structured interview are first processed through validation, editing and coding. Simple statistical methods were used. The result of the study was present with simple and cross tables, bar graph, pie chart and figures. Some case studies were taken during observation and by taking interaction with FIDUs which is presented in case study box.

CHAPTER-IV

INTRODUCTION OF STUDY AREA

Naulo Ghumti Nepal, DIC of female Harm Reduction Program, Shivalay Chowk Pokhara-8, Pokhara Sub-metropolitan city was the study area for this research purpose.

4.1 Pokhara Sub-metropolitan City

Pokhara is a remarkable place of natural beauty. Situated at an altitude of 827m from the sea level and 200km west of Kathmandu valley, the city is known as a center of adventure. The enchanting city with a population of around 95,000 has several beautiful lakes and offers stunning panoramic views of Himalayan peaks. The serenity of lakes and the magnificence of the Himalayas rising behind them create an ambience of peace and magic. So today the city has not only become the starting point for most popular trekking and rafting destinations but also a place to relax and enjoy the beauty of nature.

Pokhara is part of a once vibrant trade route extending between India and Tibet. In these days, mule trains could be seen camped on the outskirts of the town, bringing goods to trade from remote regions of the Himalaya. This is the land of Magars and Gurungs, hardworking farmers and valorous warriors who have earned worldwide fame as Gurkha soldiers. The Thakalis, another important ethnic group here, are known for their entrepreneurship. Based on the administrative division on hierarchical order Pokhara lies in Western Development Region, Gandaki Zone and Kaski District. The valley includes Pokhara Sub Metropolitan City', Lekhnath Municipality, and some other Village Development Committees.

Pokhara is situated in the northwestern corner of the Pokhara Valley, which is a widening of the Seti Gandaki valley. The Seti River and its tributaries have dug impressive canyons into the valley floor, which are only visible from higher viewpoints or from the air. To the east of Pokhara is the municipality of Lekhnath, another town in the valley.

In no other place do mountains rise so quickly. In this area, within 30 km, the elevation rises from 1,000 m to over 7,500 m. The Dhaulagiri, Annapurna and Manaslu ranges, each with peaks over 8,000 m, can be seen from Pokhara and there is a lake named Phewa Tal (Tal means lake in the Nepali language), three caves (Mahendra, Bat and Gupteswor) and an impressive fall (Patale Chhango or Devi's Fall) where the water from the Phewa Lake thunders into a hole and disappears. Due to this sharp rise in altitude the area of Pokhara has one of the highest precipitation rates of the country (over 4,000 mm/year). Even within the city there is a noticeable difference in the amount of rain between the south of the city by the lake and the north at the foot of the mountains.

The climate is sub-tropical but due to the elevation the temperatures are moderate: the summer temperatures average between 25–35 °C, in winter around 5–15 °C. In the south the city borders on Phewa lake (4.4 km² at an elevation of about 800 m above sea level), in the north at an elevation of around 1,000 m the outskirts of the city touch the base of the Annapurna mountain range. From the southern fringes of the city 3 eight-thousanders (Dhaulagiri, Annapurna, Manaslu) and, in the middle of the Annapurna range, the Machapuchare (Nepali language: Machhapucchare: 'Fishtail') with close to 7,000 m can be seen. This mountain dominates the northern horizon of the city and its name derives from its twin peaks, not visible from the south.

Originally Pokhara was largely inhabitated by Brahmins, Chhetris and Thakuris (the major villages were located in Parsyang, Malepatan, Pardi and Harichowk areas of modern Pokhara) and the Majhi community near the Fewa Lake. When the Newars of Bhaktapur migrated to Pokhara, they settled near main business locations such as Bindhyabasini temple, Nalakomukh and Bhairab Tole. Newars also brought many cultural dances like, "BHAIRAB DANCE, TAYA MACHA and LAKHE DANCE" which add cultural diversity of the Pokhara. After the British recruitment camp was shifted here Magar and Gurung communities settled here in large numbers coming down from the hills. At present Gurung (Tamu), Khas (Brahmins, Chhetri, Thakuri and Dalits) form the dominant community of Pokhara and the nearby hill areas in terms of population. Sizeable population of Newari community is also present within the Pokhara metropolitan area, however, in adjoining areas of Pokhara there are no

Newar settlements. A small muslim community is located on eastern fringes of Pokhara generally called as Miya Patan.

4.2 Naulo Ghumti Nepal

Naulo Ghumti was started as a program by the International Nepal Fellowship (INF) in 1995. In the beginning, a day care center and outreach work for Harm Reduction was established. The programs have been gradually extended into Counseling and Treatment Centre with day-care and residential facilities, a community based Drug Prevention Initiative and Vocational Training to ex-drug users. Training and Awareness activities to prevent drug and HIV/AIDS in the community have been intensively implemented at community level.

Naulo Ghumti started getting involved in local, regional and national initiatives as the country becomes increasingly aware of the issues surrounding drug use and HIV/AIDS. These include forging relationships with the other NGOs working in this sector, District Administration Office, the District Police Office, and Drug Control Law Enforcement Unit and the District Public Health Office, District Development Committee amongst others.

Naulo Ghumti was the first program working in the field of drug and HIV related counseling, treatment and rehabilitation in Pokhara. It serves the clients from all parts of Nepal as well as from India, Bhutan and Pakistan. It continues to be the only fully comprehensive prevention of drug use, rehabilitation and relapse prevention program in Pokhara. By 2003, Naulo Ghumti was sufficiently established to be handed over to the management of an executive committee. It became an independent NGO in January 2003, but continues to have close links with INF. It is registered in Kaski District and affiliated with SWC and also approved from Drug Control Program of Home Ministry.

Naulo Ghumti is renowned as a reputable organization, throughout the western region, and all over Nepal. Its name is mentioned in AHRN, Directory of UNDCP/UNODC and in drug related forum. Naulo Ghumti is also the member of NANGAN, NGO Federation, NHRN and Western Region Alliance for HIV/AIDS.

Coupled to the above, Naulo Ghumti has excellent credibility among the national and international community.

Currently NGN is working with the partnership of ICCO, KIA Netherlands, UNODC, FHI360/USAID, VSO-N, European Union, WHO, MDM and UNODC. However, we are still interested to work with other more committed development partners from all parts of the world who share with us, the same vision and mission and are committed to Drug rehabilitation, treatment and HIV/AIDS Prevention programs.

CHAPTER-V

PRESENTATION AND ANALYSIS OF DATA

Relationship between Drug Abuse and Social and Individual Factors

5.1 Distribution of the Respondents by Socio-Demographic Characteristics

Age

Age is a biological factor that contributes to social differentiation. It distributes privileges and responsibilities, rights and duties in terms of separate status (Rao 2005). Age structure is crucial demographic data in examining population characteristics. These demographic variables have direct implications for several issues related to socio economic aspects of population. Such as trend of population, increase labor force, female population in the reproductive age etc. Therefore, age is an important factor for female drug abuser to know by how long they fall to drug by time frame.

Table 1: Distribution of the Respondents by Age

Age Group	Number of respondent	Percent
15-19 yrs	30	30
20-24 yrs	35	35
25-29 yrs	16	16
30-34 yrs	10	10
35-39 yrs	6	6
40-44 yrs	3	3
Total	**100**	**100**

Source: Field Survey-2069.

Above table shows that most of the respondents were in age group of 20-24 years and 15-19 years each comprised of 35 (35%) and 30 (30%). It was found that the least (3%) of the respondents were in the age group of 40-44 years, demonstrated that drug use was common among young adult. 30 % of females began drug at early age i.e. 15 to 19 years.

Address

Address represents the geographical / physical setting of human beings. It shows the people's setting arrangement, density of population and making the service plan. Address supports to find out that female injecting drug user may come from other neighboring districts.

Table 2: Distribution of the Respondents by Address

Address	n=100	Percent	Outside Pokhara Valley	n=18	Percent
Inside Pokhara Valley	82	82	Rural Area	6	33
Outside Pokhara Valley	18	18	Urban Area	12	67
Total	**100**	**100**		**18**	**100**

Source: Field Survey-2069.

Majority of the subjects (82%) were from Pokhara valley and only 18 (18%) were outside Pokhara valley. The respondents who were from outside Pokhara valley were found that 6 (33.33%) out of 18 were from VDC and 12 (66.67%) were from municipality.

Religion

"Religion is the belief of supernatural force that have some influence or control upon world....the supernatural" Malinowski's (distinctive continuation to sociology of religion) has agreed that religion promotes social solidarity by dealing with situations of emotional stress which threaten the stability of society (Haralmbos, 2004).

Religion regulates the activities of people in its own way. It is major component of demography as it has strong effect on people of the country. Religion is one of the important factors/elements of any society which maintains law and order in society. It also guides behavior, thinking and working pattern. Some religious people use drug at the time of baby birth and use of drugs is a kind of religious custom.

Table 3: Distribution of the Respondents by Religion

Religion	Number of respondent	Percent
Hinduism	47	47
Buddhism	45	45
Christianity	8	8
Islam/Other	0	0
Total	**100**	**100**

Source: Field Survey-2069.

Table 3 shows that majority of the respondents (47%) were Hindu, 45 (45%) were Buddhist and only 8 (8%) were Christian. None of the respondents were the followers of Muslim and other religion. Some religious people using drug at the time of baby's birth is a kind of religious custom.

Caste and Ethnicity

Caste and ethnicity is the identification of a person. This makes one group distinct from other. Most of the social codes are established according to culture of caste/ethnicity group. Caste represents any of the heredity such as Hindu social cast Brahmin, Chhetri, Gurung and Newar ethnic group. In Nepali culture some of the Nepali caste use drug pfor any kind of occasions. Mostly the ethnic groups use alcohol for their every function.

Table 4: Distribution of the Respondents by Caste/Ethnicity

Caste/Ethnicity	Number of respondent	Percent
Gurung	36	36
Chhetri	14	14
Magar	15	15
Tamang	5	5
Brahman	6	6
Thakali	5	5
Newar	7	7
Dalit	9	9
Thakuri	3	3
Total	**100**	**100**

Source: Field Survey-2069.

From the above table it shows that 36 (36%) were from Gurung caste followed by Magar (15%). Only 14 (14%) were Chhetris and it was found that Tamang Brahman, Thakali, Newar and Dalit were 5 (5%), 6 (6%), 5 (5%), 7(7%), 9(9%) respectively and the least was Thakuri 3 (3%). In Nepali culture some of the Nepali caste use for any kind of occasions. It indicates that the ethnic group use alcohol for their every function that may help for their women partner to use drugs. It shows those most female injecting drug users are from the ethnic background.

Education / Occupation

Education in common use is merely the delivery of knowledge, skills and information from teachers to students it is inadequate to capture what is really important about being and becoming educated. Education makes the person able to perceive accurately, think clearly and act effectively to achieve self-selected goals and aspirations. Education is a process of cognitive cartography, mapping your experiences and finding a person's regular work or profession; job or principal activity.

Occupation is an activity on which time is spent by a person to get some benefits for their life sustainability. It is based on personal interest, educational and family background and the activities done by the person.

Table 5: Distribution of the Respondents by Education and Occupation

	Description	**Number of respondent**	**Percent**
Education **n=100**	Literate	97	97
	Illiterate	3	3
	Total	**100**	**100**
Literate **n=97**	Primary	4	4
	Secondary	26	27
	S.L.C. / Intermediate	66	68
	Graduate / Post graduate	1	1
	Total	**97**	**100**
Occupation **N=100**	Service	24	24
	Unemployed	48	48
	Student	16	16
	Business	12	12
	Total	**100**	**100**

Source: Field Survey-2069.

From the table 5 it is found that most of the female drug users were literate (97%) and had got formal education. Out of (97), majority of the respondents (68%) had received SLC/ Intermediate level education followed by secondary level education (27%), (4%) had got primary level education and only one had got higher/Post Graduate level education. This shows that drug abuse was most prevalent among youths. Out of 100 respondents 24 (24%) were service holders followed by the population of unemployed 48 (48%), 16 (16%) were students, least of them were businessmen i.e.12 (12%). Based upon occupation majority of the respondents were unemployed, it showed that unemployed females might involve in sex business.

Marital Status/Type of Family

The marital status is the civil status of each individual in relation to the marriage laws or customs of the country. It shows that the person is marital status of living situation. Marriage is a social union or legal contract between people called spouses that create kinships. Marriage is interpersonal relationships, usually intimate and sexual those are acknowledged. Such a union is often formalized via a wedding ceremony. Many cultures limit marriage to two persons of the opposite sex, but some allow forms of polygamous marriage, and some recognize same-sex marriage. In some cultures, marriage is recommended or compulsory before pursuing any sexual activity.

Family

Family is the basic unit in society traditionally consisting of two parents rearing their children; also any of various social units differing from but regarded as equivalent to the traditional family. Family is more accurately described as a group of people who might not be related by blood or marriage but who sincerely care and love each other. Family is there for you in every step of the way and provides support you could never get anywhere else. Families are the building blocks of any society and have been this way since the beginning. Almost every aspect of our lives involves the term family. In our religion we are part of a “family” of believers.

Table 6: Distribution of the Respondents by Marital status and Types of Family

Marital Status n=100	**Characteristics**	**Number of respondent**	**Percent**
	Unmarried	55	55
	Married	30	30
	Divorced	12	12
	Separated	3	3
Type of Family n=100	Joint	57	57
	Nuclear	43	43

Source: Field Survey-2069.

In table 6 majority of them (55%) were unmarried around one third (30%) were married and only 12 (12%) were divorced and 3(3%) are separated. This shows that drug abuse is common among unmarried population. Majority of them (57%) were from joint family and only 43 (43%) were from nuclear family. Most of the female injecting drug users (55%) used the drug before the marriage. By analyzing the table 6 it is clearly that the person was from joint family is high; father and mother are on service, employed in foreign countries, business and other service. They were with their grandfather/mother. In nuclear family parents did not give enough time to their children for care and they gave much money instead of time and misuse it by their children.

Father and mother's Education and Occupations

Table 7: Distribution of the Respondents by Father and Mother's Education and Occupations

	Characteristics	**Number of respondent**	**Percent**
Father's Education	Illiterate	11	11
	Literate	89	89
n=89	Informal Education	7	7.87
	Formal Education	82	92.13
Level of Education n=82	Primary	22	25
	Secondary	34	38
	S.L.C. / Intermediate	24	27
	Graduate / Post graduate	9	10
Father's Occupation	Service	39	39
	Abroad (Employed on foreign countries)	28	28
	Business	18	18
	Agriculture	10	10
	Labor / Wage	5	5
Mother's Education	Literate	86	86
	Illiterate	14	14
n=86	Formal Education	70	81.4
	Informal Education	16	18.6
n=70	Primary	12	17.14
	Secondary	34	48.57
	S.L.C. / Intermediate	15	21.43
	Graduate / Post graduate	9	12.86
Mother's Occupation **n=100**	House - Wife	53	53
	Business	28	28
	Abroad (Employed on foreign countries)	10	1
	Service	4	4
	Agriculture	2	2
	Labor / Wage	3	3

Source: Field Survey-2069.

Fathers' Education

From table no 7, almost all fathers (89%) of the respondents were literate whereas only 11 (11%) were illiterate. Among the literate fathers 82 (92.13%) got formal education and 7 (7.87%) got informal education. Out of 82 fathers who had got formal education, most of them had received secondary level education i.e. 38.2% followed by SLC/ Intermediate level education (27%), least of them (10%) had received graduate/post graduate level education. It represents that the female drug users were from educated families.

Fathers Occupation

From the table 7 Service, abroad, business and agriculture were the major occupations of fathers of female injecting drug users, most of them (39%) were service holders followed by (28%) abroad workers, 18% were engaged in business and 10% in agriculture. 5 % of the fathers were engaged in labor /wages. Fathers of the respondents have good income source for their expenses so they got money from fathers and used it for drug purpose and did not use as father wanted.

The daughter of service holder father could not keep in touch with their daughters because they got transferred from one place to another place in course of their duty. So the daughter could go out easily and were out of control of mother and enjoyed by using drug. In this study most of respondents' fathers were involved in international projects, government offices and banking/financial institutions some were involved in business complex.

Mothers Education

Table 7 shows that majority of the mothers (86%) were literate, only 14(14%) were illiterate. The mothers who were literate, 70 (81.395%) out of 86, had received formal education and 16 (18.61%) had received informal education, out of 70 mothers who got formal education, majority of them (48.57%) had received secondary level education.

Mothers Occupation

From the table 7 a high proportion of mothers (53%) were housewives followed by mothers involved in business (28%). 4% were foreign workers (abroad) and the remaining was engaged in service and 2 % in agriculture. 30% of the mothers were engaged in labor /wages. It indicates that mostly drug user family member depended on his father's income and mother was gateway to get money from father.

Source of Income and Economic Status

The source of income is related to person's or households occupations. It depends upon the person's education, skill, investment and service. The source of income and economic status are interrelated to each other.

Economic status is an economic measure of a person's work experience and of an individual's or family's economic position in relation to others, based on income,

education, and occupation. When analyzing a family's economic status, the household income, earners' education, and occupation are examined, as well as mutual income, versus with an individual, when their own attributes are assessed.

Table 8: Distribution of the Respondents by Source of Income, and Economic Status

	Characteristics	**Number of Respondent**	**Percent**
Main Source of Income n=100	Service	31	31
	Abroad	27	27
	Business	16	16
	Pension	12	12
	Agriculture	10	1
	Rent	4	4
Economics Status n=100	Less than 6 months	12	12
	6- less than 12 months	14	14
	Only for 12 months	25	25
	More than 12 months	49	49
Alternative Sources of Income n=100	Business	38	38
	Agriculture	20	20
	Rent	18	18
	Pension	16	16
	No	8	8

Source: Field Survey-2069.

Table 8 shows that the main source of income of most of the family of the female injecting drug users was service (31%) followed by working abroad, business, pension, agriculture and rent. Most of the FIDUs' (49%) main source of income was sufficient for more than 12 months. Business was the alternative source of income for most of the respondent's family. Multiple alternative sources of income in their families were found in many families but 8% family had no alternative source of income.

5.2 Distribution of the Respondents by Causes of First Time Drug Use due to Stress

Stress

Stress is a feeling that's created when a person react to particular events. It's the body's way of rising to a challenge and preparing to meet a tough situation with focus, strength, stamina, and heightened alertness. We generally use the word "stress" when a person feels that everything seems to have become too much-he is overloaded and wonder whether he really can cope with the pressures placed upon his. Anything that poses a challenge or a threat to our well-being is a stress. Some stresses get going on and they are good for every person - without any stress at all many say their lives would be boring and would probably feel pointless. However, when the stresses undermine both our mental and physical health they are bad.

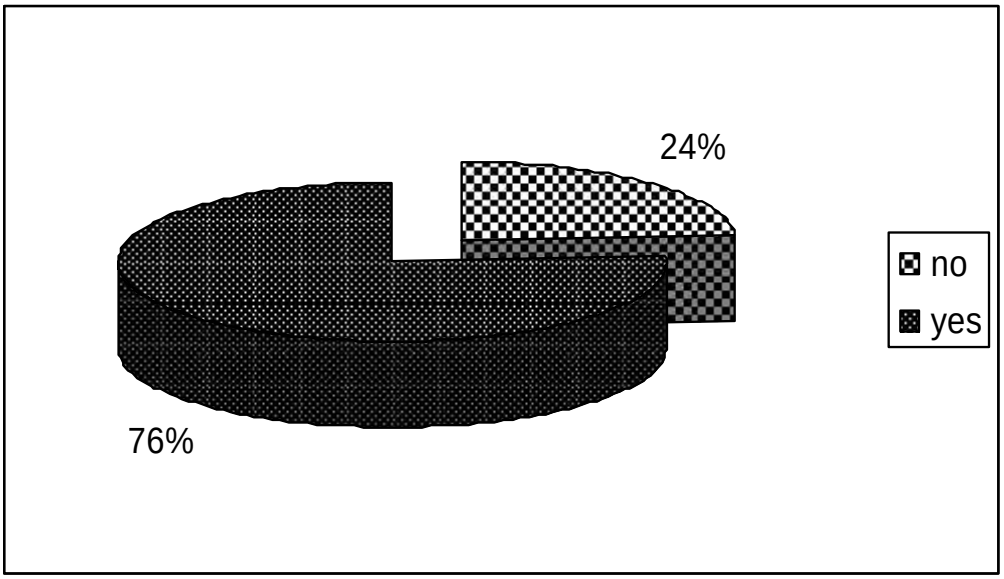

Fig. 2: Distribution of the Respondents by Causes of First Time Drug Use due to Stress (n=100)

Figure 2 shows that majority of the subjects (76%) had not initiated drug due to stress, only 24 (24%) had started due to stress. There is the strong correlation between stress and drug abuse, particularly relapse to drug use. Stress was also major contributor to the initiation and continuation of addiction to drugs, as well as to relapse or a return to drug use after periods of abstinence.

5.2.1 Distribution of the Respondents by Causes of First Time Drug Use According to Type of Stress (n=24)

Table 9 Distribution of the Respondents by Causes of First Time Drug Use According to Type of Stress

Type of Stress	Number of respondent	Percent
Family Tension	16	66.67
Love tragedy	4	16.67
Unemployment	4	8.33
Job frustration	4	8.33
Total	24	100%

Source: Field Survey-2069.

Fig. 3: Distribution of the Respondents by Causes of First Time Drug Use According to Type of Stress (n=24)

Figure 3 shows that the majority of the respondents, 16 (66.66%) out of 24, who mentioned the stress as the cause of drug use had initiated to use drugs due to family tension followed by love tragedy (16.66%) and least started drug due to unemployment and job frustration both comprised of 2 (8.33%). It shows that the most of stress was created by their own family such as death of mother, step mother, father, low income source, less care to children and remarriage by husband. Stress created from the own family unknowingly and at the end it became broken family. After this kind of situation the female came to street and began using the drug.

5.3 Distribution of the Respondents by Social Factors Leading to Drug Abuse

The social factors are those factors that influence to take drugs such as peer pressure, broken home, lack of love and affection from parents, lack of attention of parents and lack of knowledge/ information. In this study only 84 reported that the reasons for using drug are social factors.

Table 10: Distribution of the Respondents by Social Factors Leading to Drug Abuse (n=84)

Social Factors	Number of respondent	Percent
Peer Pressure	59	70
Lack of attention of parents	13	15
Lack of education and information	3	3.5
Broken Home	3	3.5
Lack of love and affection from parents	3	3.5
all of above	3	3.5
Total	**84**	**100**

Source: Field Survey-2069.

Table 10 shows that out of 100 respondents 84 (84%) were influenced by social factors. Among social factors peer pressure (70 %) was the main factor leading to drug abuse. Parents attention (15%) was in second position and other were nominal. Most of the drug users came to use drug by their friends i.e. peer pressure. Out of 100, 3.5% respondents had reported that all the social factors were responsible for them to initiate drug abuse and 16 respondents reported that none of the social factors were related to initiate drug abuse. It indicated that the female injecting practice became very high.

Conditioning theories leave open one critical question: What is a reinforcing activity? i.e. peers pressure. The assumption in narcotic addiction is usually that the drug provides an inherent, biologic reward and/or that it has strong reinforcement value due to its prevention of withdrawal pain (Wikler 1973). This assumption is part of a wide range of theories of addiction (Goldstein 1976a :). Indeed, the belief that narcotics are irresistible to any organism that, once having tried them, has free access to drugs is the epitome of the exposure model of addiction.

5.4 Distribution of the Respondents by Individual Factors Leading to Drug Abuse

Individual factors ware factors of the individual such as curiosity, pleasure seeking and search for the identity that lead to drug abuse as mentioned by the respondents.

Table 11: Distribution of the Respondents by Individual Factors Leading to Drug Abuse (n=16)

Social Factors	Number of respondent	Percent
Pleasure seeking	9	56
Curiosity	4	25
Search for identity	1	06
Be beautiful	2	12
Total	**16**	**100**

Source: Field Survey-2069.

Table 11 shows that majority of the respondents (56%) had started to take drugs due to pleasure seeking, 4 (25%) had started to take drugs due to curiosity 6 (6%) had initiated to take drugs to search for identity and 2 (12%) started to be beautiful. It reveals that pleasure seeking is the dominant factor to initiate drug user.

5.5 Relationship between Father's Occupation and Stress of the Respondents Leading to Drug Abuse

Table 12: Relationship between Father's Occupation and Stress of the Respondents Leading to Drug Abuse

Father's Occupation	Number of respondent	Stress	Percent
Service	39	6	25
Abroad	28	1	4
Business	18	4	17
Agriculture	10	9	37
Labor	5	4	17
Total	**100**	**24**	**100**

Source: Field Survey-2069.

Table 12 shows that out of 100 respondents only 24 (24%) respondents had reported the cause to initiate drug abuse to be stress (poor academic achievement, love tragedy, unemployment, job frustration and family tension). Among them the respondents whose father's occupation was agriculture were more likely to initiate drug abuse due to stress (37%) followed by the respondents whose father's occupation was service (25%) business and Labor (17%). The respondents whose fathers were abroad were less likely to have stress leading to drug abuse (4%). From the above analysis it clearly shows that agricultural family has many more stress than other occupation adopted family.

5.6 Relationship between Father's Occupation and Social Factors Leading to Drug Abuse

Table 13: Relationship between Father's Occupation and Social Factors Leading to Drug Abuse

Father's Occupation	Number of respondent	Social Factors	Percent
Service	39	33	39
Abroad	28	25	30
Business	18	14	16
Agriculture	10	8	10
Labor	5	4	5
Total	**100**	**84**	**100**

Source: Field Survey-2069.

Table 13 shows that out of 100 respondents 84(84%) respondents had reported that the social factors were responsible for them to initiate drug abuse. Among them the FIDUs whose father's occupation was service were more likely to be affected by social factors that led them to start drug (39 %) followed by the respondents whose father's were abroad (30%), were engaged in business (16%) and the respondents whose father's occupation was agriculture were (10%) and labor (5%). The social factors include peer pressure, broken home, lack of love and affection of parents, lack of attention of parents and lack of education and information, which were asked in the interview.

Women in general are centrally involved as sexual partners of male IDUs, as careers of people with HIV/AIDS, STI, tuberculosis and other blood borne diseases. The links

between drug use, HIV and gender in developing regions are not yet well understood and needs further exploration. It is clear however that the problems surrounding HIV and gender are greatly compounded when drug use is an added factor.

5.7 Relationship between Father's Occupation and Individual Factors Leading to Drug Abuse

Table 14: Relationship between Father's Occupation and Individual Factors Leading to Drug Abuse (n=16)

Father's Occupation	Number of Respondents	Individual Factors	Percent
Service	39	6	38
Abroad	28	4	25
Business	18	3	19
Agriculture	10	2	12
Labor	5	1	6
Total	**100**	**16**	**100**

Source: Field Survey-2069.

Table 14 shows that out of 100 respondents, 16 of them were affected by individual factors. Among them the FIDUs whose father's occupation was service were more likely to be affected by individual factor factors that led them to start drug (38%) followed by the respondents whose fathers were abroad (25%); the father engaged in business (19%) father's occupation was agriculture (12%); and Labor (6%). The services, business, working abroad or agriculture have significant role to drug abuse because all the respondents seem to be affected by individual factors that inspired them to adopt drug.

5.8 Relationship between Age at onset of Drug Abuse and Stress Leading Abuse Drug

Table 15: Relationship between Age at onset of Drug Abuse and Stress Leading to Drug

Age at onset of Drug	Number of respondent	Stress	Percent
15-19 yrs	30	03	12
20-24 yrs	35	08	33
25-29 yrs	16	10	42
30-34 yrs	10	02	8
35-39 yrs	6	01	5
Total	**100**	**24**	**100**

Source: Field Survey-2069.

Table1 15 shows that out of 100 respondents only 24 (24%) respondents had reported the cause to initiate drug abuse to be stress. The respondents who had started drug abuse when they were below 19 years and in between 20-24 years began to be influenced by somehow any type of stress. Out of 24 respondents 12% had started drug abuse between 15-19 years, due to stress. 8 (33%) had started in between 20-24 years. 10 (42%) had started in between 25-29 years. This showed that stress was the leading cause for drug abuse in the people age between 25-29 years. It means that most of the female (42%) were stressful after reaching the age 25 years. The age of highly reproductive period for female was stressful. Addiction was its strong association with certain social groups and lifestyles (Gay et al. 1973; Rubington 1967).

5.9 Relationship between Age at Onset of Drug Abuse and Social Factors Leading to Abuse Drug

Table 16: Relationship between Age at onset of Drug Abuse and Social Factors Leading to Abuse Drug

Age at onset of Drug	Number of Respondent	Social Factors	Percent
15-19 yrs	30	26	31
20-24 yrs	35	29	35
25-29 yrs	16	14	17
30-34 yrs	10	8	9
35-39 yrs	6	5	6
40- 44 yrs	3	2	2
Total	**100**	**84**	**100**

Source: Field Survey-2069.

Table 16 shows that, social factors were the leading cause for individuals who had started to abuse drug between 20-24 years. Out of 84 respondents, who started to abuse drug between the age of 15-19 years, 26 (31%) of them were influenced by social factors. As the age grew older, it was found that the social factors leading to start drug was less effective. It means that when they reached the age of 25 years themselves.

5.10 Distribution of the Respondents by Age at Onset of Drug Use

Table 17: Distribution of the Respondents by Age at Onset of Drug Use

Age at onset of Drug	Number of Respondent	Percent
15-19 yrs	30	30
20-24 yrs	35	35
25-29 yrs	16	16
30-34 yrs	10	10
35-39 yrs	6	6
40-44 yrs	3	3
Total	**100**	**100**

Source: Field Survey-2069.

Table 17 shows that most of the respondents (35%) had started to use drug use from 20-24 years followed by 30 (30%) from 15-19 years and the least of the respondents had started to use drug above 40 years. The age below 25 is very sensitive for the socialization and during this age period family and society has gone to opposite to their views and make them stress. Thus female drug abusers are increased. Age is the most important factor for making the people good in future and making more productive. From analysis of above data drug problems on female are settled mostly in between 15 to 25 years of age. During this period females are highly reproductive age so it seems that the drug may be transferred to their generation.

5.11 Distribution of the Respondents by Drugs Use in the First Time

Table 18: Distribution of the Respondents by Drugs Use in the First Time

Name of Drugs	Number of Respondent	Percent
Ganja	58	58
Brown Sugar	28	28
Nitrosun	06	6
Phensidyl	04	4
Fortwin	02	2
Valium	02	2
Total	**100**	**100**

Source: Field Survey-2069.

Table 18 shows that majority of the respondents (58%) had used ganja first time followed by brown sugar (28%), Nitrosun (6%), Phensidyl (4%) Fortwin and Valium users are 2% respectively. Only (2%) respondent had used injecting drug for the first time. From these scenarios we can conclude that the ganja is easily available drug for young people. Reviewing the various studies on drug and drug abuse ganja is mostly entrance window of injecting drug user for both male and female. The reason behind female drug user is that most of them start by their male colleagues.

5.12 Distribution of the Respondents by Source of Getting Drug for the First Time

Table 19: Distribution of the Respondents by Source of Getting Drug for the First Time

Source	Number of respondent	Percent
Friends	78	78
Self	14	14
Pharmacy	04	4
Local Drug Sellers	04	4
Total	**100**	**100**

Source: Field Survey-2069.

Table 19 shows that majority of the respondents (78%) had got the drug for the first time by their friends followed by self (14%) Pharmacy and local drug seller are (4%), which indicates that peer influence is highly dominant factor to start drug. Most of female drug abuser starts to use drug by the pressure of their male friends.

5.13 Distribution of Respondents by Reasons of Injecting Drug Use

Table 20: Distribution of the Respondents by Reasons of Injecting Drug Use

Reasons	Number of respondent	Percent
Fast and long lasting action	43	43
More economical than others	20	2
Greater Satisfaction	17	17
Curiosity	10	1
Substitute of Brown Sugar	4	4
Convenient	2	2
For Beauty	4	4
Total	**100**	**100**

Source: Field Survey-2069.

Table 20 shows that the main reason for preferring injecting drug reported by them were due to its fast and long lasting action (43%) and more economical than others (25%), using injecting practices for grater satisfaction (17%), for curiosity (10%), shortage of brown sugar in the market (4%) easier to use in no time (2%) since it

needed no preparation like that of brown sugar. Out of 100 respondents 4 (4 %) were taking drug for the purpose of beauty and smart.

5.14 Distribution of the Respondents by Reuse/Relapse

Relapse is that case that the drug users make free from their addiction and rejoin to drug use same as past.

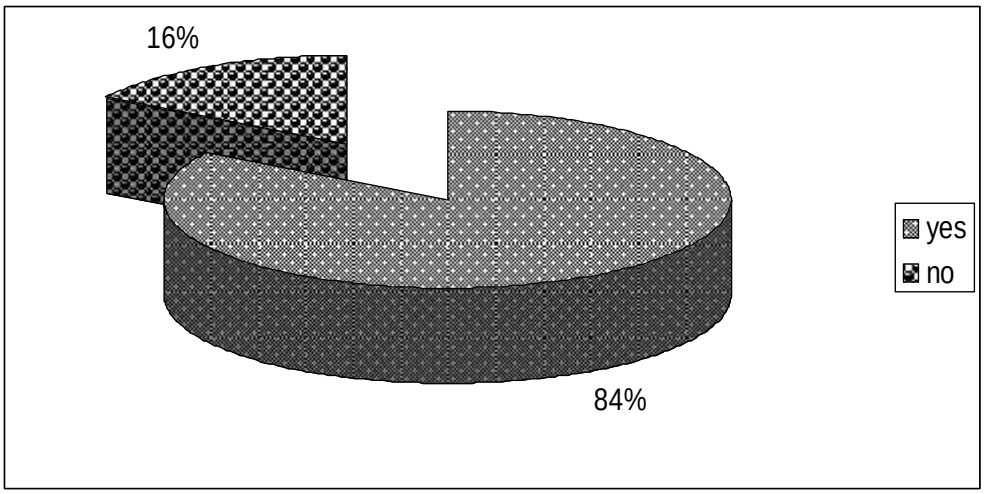

Fig. 4: Distribution of the Respondents by Relapse (n=100)

Figure 4 shows that majority of the respondents (84%) had given up drugs for sometime but could not get rid of drugs. Only 16 (16%) had used drug continuously. The relapse case is common on the drug user. Females are more vulnerable than male in relapse case. Female addicts are more vulnerable to social stigma also because of the traditional mindset and cultural stereotypes. “The parents don’t take their daughters even for treatment fear that they may not be able to marry of their daughters if they are labeled as drug addicts.” Other regions for relapse of female injecting drug user are based upon their boyfriends or husbands who are current drug users and they press reuse of drugs. Mostly the female drug user marriage with male drug users and they compile to her for taking drug. They start to take injecting drug as it is easer to use in no time since it needs no preparation like.

5.15 Distribution of the Respondents by Reasons for Relapse

Table 21: Distribution of the Respondents by Reasons for Relapse (n=88)

Reasons	Number of Respondent	Percent
Peer Pressure	46	55
Physical and Mental Dependence	11	13
Pleasure Seeking	09	11
Lack of Friends	07	8
Prejudiced Behaviors of Family	06	7
Family Tension	05	6
Unemployment	03	4
Lack of Attention from Parents	01	1
Total	**88**	**100**

Source: Field Survey-2069.

Table 21 shows that the main cause of reuse or drugs or relapse was peer pressure followed by physical and mental dependence on drug. It is repeated as peer pressure to begin using drugs.

5.16 Distribution of the Respondents According to the Source of Getting Drug at Present

Table 22: Distribution of the Respondents by the Source of Getting Drug at Present

Source	Number of Respondent	Percent
Local Drug Seller	44	35
Friends	40	32
Boarder Area	24	20
Pharmacy	16	13
Total	**100**	**100**

Source: Field Survey-2069.

Table 22 shows that the main source of getting drug was local drug seller (35%) and 32 % from friends. Likewise broader area and pharmacy is 20 and 13%% respectively. They had reported that their friends were the dealer of drugs; they

occasionally got drugs from pharmacy such as phenargan and avil to mix with other narcotic drugs.

The narcotic drugs were not easily available in the pharmacy these days. Most of the local drug seller and friends were current drug users who sold drug as their using purpose. The respondents reported that if the female injecting drug users sold three doses to other users, she would get one dose free from friends or local drug sellers.

5.17 Distribution of the Respondents by Daily Expense on Drugs

Table 23: Distribution of the Respondents by Daily Expense on Drugs

Cost Range in Rs.	Number of respondent	Percent
Below 200	06	6
200-400	13	13
400-600	06	6
600-800	06	6
800-1000	12	12
Above 1000	57	57
Total	**100**	**100**

Source: Field Survey-2069.

Table 23 shows that most of the respondents (57 %) had their daily expense on drugs above Rs 1000, followed by 13 % who reported their expense was between Rs 200-400, 6% paid Rs 400-600, Rs 600-800 and 12% were paid Rs 800-1000. This shows that most of the respondents had daily expense more than Rs 1000.

It indicates that if one female injecting drug user spends in a day Rs 57000 thousand rupees go to the drug user by a day.

5.18 Distribution of the Respondents by Source of Expense on Drugs

Table 24: Distribution of the Respondents by Source of Expense on Drugs

Cost Range in Rs.	Number of respondent	Percent
Dally work at Hotel/Resturant	45	45
Boy Friends	34	34
Peers	09	9
Parents	08	8
Friends	02	2
Not preferred to say	02	2
Total	**100**	**100**

Source: Field Survey-2069.

Table 24 shows that most of the respondents (45 %) had their daily expense on drugs from working on hotel or restaurant (i.e. sex business), followed by 34 % who reported their source was boyfriend. Parents and peers were 8% and 9% respectively 2% did not mention the source. It is very serious issue for our society that the productive/reproductive age of female has gone in this way in coming future health status and national productive women would gone down and poverty and criminal activities would have been increased. In other way HIV and STI problems will raise and society will have wide discrimination.

CHAPTER-VI

SUMMARY, CONCLUSION AND RECOMMENDATION

6.1 Summary of the Research

Drug abuse refers to the regular use of drugs for other than the accepted medical purpose and to the extent that results in physical and psychological harm to user or used in a way that detrimental to society.

On the background of ever increasing number of drug abusers in the world, factors associated with drug abuse among injecting drug users is thought as relevant topic to be studied. The overall objective of the study is to identify the factors associated with female injecting drug users and the specific objectives of the study are to identify the relationship between social factors and drug abuse. And to identify the individual factors associated with drug abuse. Much of the available research have focused on the male injecting drug users, male rehabilitation center, male focus voluntary testing, counseling centre and social integration for male factors related on male drug users. Lack of reliable information on size and characteristics of drug users was bottleneck in formulating effective plans/programs and implementation.

The theoretical approach of this study is guided by Global biological theory of Addition, Social Learning & Adaptation theory and Gender based theory. The Global biological theory includes inevitability of Narcotic Addiction, Cigarette addiction Alcohol dependence. Likewise gender theory explain in this research social cognitive theory of gender-role development and functioning integrates psychological and socio structural determinants within a unified conceptual framework. In this perspective, gender conceptions and role behavior are the products of a broad network of social influences operating both family and in the many societal systems encountered in everyday life. Thus, it favors a multifaceted social transmission model rather than mainly a familial transmission model.

The research area Pokhara Sub-metropolitan city is a tourism city of Nepal. In this city there are various facilities, so people come out leave from every part of countries for various purposes. In Pokhara, there are various types of drug users. In the field of male injecting drug user area a little bit studies are made but not in female Drug user.

In this research Female Harm Reduction Program Drop in Center Pokhara Sub metropolitan city -8, Shivalaya Chowk and its outreach Spot (Banglung Buspark, Rambazar, Baidam, Lakside, Prithivi Chowk, Naya Gaun, Gharipatan, Deep Kaseri, Bhadrakali) of Naulo Ghumti Nepal are used as research area.

The study is based on cross sectional descriptive study design. The interview technique was applied to collect primary data among 100 female injecting drug users with non probability purposive sampling technique. Simple statistical methods were used. The result of the study was present with simple and cross tables, bar graph, pie chart and figures. Some case studies were taken during observation and by taking interaction with FIDUs which is presented in case study box.

Major Findings

Most of the respondents (35%) are young people of age 20-29 years, majority of them (82%) are from Pokhara valley, 36% are Gurungs, 66% have received secondary level education and 55% are unmarried.

It is found that none of the single factor is responsible to initiate drug abuse. Among 3 major factors studied in this study stress (poor academic achievement, love tragedy, unemployment, job frustration and family tension), social factors (peer pressure, broken home, lack of love and affection from parents, lack of attention of parents and lack of knowledge/information) and individual factors (curiosity, pleasure seeking and search for identity).

Only 24% have reported the reasons the cause of drug use due to stress. While considering the social factors, 70% have reported the cause of drug use due to peer pressure which is found to be the dominant factor to initiate drug abuse. This shows that peer pressure and lack of attention of parents are the main factors of drug abuse.

Portion of the respondents (30%) have started to use drugs when they are 15-19 years of age and (58%) have used Ganja for the first time. The major reason for injecting drug use is due to its fast and long lasting action (43%) and 46% mentioned the cause for relapse to be peer pressure. Most of the respondents (57%) have their daily expense on drugs more than Rs 1000.

Most of the respondents (48%) have started to take drug when they are 12-15 years of old and commonly ganja is used for the first time.

The common transition form of drug use is found smoking Ganja brown Sugar injecting drug. The higher proportion (44%) of the FIDUs have got drug from local drug seller and their friends (40%) for the first time. The reason for preferring injecting drug use is found (43%) to be due to its fast and long lasting action of injecting drug.

Relapse is common among IDUs, 88% have relapse case, 46% of IDUs report that they get relapse due to peer pressure. One respondent have reported that he relapses more than 5 times and he has stayed in different rehabilitation centre of Nepal .If clarifies that self determination and motivation of the drug users are the essence through which they can get rid of drug abuse, not merely the rehabilitation centre.

It's amazing to find that the people of age 40-44 years having grand children are also involved in drug abuse.

Most of the respondents (57%) have reported that their daily expense on drug is above Rs 1000. Their levels of expense show that it is very difficult to fulfill their desires according to their income. Therefore, they look for other alternatives such as stealing, borrowing and selling their own goods, exchange of sex etc.

The strength of this study for the researcher is that it is completely new subject for an investigator so it is very beneficial for her to carry out further study.

The researcher experiences ease in data collection due to good cooperation of the respondents and the members of Naulo Ghumti Nepal. Sufficient literature has been collected from various books, journals, research reports, internet and websites from which the researcher has gained a lot of information on this topic.

Case Study

My Papas Dream and Reality

I am Rupa (changed original name) I was born in a poor family. My mum was simply a housewife and my papa was daily paid worker. However, he had a dream and I used to go in private boarding school to flourish my father's dream. Like other family, my papa loved me more than my brother. He proudly used to say my daughter would get scholarship and be a nurse and serve people. No doubt my childhood days were very happy and everyone loved and cared me. I loved my school days very much and used to get good position in my class. My family members liked me as well as they appreciated my performance. Days, months and years rolled down. I was in class 8; my friends were from rich family. Every day they used to bring pocket money in school. Very often they went to restaurant, cinema and disco. I was very jealous to their life. I was so sad to be from poor family. I had also desire to buy new clothes and go to disco and restaurant. Alas! If my parents were reaching they could provide pocket money for entertainment.

Time passed slowly and my interest in study was reducing. Once my friend proposed to me for go to disco. I could not stop myself and agreed with the proposal. A new fun with many friends and enjoyed a lot at disco. That day I laid my papa saying that I was with my friend and studying at her house. I tasted beer for first time that night. I was waiting for invitation to attend disco by my friends. I started to take alcohol and drugs like brown sugar and started to inject in my warm blood. My relation with family was badly broken and I was very far from my carrier. In this way day by day I was turned into futureless and passive like a lifeless person.

Fortunately, during this course I came across with outreach worker of NGN. He supplied syringe for us and inspired to visit NGN. I started to visit DIC of NGN daily. I was suggested to get rid of drugs. The outreach worker interacted with my family members which had developed sympathy on me.I felt very easy with them and decided to free from drugs as my past experience was very dark and painful. At any cost I determined to get rid of drugs and bad habits. It has been two years, I was free from drugs and I am trying to forget past mistake and making for future plan. Few months later I met my friend Rojani, She was very happy and getting

Cont…..

fashionable clothes and having a handsome boy and a new car. The reason behind it was that she is a local supplier of drug. She purposed me a good business partner then I made confusion and said ok. After 3 days I was arrested by civil police during the dealing with other drug buyer.

Now I am in jail Sorry parents forgive and forget me.

"God never Close one Door without Opening Another"

I am Saloni (Change original Name) 22 years beautiful girl, I had been taking drugs since the age of 15. I had 11 members in family. There were some circumstances that may become a chronic drug user. My father, a British army officer had to live overseas most of the time and it was too easy for manipulate my mum. Slowly, I could not concentrate on my study and started using drugs. After long time period, I became totally depended on drugs. I was physically, mentally, spiritually and emotionally bankrupted. I used to continue my addiction life, so I had to do like stealing in home, police harassment and many physical sicknesses including a time remembered when I was in a stage, could not even sleep in the night.

Mean-time I had mostly problem for taking drug in easy way. One day I met my intimate friends Raju (Changed Name) he was very brilliant student of my school, but he also fell to drug by 2 years after me. Raju asked me for small drug seller and I agreed to do. So it was my pleasure for taking drug in easy way.

When I knew about illegal selling of drug which is very dangerous then I asked NGN staff for job but they counseled me to go home and continue study. When I tries to go back home my family member did not pay attention to me, then I decide to go to visit my friends Saloni who was a dancer of Lakeside. With the support of Soloni now I am working in one hotel and getting money and taking drug as my wish. Now I have no problem for living in Pokhara city and getting drug. In my opinion and feelings:

"God never close one door without opening another".

Me with Drug

This is me Aarati (Changed original Name), 30 years married woman living in my own house. My association with alcohol addiction subsequently to drug addiction began during my school days. To ensure that I had a proper education I was sent to a boarding school.

Being away from the family was always emotionally trying and I had to constantly adjust to the changing environment. Although today I understand well their intention, at that time I felt neglected and was full of resentment. To cope with emotional insecurity and my low academic grades, I instinctively drifted towards the male group of friends who introduced me to alcohol. I was only 15 years of age. I started seeking instant refuge in illegal activities to deal with the daily pressures of survival. After marriage, I was unable to join my husband who was working in a different country, due to complications during my second pregnancy. The feeling of being neglected and insecure grew even stronger.

I drowned my sorrow by drinking with old schoolmates and frequenting night clubs and bars. Gradually I began taking pharmaceutical sedatives and heroin. Things became worse when one day my husband discovered my dependence on drugs. With no regular source of income, I started experimenting with injecting pharmaceuticals intravenous drugs such as tidigesic, norphine which were very easily available. I was regularly arrested by the police officials. I was admitted for detoxification at treatment centers several times and was unable to quit drugs and had episodes of frequent relapses. Again

I am play with drug and fully enjoy with it.

6.2 Conclusion

The study entitled 'Factors Associated with Drug Abuse among Injecting Drug Users is came out by attending Harm Reduction Program's of Naulo Ghumti Nepal, Pokhara with overall objective to find out the factors associated with drug abuse. The study is conducted among 100 female injecting drug users by applying cross sectional

descriptive research design, non-probability purposive sampling technique and technique of interview is used to collect data.

The IDUs whose fathers are engaged in service are found to be more affected by social factors. Whatever may be the father's occupation, it was found that it has no significant role to initiate drug abuse due to individual factors. The IDUs who have started to use drug when they are 15-19 years are more affected by stress leading them to abuse drug. The IDUs who have started drug below 12 years of age are found more affected by social factors to initiate drug. As the age grew older to start the drug abuse, it is found that the social factors leading to start drug are less effective. Peer pressure is very high both type of female injecting drug user i.e. from beginning period and relapse time. Irrespective of the age of IDUs while initiating drug use, each and every IDUs is affected by one more individual factors leading to drug abuse.

Drug use further weakens the disadvantaged position of women, especially in societies with a high degree of gender inequality. It also increases their vulnerability to intimate partner violence, to drug peddling and/or sex work required to sustain their drug habit and with that the risk of health consequences. The stigma and subsequent social isolation is more severe for women compared to male drug users, which often holds them back from reaching out for help.

This study suggests that the initiation, continuation and relapse of drug abuse is not the result of single factor but the impact of multiple factors. For the prevention of female drug abuse every people of society and government showed play positive treatment therapy, free psychosocial counseling in police institution, reduce police harassment, rehabilitation package, strike monitoring and stop for illicit trafficking of drug.

6.3 Recommendations

On the basis of the study findings the following recommendations have been made:

- This study was carried out in organizational setting where only a minimum number of sample size was included, therefore, it is recommended for further study in large scale and in the community setting with snow ball sampling technique.

- The NGO/INGO working on drug abuse should give emphasis on prevention programmed and should extend treatment and needle sharing programs.
- It is also recommended for the government to run treatment and rehabilitation centers and government should encourage NGOs to run such activities with financial assistance and drug abuse awareness program should be broadcasted through television, radio and mass meeting for prevention of drug abuse.
- Police and social harassment for the female injecting drug users should be reduced.

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ANNEX-I

INTERVIEW SCHEDULE

Serial No: **Date:**

Part I: Related to Socio-Demographic Data

1. Age: ☐

1. Current Address:

a) Inside Pokhara Valley ☐ b) Outside Pokhara Valley ☐

2.1. If Outside Pokhara Valley,

a) VDC ☐ b) Municipality ☐

3. Religion:

a) Hinduism ☐ b) Buddhism ☐ c) Islam ☐ d) Christianity ☐

4. Caste / Ethnicity:

a) Brahman ☐ b) Chhetri ☐

c) Newar ☐ d) Gurung ☐

e) Magar ☐ f) Dalit ☐

g) Others ……

5. Educational Status:

a) Literate ☐ b) Illiterate ☐

5.1. If literate,

a) Informal Education ☐ b) Formal Education ☐

5.2. If Formal Education

a) Primary (1-5 Class) ☐ b) Secondary (6-10 Class) ☐

c) S.L.C. / Intermediate ☐ d) Graduate / Post Graduate ☐

6. Occupation:

a) Service ☐ b) Business ☐ c) Student ☐ d) Unemployed ☐

7. Marital Status:

a) Unmarried ☐ b) Married ☐ c) Divorced ☐ d) Separated ☐

8. Which type of family do you live in?

a) Nuclear ☐ b) Joint ☐

9. What is your father's education status?

a) Literate ☐ b) Illiterate ☐

9.1. If literate,

a) Formal Education ☐ b) Informal Education ☐

9.2. If formal Education

a) Primary (1-5 Class) ☐ b) Secondary (6-10 Class) ☐

c) S.L.C. / Intermediate ☐ d) Graduate / Post Graduate ☐

10. What does your father do?

a) Service ☐ b) Business ☐

c) Agriculture ☐ d) Labor / Wage ☐

e) Abroad ☐

11. What is your mother's educational status?

a) Literate ☐ b) Illiterate ☐

11.2. If Formal Education

a) Primary (1-5 Class) ☐ b) Secondary (6-10 Class) ☐

c) S.L.C. / Intermediate ☐ d) Graduate / Post Graduate ☐

12. What is your mother's occupation?

a) Service ☐ b) Labor / Wage ☐

c) Abroad/working ☐ d) House - Wife ☐

13. What is the main source of income of your family?

a) Service ☐ b) Business ☐

c) Agriculture ☐ d) Rent ☐

e) Pension ☐ f) Labor / Wage ☐

g) Income from foreign countries ☐

14. Is the main source of income of your family sufficient?

a) Less than 6 months ☐ b) 6- less than 12 months ☐

c) Only for 12 months ☐ d) More than 12 months ☐

15. Are there any alternatives for your family income?

a) Business ☐ b) Agriculture ☐

c) Rent ☐ d) Pension ☐

e) No ☐

Part II: Related to Drug Abuse

1. Have you had any stressful situation before you have started using drug?

a) Yes ☐ b) No ☐

1.1 If yes, which of the following conditions are responsible for it?

a) Poor academic achievement ☐ b) Love tragedy ☐

c) Unemployment ☐ d) Job frustration ☐

e) Family tension ☐

2. Is any of your family members taking drug in that time?

a) Yes ☐ b) No ☐

3. What other factors compel you to start drugs?

a) Peer Pressure ☐

b) Broken home ☐

c) Lack of love and affection from parents ☐

d) Lack of attention of parents ☐

e) Lack of education and information ☐

4. Is it curiosity that leads you to take drugs for the first time?

a) Yes ☐ b) No ☐

5. Did you believe that drugs could give pleasure so you started taking drugs?

a) Yes ☐ b) No ☐

6. Did you start taking drug for the sake of your identity?

a) Yes ☐ b) No ☐

7. At what age did you start taking drugs?

a) Less than 12 years ☐ b) 12-15 years ☐ c) 16-19 years ☐

d) 20-23 years ☐ e) Above 23 years ☐

8. Which drug did you use at the first time?

……...

9. How did you obtain drugs for the first time?

a) Pharmacy ☐ b) Local drug seller ☐

c) Friends ☐ d) Boarder area ☐

10. Why did you prefer injecting drugs?

a) Greater satisfaction ☐ b) Fast and long lasting action ☐

c) More economical than other ☐ d) Curiosity ☐

11. Did you give up drugs anytime after you started to use drugs?

a) Yes ☐ b) No ☐

12. If yes, which factors compel you to use drugs again?

a) Peer pressure ☐ b) Prejudiced behavior of family ☐

c) Lack of friends ☐ d) Pleasure seeking ☐

e) Lack of attention from parents ☐ f) Family tension ☐

g) Physical and mental dependency ☐

13. How did you obtain drugs for the first time?

a) Pharmacy ☐ b) Local drug seller ☐

c) Friends ☐ d) Boarder area ☐

14. How much money did you spend on drugs daily?

a) Below Rs200 ☐ b) Rs 200-400 ☐

c) Rs 400-600 ☐ d) Rs 600-800 ☐

e) Rs 800-1000 ☐ f) Above Rs 1000 ☐

15. From where did you obtain money for Drug?

a) Daily work on hotel & restaurant ☐ b) Boy friends ☐

c) Peers ☐ d) Parents ☐

d) Parents ☐

ANNEX-II

CHECK LIST FOR INTERVIEW WITH KEY INFORMANTS

- Brief description of Female Harm Reduction.
- Main activities for Female Injection Drug User.
- Daily attendance of Female Drug User in DIC.
- Composition of FIDUs by caste, religion, age, marital status, ethnicity and family class.
- Outreach spot or location of FIDUs resident.
- Hunting place and methodology to reach with FIDUs.
- Peer educator role in program and mobilization for this research.
- Issue of currant Female Injecting Drug user.
- Government policy regarding drug abuse.
- Social Discrimination of FIDUs.
- Risk behavior of Female Injecting Drug user.
- Sexual and other exploitation of FIDUs.
- Police Harassment regarding the FIDUs.
- Rehabilitation program for FIDUs.
- Suggestion for rehabilitation

ANNEX-III

PHOTOGRAPHS

Outreach Spot map of Naulo Ghumti Nepal

Interview with FIDUs

Interview and Interactions with FIDUs

Smoking before injecting

Preparing of Injection for friends

Female Inject with support of friends